Birth Junkies: Labor Support and Resistance in American Birth

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Introduction[1]

I once told a stranger. He said, "Oh, what do you do?" And
I told him, "I'm a doula." And he said, "A tulip? What?"
And, invariably, people say, "Is that a midwife?" and you
have to explain the difference.
—*Michelle, doula, on telling strangers about her career*

Over one in every three women in New Jersey entering a hospital to give birth to her baby will have a cesarean section. New Jersey is home of the highest cesarean rate in the United States, a 60 percent higher than average maternal mortality rate, and a 7.8 percent vaginal birth after cesarean (VBAC) rate, providing a unique case for studying American birth practices. As of 2008, the rate of cesarean section in the United States is 31.1 percent; in New Jersey, that figure reached an average of 38.9 percent in 2007 (Grady 2008; ICAN 2008). This figure appears in stark contrast to the World Health Organization's recommendation that the cesarean rate for any country, and hospital, settle between 10 and 15 percent (ICAN 2008). While the medicalization of birth has received relatively little attention from popular media, a small subset of women have taken it upon themselves to reinstate the support role of women aiding women in labor to counter the highly medicalized effects of American childbirth. Enter the doula.

Doulas are non-medical professionals who have been trained to provide emotional and physical support for women in labor. Labor support is both a novel American commodity and hailed as a traditional role for women in the birth process. The study of doulas incorporates a mix of politics, feminism, and humanism that provides an

[1] I intentionally replace standard medical parlance of birth, such as "delivered" or "go through labor" in order to more accurately reflect the viewpoint of most doulas regarding the birth process.

interesting cross-section for a variety of women's issues in America. For example, while families across America are hiring private doulas to ease them through their labor, other doulas may provide reduced rates or volunteer doula services for women whose husbands are serving in Iraq through Operation Special Delivery and support women receiving abortions or who are delivering while incarcerated.

This study uses ethnographic research methods such as participant observation, content analysis, and interviews to situate the role of the doula within the larger framework of American birth. In particular, I hope to shed light on power relations between medical caregivers, patients, and third-party actors within the hospital system. Vocally opposed to the medicalization of American birth, doulas play an extraordinarily liminal role in hospital room dynamics. As non-medical professionals, they both work within the childbirth system they fight against, and yet actively resist the hegemonic power of American obstetrical practices. The word "subversive" becomes apropos when documenting this subset of birth activists and educators who work within "the system," while undermining technocratic standard procedures in a hidden, behind the scenes way.

Furthermore, I will be examining the role of the doula from a critical-medical perspective. This anthropological sub-discipline seeks to show biomedicine as a culturally constructed system of medicine, just like any other medical system, and attempts to highlight issues of power and inequality present in medical systems throughout the world (Farmer 2004; Scheper-Hughes 1995). I hope that this study, in addition to highlighting issues of power, privilege, and agency within American childbirth culture, will also show the dire position in which we currently find American

obstetrics. Despite data supporting the conclusion that the majority of standard procedures for a hospital birth are detrimental to labor progression (Sakala and Corry 2008; Block 2007: 37), these practices continue. Both cross-cultural evidence and scientific studies tell us that allowing a woman to walk during labor aids dilation; squatting, as opposed to the supine position, helps a woman push her baby out by opening the pelvis (BWHBC 1976: 275-277; Davis-Floyd 1992: 86-87; Simkin, Whalley, and Keppler 2001: 263). Why, then, would doctors—mainstream, American, medical care—continue to practice this way? At least a partial explanation of this question includes that within the hospital system of childbirth, there is a reproduction of cultural values that are often enmeshed in patriarchy and capitalist social structures.

While anthropology is not new to the study of gender issues or even childbirth, a significant gap exists in the literature regarding American childbirth and, in particular, doulas. Only sociologists Bari Meltzer Norman, of the University of Miami, and Barbara Katz Rothman, of the City College of New York, have conducted an academic study focusing on doulas. In their research, Norman and Rothman interviewed 30 doulas based in both the tri-state and Miami area over the course of two years. Their interview process included 30 in-person interviews, with fifteen follow-up interviews via phone. Similar to the methods used in this study, Norman and Rothman pulled their informants from membership lists of local and national doula organizations. Their analysis led to a more negative conclusion than my own as to the effectiveness of doulas. Because doulas do not directly challenge doctors and, as they state, the role is predicated on a "deeply gendered role play," Norman and Rothman decide that doulas provide very little concrete help in

an increasingly dehumanized birth system (Norman and Rothman 2007: 265). Success, for Norman and Rothman, is in the "ends," rather than the means: the usefulness of doulas is predicated on the amount of change they effect in the overarching American system of childbirth, such as altering hospital protocol that requires women to be hooked up to an IV and the electronic fetal monitor upon their entrance in the hospital or increasing the amount of VBACs in American hospitals. In this study, I argue that the process by which doulas interact with medical professionals meets doula standards of success, i.e. a woman's personal satisfaction with and control over her birth experience, and incorporates resistance practices that alter the interactions between doulas, clients, and the medical birth system in a more individualistic manner.

The purpose of my research is to dig deeper into the role of the doula. Are they merely fulfilling a "gendered role play," using passivity as their only approach in the face of a medical system they wish to transform? Because cultural anthropology has a long history of attempting to see the world through the eyes of the "other," using ethnographic research methods and a mixture of both emic/insider and etic/outsider perspectives to describe the doula worldview, I view their agency within the hospital differently. Doulas *do* work within the medical system and may seemingly reinforce power hierarchies, but they also resist it. Resistance, subversion, and power plays are often elusive and intertwined and the questions regarding agency within a doula-attended birth abound. If a doula empowers a woman to decide that she needs a cesarean, has she failed to advocate? Or, has she subverted the discourse of power, enabling a woman to have control over her body, coincidentally choosing a highly medicalized procedure? I hope that this study

enables the doula's perspective of her own success in changing a dehumanized medical system to be presented. The world is not black and white, and the gray-ness of our lives and our thoughts would enable us to answer that it is a little bit of both.

Methods

In this study, I interviewed 40 individuals who defined themselves as either doulas, midwives, obstetricians, chiropractors, or clients of doulas over the course of one year. Almost all of those interviewed lived in Northern New Jersey, though one doula and one midwife primarily operated in New York state, but had taken clients in New Jersey. All but one doula was still active, and 24 out of 25 doulas were primarily labor doulas, taking on post-partum doula work periodically. One doula was also a midwife, and another doula was in the process of becoming an acupuncturist. Midwives, obstetricians, clients, and chiropractors were contacted through recommendations from doulas; the doulas were contacted through the Doulas of North America website according to geographical location. To ensure confidentiality, all informants were given pseudonyms.

Interviews were conducted in person for 15 of the doula interviews, two midwives, two clients, and one chiropractor interview. The rest were conducted over the phone. A mutually convenient time and meeting location was chosen to conduct the interviews. A consent form (see Appendix 1) was given to interviewees in person for them to read over, ask questions, and sign. For interviews conducted over the phone, the informed consent statement was read to the person being interviewed and they verbally agreed to the transcription or digital recording of their responses. The interview itself was conducted as

a semi-structured interview where the informant was asked a list of questions that were open-ended so as to enable a broad, more free-form discussion of the informants' viewpoints and feelings toward birth and labor support. Different questions were outlined for doulas, obstetricians, midwives, chiropractors and clients (see Appendices 2, 3, 4, 5, and 6); the questions varied slightly by the end of the study, though no questions were dropped. All interviews were transcribed and coded for major themes. The coding system used was developed specifically for this study and was created through an inductive approach.

In addition to interviewing, I also attended a doula training workshop in Philadelphia, PA for two days, for nine hours per day from April 12 to April 13, 2008. At the training, students were taught the basics of what a doula is, the history of doulas, positions for labor, doula tools and techniques to alleviate pain without medication, and how to deal with non-natural births, such as cesarean sections or stillbirths. Students were able to try techniques on each other, such as the pelvic press in which the tops of a woman's hipbones are pressed together from a support person from behind. All attendees received a certificate of having attended, as well as forms and directions from DONA to become certified doulas.

Many of the doulas interviewed also taught birth education classes. Those most commonly taught were Lamaze, Bradley, and prenatal yoga, though other methods, such as HypnoBirth and Calm Birth were taught by a few of the doulas. I attended at least one session of the three most commonly taught birth education courses and both observed and participated in the activities. The Lamaze course was taught in the doula's home, whereas

Bradley and yoga were taught in a midwifery office and a local YMCA respectively.[2] The number of couples attending each class ranged from one to five, though prenatal yoga was only attended by the mothers. The notes I took in these classes and the doula training were also coded in the same fashion as the interview material and were included in my ethnographic data. Additionally, I coded and analyzed my notes taken at the Midwifery Today conference I attended March 27, 2008 in King of Prussia, PA.

I transcribed all of the interviews I conducted with my informants. To analyze my data, I constructed a code specific to this study to identify common themes within these open-ended interviews. Larger categories included codes for how and when doulas entered their profession, feelings about the medical establishment, and common philosophies of childbirth, i.e. every woman's birth is unique. Within each larger category, subsets of smaller, more specific codes were developed. These codes were written in the margins of transcribed interviews, field notes, and other ethnographic materials. No software analysis system was used in this study. As I developed the outline and theoretical perspective of this study, I visually scanned each interview to find codes relevant to the topic being discussed. For example, in the section of this study where doulas' personal birth experiences are explored, I searched for the code that signified "personal birth story." Stories and examples that I believed to be representative of the larger doula community were highlighted and, later, included in the text.

Predecessors

[2] I attended these classes on June 3 (Lamaze), June 1 (Bradley), and January 14, 2008 (pre-natal yoga).

In his history of social medicine, Michel Foucault described the process of medicalization as "the fact that, starting in the 18th century, human existence, human behavior, and the human body were brought into an increasingly dense and important network of medicalization that allowed fewer and fewer things to escape" (Foucault 1994: 135). In evaluating the discipline of medicine, obstetrics, it is easy to see how the female body, as "biopolitical reality" (Foucault 1994: 137) becomes a terrain upon which cultural values and the power of the state thrive. Critical medical anthropology has a long history of studying this medicalization of body processes, including birth (Davis-Floyd 1992; Davis-Floyd and Sargent 1997; Ginsburg and Rapp 1995; Jordan 1993; Martin 1992; Rapp 2000).

While birth has been studied from a number of vantage points, a prominent theme in critical medical anthropology is "birth as pathology." Doctors, in this analysis, view pregnancy as a disease. From a doula's perspective, one of the women I spoke with lamented that there is no "normal," or baseline expectation for what constitutes a healthy birth. Other researchers, in particular anthropologists Robbie Davis-Floyd and Emily Martin, explain the "birth as pathology" construct as bound to Western notions of femininity and an historical emphasis on "American core values" of science, technology, and patriarchy (Floyd 1992: 47). Both Martin and Davis-Floyd have argued that obstetrical practices reproduce cultural values, such as technology and science, by placing authority in the hands of scientifically trained obstetricians, rather than encouraging the intuitive knowledge of birthing women.

To understand the doula's importance in buffering the often competing desires of the hospital and individual, birthing woman, it is important to understand the interplay between medicine and culture. The materials of American culture, i.e. the obstetrician's tools and photographs of pregnancy shown in popular settings, provide an excellent vantage point from which researchers and academics can see these larger metaphors. In Emily Martin's *The Woman in the Body* (1992), she analyzes birth literature to expose a larger cultural construct of the body as machine. However, because the process of birth implicates a discussion of the "female machine," Western core values suggest that the female body is inherently broken or malfunctioning because it is not the norm, it is not the male body. A woman's labor is "managed" by an attending obstetrician, a word that differs greatly from the, typically, midwife stance of "guiding." It is within this management role that a doctor performs the delivery. It is not the mother who is laboring to birth her baby. As such, the cesarean section, arguably the epitome of medical intervention in birth, is the ideal means through which doctors can control birth, in addition to a woman's conception of herself and body.

In an interview conducted with an informant, Martin documents a woman's conversation with her doctor after a repeat cesarean. She said, "It really showed me how naïve they are: put this woman out of her misery and she'll be eternally grateful for us giving her her baby. I told him about my disappointment, missing the birth, and the pain afterward, and he said, 'Really! Wow! (Martin 1992: 65).'" Because there is a cultural assumption that labor is an excruciating process for both mother and baby, then the procedure that requires little to no labor on the part of the mother is seen as the best in

technology. The doctor manages the birth to such an extent that, it would appear, there is no room for mistake. The baby becomes the perfect product who has been saved from the traumatic event of vaginal birth.

For Robbie Davis-Floyd, birth and death are emotionally-charged and highly unpredictable "rites of passage" within any culture (Davis-Floyd 1992: 45). As such, those who are culturally sanctioned to guide individuals through these life events are likely to rely on strict, ritualistic procedures. She argues that this is especially true in the case of American childbirth, despite obstetrics' vocalized emphasis on science and technology. When hospital procedures diverge from helping a woman to almost purely superstitious rituals, women's health suffers while predominant paradigms flourish. For doulas, their liminal position allows them to question the ritual devices of the doctor, while also guiding women through this transformative event in a slightly, albeit not commonly recognized, socially sanctioned way.

In *Birth as an American Rite of Passage*, Davis-Floyd (1992) details eight "dilemmas" of birth that can be resolved by rituals and beliefs within the obstetrical system. These dilemmas, or contradictions between biological fact and cultural interpretation of pregnancy, include making birth appear to confirm the "Technocratic Model," appearing to control an unpredictable, natural process, enculturating the next generation, among others. One of the more potent, and obvious, dilemmas is removing sexuality from the sexual aspect of childbirth. Related to inhibitions regarding female sexuality, sexuality is also viewed as a "conceptual threat" to the creative powers of technology and science (Davis-Floyd 1992: 69). Doctors are less likely than midwives to

use perineal massage to help stretch the cervix during labor, and the hospital system is also more likely to use Pitocin to augment labor, rather than the overtly sexual techniques of clitoral and nipple stimulation (Davis-Floyd 1992: 69). Such attitudes are also shown today in the online response to a *New York Times* blog announcing the new documentary *Orgasmic Birth*. Comments ranged from utter disgust to religious references arguing that God's punishment for women was to have painful births (Belkin 2008).

A more extreme example of the lack of authority and agency given to women over their bodies and the cultural sanction given to the biomedical discipline can be found in cases of court-ordered cesareans. Anthropologists Susan Irwin and Brigitte Jordan (1987) studied nine cases of court-ordered cesareans to document the ways in which power was maintained in instances of individual resistance. Six of the nine cases resulted in cesarean sections, and, the authors note, the majority of the cases involved women outside of the "mainstream," i.e. immigrants, women of color, and religious women. In analyzing this data, Irwin and Jordan conclude:

> Court-ordered cesarean sections fall along a continuum that begins with those who undergo sections because they are socialized to accept medicalized birthing and ends with those who are forcibly anesthetized. This continuum of coercion extends from symbolic to actual and works to establish, maintain, display, and enforce existing power relationships (327-328).

Ultimately, the lesson learned is that biomedicine, and subsequently, American core values, are naturalized and further legitimized by the state on a very personal level. In more recent years, the American College of Obstetricians and Gynecologists has spoken out against this practice, stating "overriding a woman's autonomous choice, whatever its potential consequences, is neither ethically nor legally justified, given her

fundamental rights to bodily integrity (ACOG Committee on Ethics 2005: 6-7).” The actual implementation of this statement, however, has been countered by the experiences of both doulas and clients in this study and in birth literature at large. For example, while ACOG has specifically stated that it does not support “Patient-Requested Cesareans” in response to the vast increase in cesarean delivery in America in the past three decades (ACOG 2006), Block notes “In 2004, the *New York Times* reported that some 300 U.S. hospitals has banned VBAC, and the 2005 *Listening to Mothers* survey found that 57 percent of women who sought a VBAC were denied the option by either the hospital or their caregiver” (Block 2007: 77). If ACOG were genuinely dedicated to lowering the cesarean rate in America or maintaining bodily integrity in pregnant women, allowing VBAC would be a primary means by which women could bring down the cesarean rate. Thus, when a doula “holds the space” for one of her clients, I maintain that she is directly refuting this lack of authority typically given to laboring women.

From alternative viewpoints to childbirth to mainstream perceptions of pregnant women, cultural values and desires are inevitably projected onto one of the most crucial, and certainly universal, human activities: the creation of the next generation that will, in itself, imbibe the cultural values of its predecessors. As such, studies examining how our own cultural perceptions affect the process of childbirth in America offer unique insight into the construction of scientific facts and their practice. Furthermore, counter-points to the predominant, birth-as-pathology paradigm create means by which we can study and better understand acts of resistance in larger societies in which knowledge and power exist on a hierarchical plane.

Birth junkies

Despite the fact that little research has been conducted on the doula herself, I hope that this study provides more than a glimpse into who and what doulas are. Based on the interviews I conducted and my experiences in doula training and birth education classes, I hoped to document a "re-awakening" of natural birth in American society. In particular, despite an overt appreciation for the technologies of biomedicine, I found that many doulas were finding ways to resist, subvert, or work around hospital protocol on behalf of their clients. Their outspoken understanding of changes that need to be made within the obstetrical system makes doulas a prime group of persons with whom we can better understand how medicine, power, and resistance interplay within a complex, Western society.

My understandings of power and resistance are heavily influenced by Foucault's (1994) analysis of power, de Certeau's (1984) definition of tactics, and John Fiske's (1989; 1993) understanding of resistance. What is particularly unique about doulas, and childbirth in general, is that it almost exclusively concerns women. Unlike most doctors, all of an obstetrician's, or midwife's, patients are female. Emily Martin quotes theorist Antonio Gramsci's (1971) definition of hegemony as "the permeation throughout civil society of an entire system of values, attitudes, beliefs, morality, etc. that is in one way or another supportive of the established order and the class interests that dominate it" (*quoted in* Martin 1992: 23). As such, the power-bloc maintain its power by consistently indoctrinating and perpetuating cultural values through power, i.e. the reality of available

options for action at any given time, and by de-legitimizing any alternatives to the predominant status quo. Resistance, on the other hand, or what John Fiske calls the "social force" (1993: 11), is a means by which the disenfranchised find ways to incorporate non-hegemonic power into their own lives. It is the art of "making do." Jordan and Irwin's conclusions reflect the ways in which hegemony presents itself in American experiences of pregnancy:

> Pregnant women are not collectively organized. When they are together, it is with a few friends, perhaps a sister, or a childbirth class (where the legitimacy of medical discourse, not collective action, is taught). Because of the isolation of most women, refusing a section is a personal act, known only to the women involved and perhaps a few family members and friends. The knowledge that some women resist medical advice is not publicly available to large numbers of people.
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> Hospital staff members, on the other hand, are part of a collectivity: in the hospital, in local professional associations, in the readership of specialized journals… It is this community, and not birthing women, that determines the structure of childbirth and the acceptable alternative practices (Jordan and Irwin 1987: 328).

Doulas can be that unifying collective. From individual birth experience to individual birth experience, doulas are sharing with their clients locally-based knowledge databases. They offer stories from the woman in the next town who refused to accept an IV upon arrival to the hospital; of the woman who chose to squat on the hospital bed to give birth to her baby in a more comfortable position. It is through doulas that this knowledge is collected and shared. Furthermore, it is through doulas that this knowledge is generated. Doulas have first-hand experience of birth and, by organizing around each other and their clients, they are creating a collectivity of pregnant women in such a way that resistance is not only likely, but it is inevitable for women who are part of this birth world.

Of the women I interviewed, a few would call what they do resistance, others would describe it as support, and others would refute any political aspect of what they do at all. In the stories that the doulas told me, I saw women who were, and are, unhappy with the system in which they and other women are giving birth, a life-changing event in any woman's life. As such, they decided to come together and provide support for fellow women. Sometimes, the medical establishment "wins," by convincing a mother to undergo an unnecessary intervention. Other times, doulas enable their clients to find the voice to advocate for themselves and, when that fails, to find ways around hospital protocol that may be impeding a natural or minimally interventive birth. These ambiguities are reflective of Sherry Ortner's findings in her article "Resistance and the Problem of Ethnographic Refusal," in which she states, "Individual acts of resistance, as well as large-scale resistance movements, are often themselves conflicted, internally contradictory, and affectively ambivalent, in large part due to these internal political complexities" (Ortner 1995: 179). I believe that, despite their own self-definitions as feminists, humanists, or apolitical persons, doulas are actively engaging in feminist resistance of a power struggle over women's bodies and, more specifically, childbirth.

As one doula said to me, as we sat on her couch amidst the toys of her three boys, "We have a crisis in maternity care. I don't know why this isn't on the cover of *Newsweek* magazine. And, with movies like Ricki Lake's *The Business of Being Born*, it's a crisis that we are just starting to wake up to."

Who are doulas?

In 1976, anthropologist Dana Raphael coined the term "doula" to refer to a social role in which female labor support figures provided new mothers with physical and emotional assistance during labor and the post-partum period. Having conducted research on the presence of support during birth among other mammal species, particularly primates, Raphael described the doula among humans as, historically, "the woman who came to the home when there was a new baby, cared for the older children, cooked the dinner, bounced the fretting baby, and generally helped the new mother through the early post-partum period" (Raphael 1988: 76). Though the word doula actually means "a woman's servant" in Greek, Raphael argued that a variety of persons could fill the role of support during labor, ideally belonging to the mother's family. In a modern industrial society, travel and career make such kin-based support difficult. At the time when Raphael wrote her article, lactation consultants and birth educators were most likely to fill the role of doula.

Later, when physicians Marshall Klaus and John Kennell accidentally stumbled across the benefits of female support in childbirth, American doulas were developed (Block 2007: 155). Conducting research on mother-infant bonding, Klaus and Kennell found that the presence of their observers was changing the outcome of the births. Women who had an observer in their room had fewer complications during their labor and, subsequently, were better able to bond with their babies immediately after. Further studies led the researchers to publish their findings, adopt the word *doula*, and, later, help found the international doula organization Doulas of North America.

The findings were significant, indeed. In one study of clinic patients in Texas, women with doula support had "half as many cesareans, one-third as many uses of forceps, and minimal requests for epidural anesthesia—11 percent compared to 60 percent among the unsupported group" (Block 2007: 155). Overall averages of the effects of doula support result in a reduction in c-section by 45 percent, a shortened labor by 25 percent, half of the amount of Pitocin use, 31 percent less pain medication, the use of forceps by 34 percent, and a reduction in the use of epidurals by anywhere from ten to 60 percent (Klaus, Kennell, and Klaus 2002: 98).

There are long-term effects as well. Studies conducted by W.L. Woolman (*quoted in* Klaus, Kennell, and Klaus 2002: 104-109) suggest that the use of a doula affects more than just the perception of and actual process of childbirth. Among women who used doulas in Woolman's study, 51 percent were breastfeeding after six weeks, as opposed to 29 percent who did not use doulas; were more likely to be healthy, i.e. not suffering from colds or poor appetite, which is, Woolman argued, likely attributable to the higher incidence of breastfeeding in supported mothers; ten percent versus 23 percent of mothers considered themselves depressed; and 85 percent of labor-supported women reported satisfaction with their partner after the baby was born as opposed to 49 percent (*quoted in* Klaus, Kennell, and Klaus 2002:106-107). Because the use of a doula is more likely to expose women to the benefits of breastfeeding and provide support and control throughout the labor process, the mother's knowledge base and self-esteem are more likely to reflect positively on her relationship with her newborn. As Klaus and Kennell have been quick to note, such findings do not suggest that women who do not use doulas

are less likely to bond with their babies; they do suggest, however, concrete and long-term results that implies the importance of labor support during childbirth.[3]

Doulas themselves are women from a variety of backgrounds. Most, but not all, have given birth themselves. To become a doula, one trains for anywhere from two days to a week, learning the responsibilities of a doula and techniques for pain relief, emotional support, and positions to progress labor. They are non-medical professionals, most often hired privately, though as volunteer groups spring up across the nation, many doulas are working with community- and hospital-based groups to provide labor support to a variety of women.

Concretely, a doula provides emotional and physical support during a client's labor. In general, doulas are contacted by a prospective client, over the phone or through e-mail. They may meet at the client's home or in a mutually convenient location to judge whether or not they make a good team. If the doula is chosen, she will arrange anywhere from one to three prenatal visits with her client to discuss birth preferences, any concerns or worries the mother may have, and to get to know her client better. The doula is on call 24/7. She will generally block off two weeks before her client's due date and two weeks after in anticipation of the delivery. When she receives the phone call that her client is in labor, she will either meet her at home, at the hospital, or at the birth center, depending on what stage of labor she is in and where her birth will take place.

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[3] It should also be noted that the primary users of doula services are women who have the financial means to do so. Doulas are not covered by most insurance plans, which can lead interested middle- to lower-income women to opt out of hiring a doula.

Because the overwhelming majority of American women birth in the hospital, most doula-clients will give birth in a hospital. Often, a doula will meet her client at home because she is choosing to labor at home, waiting until she is further dilated to arrive at the hospital. At home or in the hospital, a doula can assist with breathing techniques, position changes, pressure points, and other suggestions that can help a woman deal with her contractions. She will also provide emotional support to a laboring woman and her family by encouraging her verbally or through supportive touch.

A doula does not replace a medical team of midwives or obstetricians. Nor does she replace the support of a woman's partner or other supportive figures, though a doula will aid in helping other supportive family members and friends become appropriately involved with a woman's birth, to the client's desire. In short, a doula is an experienced woman who, via personal knowledge and the knowledge she acquires through other births and other doulas, provides individual care and support for a woman entering a new phase in her life as a mother. She "recognizes birth as a key life experience that the mother will remember all her life…[and] perceives her role as one who nurtures and protects the woman's memory of her birth experience" (DONA Birth Workshop Manual 2008: 1.1). She is reminiscent of an era when, in Western societies, birth was a community event and other mothers in the area came to offer their advice to a laboring woman.

Because it is not mandatory to be trained to provide labor support, theoretically a doula can be a friend, a kind nurse, a mother, or partner.[4] Any doula should have a deep understanding of the needs of a laboring woman and be committed to being present for and witnessing an important event in another woman's life. As journalist and author of *Pushed: The Painful Truth About Childbirth and Modern Maternity Care*, Jennifer Block wrote, "In North America, social birth disappeared in the twentieth century: women no longer needed labor support because they were unconscious. When women woke up, the doula was roused from a long slumber as well" (Block 2007: 154).

Lay of the Land

In Chapter 1, *History of Birth*, I chronicle changes that have occurred cross-culturally in viewpoints of childbirth. In particular, I document and juxtapose Maya, Japanese, and early American approaches to childbirth as a social event to current, obstetrical and highly-medicalized viewpoints of birth in America. Furthermore, the rise and fall of industrialization that parallels the medicalization of birth is explored alongside a history of natural birth alternatives that arose in response to medicalization. I hope that this chapter situates the reader in the history of American birth in a way that enables an understanding of biomedicine's drawbacks, as well as providing a context for the criticisms of the natural-birth-oriented doula.

[4] There is a definite trend of the expansion of the word "doula." In one of my interviews, a doula referred to herself as "doula-ing" her niece who recently had knee surgery and needed extra help taking care of herself and daily activities around the house.

As stated above, the doula occupies the role of mediator between highly medical hospital procedures and the desires of the individual laboring women, and her support figures. Chapter 2, *Entering the System* explores the doulas' role within the obstetrical system. In particular, I explore the ways in which doulas "submit" to the biomedical view of childbirth. In Chapter 3, *Resistance*, I explain the political, resistance aspect of the doulas' work that I discovered through interviews and participant observation. Through my ethnographic data, I extrapolate methods by which doulas resist and subvert the biomedical system, through education, "holding the space," or alternative tactics that have a direct-parallel in the medical system, i.e. suggesting a woman birth on all fours to deliver a breech baby as opposed to opting immediately for a cesarean section.

In the conclusion, I bring to light the importance and relevance of this research in regard to popular culture. Through the use of contemporary social theory on resistance and hegemony, my aim in this study is to show the gray areas of power and resistance. I hope to incorporate the doula voice into what constitutes "success" in these grey areas when attempting to change the American birth system, one birth at a time.

1.
History

In almost all hunter-gatherer communities, a lifestyle closer to that of our human ancestors, birth is a social event that calls for the support of groups of women who have given birth before.[5] Most often, these women who provide social support also provide "medical" advice in terms of offering past experiences from both their own births, and the births of other women in the community that they have attended (Jordan 1993). This type of birth culture, known as "social childbirth" (Leavitt 1986: 38), existed in colonial America, where women labored with female attendants. The midwife signaled to these attendants, who included friends, family, and neighbors, to come and aid in delivery (Thatcher Ulrich 1990). Understandably, birth practices vary from culture to culture, with a variety of rituals for both mother and baby to highlight their new social roles in any society. However, one near-universal characteristic of human birth includes the support of other women.

Birth from a cross-cultural perspective

In non-Westernized countries, or Western countries prior to the mid-20th century, birth would have taken place at home, regardless of the type of living dwelling. Special foods may have been prepared and many cultures developed rituals to help ease the mother back into her society. These rituals often last between twenty to forty days, which not only allow ample time for healing after a vaginal birth, but provided space for new

[5] Among the !Kung, women labor alone. To go through such a transformation solo proffers the newfound social acceptance of one as a woman, rather than a girl (Davis-Floyd 2008).

mothers to accept and readjust to their new social roles. In Mexico, twenty days after birthing, a woman's midwife will return to her home for a *sobada,* a massage, and to be wrapped and bound around the stomach and breasts (Jordan 1993: 43). This ritual signals the end of the post-partum period and the beginning of resuming normal activities for new mothers. Furthermore, post-partum rituals and treatment may include special diets, bathing rituals, and dress.

It is important to consider non-Western perspectives on birth in order to have a context in which we can place the history of Western birth practices. With the risk of essentializing and exoticizing non-Western cultures in mind, it is also true that many other cultures have maintained a more holistic view of birth in relation to the mental, physical, and spiritual needs of the mother. Anthropologist Brigitte Jordan's (1993) work and Carolyn Sargent and Grace Bascope's (1998) evaluations of "ways of knowing" regarding the distribution of knowledge about pregnancy are examples of this dialogue.

Anthropological studies of birth are often couched in the discourse of local knowledge and ways of knowing, cultural authority, and power discourses (Jordan and Irwin 1987; Davis-Floyd 1992; Jordan 1993). Anthropologist Brigitte Jordan's (1993) work regarding birth and power in high-technology and low-technology situations and Carolyn Sargent and Grace Bascope's (1998) evaluations of "ways of knowing" regarding the distribution of knowledge about pregnancy are an example of this dialogue. For example, among the Inuit of Alaska, an ongoing struggle between local cultural norms and the policies enacted by the federal government have essentially forced women to give birth in a technocratic setting (O'Neil and Kaufert 1988). In the 1960s, colonial

powers “captured” (O’Neil and Kaufert 1988: 59) birth when the government instituted a law stating that no birth could take place outside of a nursing station, a small, government-run outpost for medical care.

In the 1980s, government officials then declared it illegal to give birth in the nursing stations, and that a hospital birth was a necessity. As such women were forced to travel from local communities to hospitals in larger, urban centers, effectively removing them from kin-networks and traditional methods of support. In this particular case, governmental initiatives systematically devalued traditional, Inuit “ways of knowing.” “What defines a relationship of power is that it is a mode of action that does not act directly and immediately on others. Instead, it acts upon their actions: an action upon an action, on possible or actual future or present actions” (Foucault 1994: 340). Following Foucault, Inuit women do not have the possibility of acting out a traditional childbirth, but are legally forced to accept the social legitimacy given to biomedical birth practices because of colonial, white presence in the region.

One of the earliest anthropological studies specifically focusing on childbirth, *Birth in Four Cultures* (Jordan 1993), focuses on birth practices in the Yucatan of Mexico. Midwives, such as Doña Juana, are well-known throughout the community and often provide birth control and pregnancy care for multiple generations of women. Prenatal meetings are arranged in the mother’s home and touch is quite often used as a medical tool in these meetings, i.e. via the midwife’s use of her hands to measure and judge the position of the baby to the traditional massage given to mothers throughout their pregnancies. Women give birth at home, with friends and relatives offering advice

and insight, cooking, and providing other necessities during the process. The childbirth landscape is changing in response to the recent introduction of training courses for Mexican midwives, sponsored by the Mexican Ministry of Health and the National Indian Institute. In these courses, doctors teach the basics of birth, from a biomedical perspective, to traditional midwives. In these classes, doctors often give information without regard to local, cultural perceptions that may inhibit the understanding of Western viewpoints and without a context into which biomedical techniques can be placed. For example, Jordan states, "A disembodied uterus on a screen is, for them, nothing more than a disembodied uterus on a screen, with no necessary connection to the three-dimensional organ they are used to palpating in a pregnant woman's abdomen" (Jordan 1993: 176). Furthermore, in a family planning lecture, teachers did not consider the traditional belief that to avoid pregnancy, it is best to only have intercourse at the mid-point of a woman's reproductive cycle, which is precisely when a woman is most fertile. Such a lack of consideration is representative of asymmetrical power relations and authoritativeness given to different bodies of knowledge regarding the same subject.

Even a comparison of Japanese approaches to birth shows a significantly different perspective to the viewpoint of the American obstetrical system. Medical anthropologist Deborah Cordero Fiedler (1996) found that while the obstetrician supposedly maintains cultural authority in biomedical Japan, Japanese birth culture does not "obviate the need for obstetrical intervention" (Fiedler 1996: 196). Rather, the Japanese view of birth is "that it is primarily a healthy—albeit potentially dangerous—physiological event" which, she says, results in the value of obstetrics being placed on the potential, rather than actual,

use of obstetrical intervention (Fiedler 1996: 196). Images can be potent symbols of cultural perception and such is the case in Japanese medical texts as well. In her lecture at the 2008 Midwifery Today Conference, Davis-Floyd showed images from a Japanese obstetrical text. In the images shown, the fetus was shown inside of the picture or drawing of a woman depicted from head to foot, where only her uterine region was transparent.

By contrast, in *William's Obstetrics* (Cunningham et al. 2005), the primary medical text for American obstetricians, images of the fetus are quite contrary to those shown in Japan. Throughout the text (*for examples, see* Cunningham et al. 2005: 173, 412, and 574), the fetus is consistently viewed as independent of the mother's body. Rather than showing a whole woman, the images only depict a fetus without context—stark borders on a white background where the fetus appears to be floating in air, so to speak. For a more readily comparably contrast, images of the fetus and mother from doula and natural book texts showcase images more similar to those found in Japan. According to Robbie Davis-Floyd's analysis (2008), including both mother and fetus in the picture implies a unity between the two figures. The mother has control over her body and, to a certain extent, the health of her fetus; she is in control of the nutrition she consumes, the amount of exercise she participates in, and her mental state. In *William's*, the fetus is a solitary product. No one is concerned about its nutrition or physical health; the fetus grows alone, its outcome the product of a random universe. Mother is completely out of the picture.

A history of birth in America

In Western cultures, including the United States, Britain, France, and Scandinavian countries, cultural interpretations of childbirth changed drastically in these post-industrial societies. Birth became less of a social and community event and more of a private, medical "problem." In the past, the number of women giving birth in hospitals ranged from five percent in 1900 to 55 percent in 1940 and to 88 percent by 1950 (Davis-Floyd 1992: 26; Leavitt 2003: 239). Today, 98 percent of American women give birth in a hospital (Davis-Floyd 1992: 26). At the hospital, women are given private rooms, and are very much inside of a technology-focused institution, as implicated by a host of standard practices that may or may not have any medical benefit. Such aspects of "protocol" in the hospital environment include introducing an intravenous line in a mother upon arrival to the hospital, episiotomies, a surgical incision of the perineum upon fetal crowning to increase the size of the vaginal outlet, electronic fetal monitoring, and/or the loss of midwifery-based techniques, i.e. external version, or the act of repositioning a breech baby through palpating the mother's stomach.

Laurel Thatcher Ulrich provides a detailed description of birth practices in pre-industrial American in her book, *A Midwife's Tale* (1990), in which she explores the journals of Maine-based midwife Martha Ballard from the late 1700s to the early 1800s. Documenting both professional and personal happenings in the daily life of Ballard, Thatcher Ulrich offers an individualized portrait of what might have occurred throughout towns in all of the colonies when women gave birth. Ballard took detailed notes on the status of her patients, payments, and medicines she used to combat diseases of the era

among her clients. Oftentimes, she would go directly from one labor to another, not unlike many midwives today (Block 2007). Furthermore, her life's work as a midwife provides an excellent example of the tension that arose between midwives and obstetricians during the 19th century.

> There were still midwives practicing in Hallowell at the time of Martha's death, but most of them probably slipped gradually away into the role of assistants to men like Page [a local obstetrician]. This was not because doctors had secrets that midwives did not, but because doctors, being less constrained by other obligations, could now add experience to the book learning that had always been theirs (Thatcher Ulrich 1990: 255).

Ballard herself quarreled with local physicians in her own time as their authority over matters of childbirth grew. Dr. Cony, another practicing physician in Hallowell accused Ballard of questioning his advice to a patient and treating her with her own medicines. While Ballard refuted this claim, it is representative of the willingness on the part of up-and-coming doctors to refute the knowledge of veteran midwives who were, arguably, more experienced in hands-on aspects of birthing knowledge than the young trainees (Thatcher Ulrich 1990: 256; Leavitt 1986: 63). This trend continued, with doctors becoming more and more specialized in the practice of medicine.

A major coup for the obstetrical field came with the development of a special tool, lauded in the post-industrial society: the forceps. In the history of midwifery, barbers were called upon in cases whereupon vaginal birth was judged to be completely impossible. Considered brutal in modern times, midwives faced the decision of whether or not to allow the barbers to "[crush] the fetal skull, [dismember] it in utero, and [remove] it piecemeal" or to "remove the baby by cesarean section after the death of its mother" (Katz-Rothman 2007: 10). More and more women were having problematic

deliveries as a result of urbanization and physical abnormalities that resulted from health problems and the styles of the Victorian era (Block 2007: 23). The Chamberlain family created the forceps in the early 1600s, and then kept the tool secret for three generations. Because there was a large amount of room for error in use of the forceps when they were released for "public," namely male, obstetrical, use (Katz Rothman 2007: 11; Leavitt 1986: 263), the need for training and education further gave obstetricians with skills in forceps extraction a lead in cultural authority, further demeaning the role of midwives in Western culture. This also led to a class of what were, typically, wealthy, white men being trained as obstetricians who had the social capital and means by which to co-opt labor assistance from midwives.

The conception that childbirth is a dangerous life transition, a strong belief still expressed today by obstetricians, arose from the high death rate among mothers in the 19th century. By mid-1850 in Austria, one in eight mothers died from what was known as "childbed fever" (Ewald 2002: 16). Later recognized as puerperal sepsis, it wasn't until physician Ignaz Semmelweiss recognized that women were dying of the same diseases as the corpses doctors were examining in the morgue that the medical community realized that there was a pathogenic connection between the two causes of death. Doctors would often examine bodies in the morgue before conducting pelvic exams on the mothers in the hospital preparing to give birth. Later, antiseptic and hygienic measures were adopted by both Semmelweiss and future doctors, but the aftertaste of massive mortality rates remained in the collective memory of Westerners of reproductive age.

At the turn of the 20th century, obstetrical and hospital care became a luxury of the wealthy that soon trickled down to the lower socioeconomic classes (Katz Rothman 2007: 14-15). Apart from the technical competition being waged between doctors and midwives, a social campaign to demean the midwife was being conducted in America, and abroad. In America, tactics included "advertiz[ing], using racist pictures of 'drunken, dirty' Irish midwives and hook-nose, witch-like Jewish midwives…play[ing] on women's desire to 'become American'" (Katz-Rothman 2007: 14). In Europe, midwives were often pressured to either face "extinction" or organize, which sparked the division between "lay midwives" and "professional midwives," a dichotomy that still exists today. Whereas in Europe midwives streamlined their services and eventually worked side-by-side with doctors in the medical arena, the history of American midwifery took a different route. By 1930, most states had introduced legislation regulating midwives, a standard that led, in some cases, to a criminalization of the practice of midwifery (Block 2007: 217). Consequently, between 1900 and 1950, there was a dramatic shift from home to hospital birth.

It was during this time period that the majority of obstetrical practices were developed and cemented as hospital protocol. The supine position, with women on their backs and legs in stirrups, was created so that the well-dressed obstetrician could have full access to check dilation of a laboring woman, without sullying his clothes (Davis-Floyd 2008). The fear of infection after a woman's water breaking can also be traced back to routine vaginal exams conducted early in the creation of obstetrics, before germ theory had developed (Katz-Rothman 2007: 12; Davis-Floyd 2008). The feminine

standards of modesty in this era also prompted the rise of practices such as enemas, an emphasis on pain-free, or silent, birth, and episiotomies, which often carried an extra stitch "to maintain vaginal tightness for the enhanced pleasure of a sexual partner" and is also ritually interpreted as a way by which "physicians can deconstruct the vagina (and, by extension, its representations), then reconstruct it in accord with our culture belief and value system" (Davis-Floyd 1992: 127-129). During this time period, women flocked to American hospitals to give birth (Block 2007: 214), and as they were doing so, a new concern dominated safe births: pain-free birth.

From the perspective of most doulas and natural birth advocates, the 1950s were the "dark years." Control of women's bodies through childbirth protocol reached its peak in this time period. The concern with pain, one that exists today as well, arose from women's "pain-ridden existence" (Block 2007: 168) during the Victorian era, with the use of corsets and all the difficulties that followed during childbirth. Between the 1930s and 1950s, the medical community ushered in the new hospital-based commodity of "twilight sleep," a concoction of morphine and scopolamine, for pain relief (Block 2007: 23).

Quite often, women themselves were pushing for the increased use of anesthesia in an attempt to control their bodies, quite different from the struggle today. Judith Waltzer Leavitt's history of obstetrics, *Brought to Bed* (1986), describes the consumer push for use of anesthesia in labor, in which women, many of whom were activists, rallied together to encourage the use of anesthesia in the delivery room (Leavitt 1986: 130-131). The problem with twilight sleep was that women could "feel and respond to

pain; the claim [was] only that she [would] not remember what happened. Women in twilight sleep therefore had to be restrained lest their uncontrolled thrashing cause severe injuries as the drugs left them in pain and disoriented" (Katz-Rothman 2007: 17). Furthermore, Leavitt poignantly notes, "Ironically, by encouraging women to go to sleep during their deliveries and to deliver their babies in hospitals, the twilight sleep movement helped to distance women from their bodies (Leavitt 1986: 140)."

One doula interviewed for this study gave birth to one of her three children during the final years of twilight sleep. In describing her experience, she stated, "The medicine didn't help the pain. It just makes you too stupid to complain." Of course, with women unconscious or unable to vocalize needs, the doctor became the primary actor in the actual birth of the child in the 1950s.

There are three actors in the development of the more mainstream natural childbirth movement, namely the Bradley Method of Husband-Coached Childbirth, Lamaze, and Grantly Dick-Read's *Childbirth Without Fear*. Grantly Dick-Read, an English obstetrician, published his book in 1933, in which he argued that pain was not necessary in childbirth. Pain, he said, "arises from the activation of the sympathetic nervous system by the emotion of fear" (Dick-Read 1944: 31), from which he concluded that there was a Fear-Tension-Pain Syndrome that caused pain in otherwise healthy, childbearing women during labor. The solution, he argued, was to overcome fear of childbirth and fear of pain in childbirth.

Not long after Dick-Read's arguments reached the United States, French doctor Fernand Lamaze developed one of the most commonly known types of birth education

courses in 1950. Originally, Lamaze emphasized controlled chest breathing, abdominal massage, called *effleurage*, and an external object upon which a laboring woman could focus. In popular culture, these techniques translated into what are now seen as comical "hoo-hoo, haa-haa" breathing sounds that are often mocked in television shows. Nevertheless, the Lamaze technique was based on the theory of condition response, developed by Ivan Pavlov, and psychoprophylaxis, or "the use of distraction techniques during contractions to decrease the perception of pain or discomfort" (Simkin, Whalley, and Keppler 2001: 170). *Monitrices*, a French precursor to the American doula, were nurses that worked side-by-side with obstetrical teams, aiding mothers in their Lamaze patterned breathing techniques (Raphael 1988: 76). The Lamaze technique was then imported to America by a mother who had given birth in Paris with Dr. Lamaze, Marjorie Karmel when she wrote the book, *Thank You, Dr. Lamaze* in 1959 (Katz-Rothman 2007: 24; Leavitt 1986: 215; Simkin, Whalley, and Keppler 2001: 170). Karmel teamed up with an American physical therapist, Elisabeth Bing, to create the American Society for Psychoprophylaxis in Obstetrics, an organization that is now known as Lamaze International. Having evolved over the years, Lamaze no longer incorporates patterned breathing that has the potential to cause untrained or minimally trained mothers and their partners to hyperventilate during labor. DONA currently endorses Lamaze, and thus appears to be more popular than other childbirth education methods among practicing doulas.[6]

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[6] Of the doulas interviewed in this study, most were certified in Lamaze, a decision that was further aided by Doulas of North America's (DONA) endorsement of Lamaze, particularly after the Lamaze Institute for Normal Birth announced their "Six Care Practices that Support Normal Birth":

1) Labor begins on its own.

In the 1960s, American physician Robert Bradley re-vamped Dick-Read's philosophies of childbirth. Bradley's method of "Husband Coached Childbirth" grew out of his observations of animals laboring, in which he realized that they most often sought out "quiet and safe places and then went into a state of total relaxation" (Davis Floyd 1992: 172). While criticized now for its emphasis on *husband*-coached childbirth, Bradley courses generally stress an understanding of physiological processes, while practicing relaxation techniques before labor begins. For example, in the Bradley course I attended, husbands were told to become familiar with that which relaxes their wives on a daily basis and apply this understanding to the labor room. [7, 8]

Despite the criticism of being male-centered, or heterosexist, Bradley's encouragement of the introduction of men into the delivery room was a radical step at the time. In fact, the role of the husband in childbirth during the mid-19th century has often been overlooked. When childbirth became hospitalized, fathers literally had no medical role which they could play in the birth of their child. "No medical history was taken of the birthing father. His allergies, medication, or illnesses were of no consequence to medical birthing and were ignored in the admissions process. The institution created no medical definition for him" (Reed 2005: 83-84). Judith Walzer Leavitt offers a unique

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2) Freedom of movement throughout labor.
3) Continuous labor support.
4) No routine interventions.
5) Spontaneous pushing in upright or gravity-neutral positions.
6) No separation of mother and baby after birth, with unlimited opportunities for breastfeeding (Lamaze 2008).

[7] All the couples in this particular course consisted of a man and a woman. It was taken on June 1, 2008 at a local midwifery office.

[8] From my interviews, however, some women felt that the Bradley Method was more resistant to change than other birth education courses and could be rather rigid about including women who may or may not have had previous, non-natural births.

view of fathers-to-be in the 1950s in her essay "What Do Men Have to Do With It (2003)?" While men were primarily relegated to the waiting rooms, as most hospitals forbid any non-medical persons to accompany women up until the 1980s, men found their own ways to be involved with their wives' deliveries, from the "Fathers' Books" of the hospital waiting rooms where men wrote their feelings, to actually gaining access to the delivery room by pressing hospital staff.

Other critics of husband-coached childbirth, and/or proponents of non-familial and constant labor, support have argued that this push toward husband-coached childbirth, be it in the use of Lamaze, Bradley, or any other birth education method, has put a large and unfair amount of pressure on both mothers and fathers to realize this new role of the perfect coach and the perfect, pain-free birth. Barbara Katz-Rothman, a sociologist, criticizes the natural birth movement in her essay "Laboring Then" in stating:

> In essence, the method keeps the woman quiet by giving her tasks to do. Being a 'good'—uncomplaining, obedient, cooperative—patient is the woman's primary job…The husbands are co-opted into doing the staff's work, moving the patient through the medical routines as smoothly as possible (Katz Rothman 2007: 27).

This criticism is further supported by Leavitt's conclusion that "the majority of birthing women who became interested in natural childbirth did not directly challenge medical authority," rather they "merely wanted to company of their husbands throughout labor and delivery" (Leavitt 2003: 257). Though traditional viewpoints of modesty and the female condition were challenged by both men and women wishing to participate *together* in their child's birth, they did not yet refute the authority of biomedicine, as many obstetricians feared.

Coupled with the feminist movement and the historical period in which the only other option to "awake and aware" was to be unconscious, the natural childbirth movement provided women and their partners with viable alternatives. However, as Jennifer Block notes in her book, *Pushed* (2007), birthing culture in America was changed by a new and powerful invention: plastics. She states, "Prior to the commercial availability, in the 1970s, of the flexible nylon catheter, a woman's access to regional anesthesia was a 'one shot' deal" (Block 2007: 170). With the advent of the epidural, woman were able to remain "awake and aware," while still being able to dull, if not completely eradicate, labor pains.

The medicalization of birth continued to increase despite natural childbirth education, and despite the rise in couples seeking to challenge medical authority by demanding they remain together during the labor process (Reed 2005: 77), showing even starker contrasts between the early days of American birth that Ballard experienced and the sterile, highly-controlled environments women experienced from the 1930s forward. Karla Papagni and Ellen Buckner (2006) summarize the fast transition in their article, *Doula Support and Attitudes of Intrapartum Nurses*, as such:

> In the 1920s, routine use of forceps during uncomplicated births was promoted. Anesthesia became widely used during the 1940s. By 1950, most women were not alert or even conscious while giving birth. Subsequently, continuous caudal anesthesia was developed and, soon after, was followed by introduction of continuous lumbar epidural anesthesia in the 1960s. In the early 1970s, electronic fetal monitoring was introduced into the delivery rooms (Papagni and Buckner 2006: 12).

During this time, the third-wave feminist movement ushered in a new focus on women-centered healthcare. Feminism had created a national dialogue that enabled

women demand equality and control their bodies and reproduction. While a large focus of the reproductive rights movement was on birth control and abortion, many radical feminists sought to reclaim control over their bodies through the women's health movement.[9] In particular, the Boston Women's Health Book Collective, which first published *Our Bodies, Ourselves* in 1973, gave women a significant resource for better understanding such diverse issues as sexuality, birth control, nutrition, and menopause (BWHBC 1976).

In her article, *"*Please Include this in Your Book*,"* Wendy Kline (2005) discusses the writing process of *Our Bodies, Ourselves.* Horizontally organized, the women of the BWHBC often corresponded with their readers who suggested additions and corrections to particular sections of the book where they felt their particular needs were not met. In the pregnancy section of the 1976 edition of *Our Bodies, Ourselves,* for example, the authors openly criticize the obstetrical community, stating "We, as pregnant women, are expected to put ourselves in the doctor's hands, and he or she expects to take control of our birth experience" (BWHBC 1976: 268). They followed this statement with a list of five reasons as to the cause of the medicalization of birth, including "[doctors] see it as an ordeal from which they can rescue us," "American worship of technology," and fear of malpractice (BWHBC 1976: 268). Unsurprisingly, the following section of the pregnancy chapter details the pros and cons of homebirth. This critical evaluation of biomedicine followed through to reader's letters, one of which stated "Doctors simply don't know

[9] It should be noted that some feminist groups, particularly New Jersey NOW which contains a doula as a staff member, are attempting to incorporate pregnancy into reproductive issues. Another popular, feminist blog, *Feministing.com*, as well as feminist magazine, *BUST*, have also published a wide variety of articles on pregnancy.

everything, and if their answers sound like bullshit to you, it's probably because they are. So be assertive, ask questions, and be impatient!" (*quoted in* Kline 2005: 93)

Following the feminist, women's health movement, American midwifery also gained in popularity in the counter-cultural era of the 1970s. In particular, Ina May Gaskin's *Spiritual Midwifery* (1990), originally published in 1977, sparked the resurgence of the American midwifery movement in America.[10] Currently, American midwives, who often work closely with doulas, are divided between hospital-midwives and homebirth midwives. Many of the homebirth midwives are subject to state legislation that circumscribes or prohibits their practice (Block 2007: 177-182; 213-218).

Despite the headway made by the natural birth movement in the 70s, particularly with the advent of La Leche League and the resurgence of American midwifery, statistics reflecting medicalized births began to rise again. In the 1990s in particular, episiotomies, inductions, epidurals, and cesarean sections surged: from 1981 to 1997, the use of epidurals increased from 22 percent of births at large, American hospitals to 66 percent (Block 2007: 170; Wendland 2007: 220). Currently, the cesarean section rate is 31 percent (Grady 2008). As this trend grew, and continues to grow, an alternative culture of resistance has been forming since the early 1990s, particularly with the advent of Doulas of North America.

Reclaiming Birth

[10] The overwhelming majority of doulas I interviewed for this study felt that Gaskin's works had "awakened" them to natural birth, and two doulas had taken courses on Gaskin's commune, The Farm.

In 1992, a group of doctors, nurses, and birth educators created DONA, Doulas of North America. These birth activists included doctors Marshall Klaus and John Kennell, renowned for their research in mother-infant bonding (Klaus, Kennell, and Klaus 1993: 105-109), as well as childbirth educator and writer Penny Simkin and Phyllis Klaus, a clinical social worker (DONA 2008). DONA is an organization that provides certification for doulas, as well as a directory for doulas in areas throughout the world. Their mission is to "provide training and certification opportunities for doulas of varied cultures, educational backgrounds, ethnic backgrounds, and socio-economic levels," as well as to "educate healthcare providers, the public, and third party payers of the benefits of a doula's presence during birth and postpartum" (DONA 2008). Their motto, repeated by almost every doula interviewed in this study, is to provide a doula to any woman who wants one. While certification is not necessary to practice as a doula and regional variances in certification organizations do exist, DONA is the primary organization by which doulas come together and train. From 1994 to 2007, the number of DONA certified doulas rose from 750 to 6,302 (DONA 2008).

Studies conducted have shown that the continuous labor support of doulas has been proven to reduce likelihood of cesarean birth by 51 percent, reduce labor length by 25 percent, reduce epidural usage by 35 percent, reduce use of oxytocin augmentations by 71 percent and reduce likelihood of assisted birth by 57 percent (Koumouitzes-Douvia and Carr 2006: 34; Pascali-Bonaro 2003: 5). Doulas have also been proven, among other things, to increase satisfaction with birth and reduce the risk of post-partum depression

(Pascali-Bonaro 2003: 5). Despite these statistics, only about five percent of women giving birth in America use doulas in their birth.

It is hard to refute that doulas are becoming more popular, shown by the increase in doulas certified by DONA, as well as popular representations of doulas in the media or culture at large. For example, a Google search reveals nearly 3,000 news articles relating to doulas within a 10-year period. Making appearances on television shows, such as *Frazier* and *A Baby Story*, as well as on the front pages of newspapers such as the *New York Times* and the *Wall Street Journal*, doulas are making appearances in mass media. As one local doula said, "Now it's less, 'What is that?' and more 'Oh, that's such a cool job.'"

For New Jersey doulas, doula acceptance still appears to be an uphill climb, particularly in the state that has the most cesarean sections in North America (ICAN 2008). Many of the doulas I spoke with lamented that there were no longer any birth centers, often seen as a medium between home birth and hospital birth, in New Jersey. One doula stated: "They [New Jersey birth centers] are all closed. That's bad. There are none now and there were four 15 years ago. There was one in Princeton, Englewood, and Newark Beth Israel. Now the Beth Israel is on the floor of the hospital, but it was a separately run birth center. It's unfortunate. You should have choices, safe choices." During my training with a very prominent doula in North Jersey, I asked if there were any more "birth-friendly" hospitals in our area, to which she responded by pausing and saying no.

Malpractice, in addition to an emphasis on technocratic birth models, has greatly influenced the current situation in New Jersey. One obstetrician I interviewed in this study is working on a variety of committees to address the problem of malpractice insurance, particularly in this area. His comments offered a large amount of insight into the pressures obstetricians currently face in our litigious society, a fact that does not go unnoticed by most doulas who try to "manifest compassion" for doctors. In particular, this obstetrician stated, "I'm a glass half-full guy, but there is a generation of doctors that are becoming so frustrated at rising numbers [of malpractice] that they think they're one bad case away. You could do everything right and have one bad outcome. Everybody makes mistakes. Should they be punished? Yes. Should they be put out of business? I don't know."

With all of the competing interests, both ideologically and economically, doulas represent a unique introduction into the history of birth in American culture. Having come a long way from the community supported birth of early hunter-gatherers, the medicalization of birth reflects the modernization of Western society. However, this modernizing effect has also had negative impacts on the outcomes of birth, particularly in the mental states of mothers. With more women suffering from postpartum depression and the recent addition of post-traumatic stress disorder in women who have experienced traumatic birth events, the doula is a novel introduction of an old aspect of the birthing experience. As such, they are both part of and oppositional to the current philosophical approach to American birth, thus symbolically representing the questioning of the biomedical system and an alternative approach to experiencing labor.

2.
Entering the System

Doulas are mediators. They buffer the desires of the mother from the protocol of the technocratic hospital; they translate medical needs into a woman's control over her birth experience. Many doulas believe that there are a variety of problems hospitals and doctors need to address regarding their treatment of women. At the same time, doulas are working "within the system" of technocratic birth. As one doula, Shaina, put it, "I don't have the luxury of just doing homebirths. I teach pre-natal yoga. 95 percent of my clients—even more, probably 98 percent of my prenatal yoga students—are going to birth in hospitals and they're going to birth with OBs." Though there are some doulas that only do homebirth, or, in the case of Wendy, some drop out of doula work and become homebirth midwives, the majority of labor support providers work within mainstream medical care.

As such, it is a complex web of competing desires. The doula provides resistance to the hegemonic birth system by providing alternative conceptions of birth to her clients, but rarely directly refutes the cultural authority of medicine, for reasons that will be discussed later in this chapter. If Foucault is correct in stating, "Where there is power, there is resistance," or as Lila Abu-Lughod prefers, "Where there is resistance, there is power" (Abu-Lughod 1990: 314-315), doulas provide an interesting case study of competing power dynamics within a single occupational role.

Entering the System

To become a doula, it is not yet required that one receive certification and training, though the letters CD(DONA) following a professional doula's name generally confer a certain amount of legitimacy and authority to their practice. As stated before, most doulas are trained through DONA International, in which fellow doulas offer training courses that most often last from anywhere from two days to a week. To become certified, a doula must attend a training workshop, read books from the required reading list, provide doula services to three clients, accompanied by evaluation forms filled out by the clients, nurses, and doctors/midwives of these three births, 500 to 700 word essays describing the above births, attend a childbirth education series, write an essay on the value and purpose of labor support, and sign the DONA Code of Ethics and Standards of Practice (see Appendix 7). In the doula training course that I attended, the workshops began at 8 a.m. and ended at 5 p.m. for two days. Topics covered included what a doula is, techniques doulas may use in difficult births, and how to provide support for "challenging" childbirths, such as cesarean sections. Other topics were slightly more abstract and students were often asked to perform group activities, such as practicing techniques, sharing birth or ideal birth stories, practicing non-verbal communication by not allowing feedback in conversation with a partner discussing an emotional event, and acting out dealing with difficult clients and/or family members.

Doula techniques that are taught in training workshops include massage of both hands and feet; squeezing the hoku pressure point between the thumb and index finger on the hand; the "stomp-stomp-squat," a style of walking that serves to open a woman's pelvis and help the baby drop; lunges; "shaking the apple tree," meaning to shake a

woman's pelvis to jiggle the baby into a better position for descent; the hip squeeze; the pelvic press; the circle of support; hydrotherapy; usage of the Mexican *rebozo*, a scarf type tool that can be used for reducing pressure on a woman's back or helping a baby descend; lap squatting, where the mother dips between the doula's knees; tug of war to help women who have had epidurals push the baby out; and the dangle, where a woman "dangles" from a higher plan, such as the stirrups of a hospital bed, to get a baby unstuck from the pelvic arch. These techniques were often couched in a romanticism that encouraged students to see their role of labor support as a historical and traditional role. Many of the techniques described above, particularly the *rebozo*, have been adopted by doulas and midwives that have studied in different areas throughout the world that may not have lost continuity in their midwifery traditions. At the same time, this romanticism should not discredit the effectiveness of these techniques. In actually experiencing the pelvic press and the hip squeeze, myself and other students gasped at the surprisingly open feeling we felt as our peers practiced the techniques.

Emphasis is often placed on emotional and spiritual support for the laboring mother. Providing a positive birth environment, saying encouraging words, "honoring" any and all emotions that a woman may experience in labor, and giving her "space" to make decisions regarding usage of medication or interventionist tools in the birth process were all noted as ways in which doulas were able to support and aid a laboring mother. Patricia, my doula trainer, emphasized, as other doulas also told me in their interviews, that being at a birth is an honor and aid can be found in the simple fact that a doula is there to "bear witness" to a significant event in a particular woman's life. Birth is also

identified as transformational and many doulas, particularly ones that focused on "new age" or holistic health practices, regarded birth as a rite of passage.

Despite the usefulness, and potential resistance-factors of the abovementioned techniques and viewpoints, doulas very rarely speak directly against the medical model. Of course, it is necessary to note in any work of critical medical anthropology that, despite power discourses and inequality in biomedicine, it is a medical system that provides concrete results. However, the cultural authority of biomedicine can be seen very directly in the DONA literature provided to doulas-in-training regarding "Standards of Practice." Because doulas are non-medical professionals, they are unable to provide any sort of medical advice to a client. However, as "advocates" of a birthing woman, DONA states, "Clients and doulas must recognize that the advocacy role does not include the doula speaking instead of the client or making decisions for the client" (DONA Birth Workshop Manual 2008: 2.2). Later on in the *Birth Doula Workshop Manual*, there is an article by doula Penny Simkin titled "Clarification and Application of DONA International's Code of Ethics and Standards of Practice." In it, she states:

> One of the most difficult situations for a doula is to stand by while the caregiver gives false or incomplete information, especially when the misinformation persuades the client to accept an intervention or medication that has side effects that will upset the client. But what can a doula do?... If she questions the caregiver's authority, she may find herself at risk of being made to leave because the caregiver perceives her as interfering with the client-caregiver relationship… Most successful doulas learn ways to ask questions of authority figures in an effective and non-threatening way (Simkin 2006: 2.7).

Indeed, such techniques were also taught at the doula training workshop. Patricia said she found that asking clients if they "needed to pray" before making a decision often

allowed her to have time alone with the mother, and partner, without directly confronting the caregiver's authority. While doulas emphasize a mother's satisfaction with her birth as the primary goal of their services, some people outside of the doula community critique this as a cover-up, which leads to doulas becoming just another intervention (Norman and Rothman 2007: 281)

It is in this training that doulas are introduced to both the potential resistance possible through their work, as well as becoming accustomed to, what I believe to be, the temporary acceptance of predominant power roles in order to preserve the integrity and autonomy of the women they support. Questions of whether or not hospital doulas, doulas who work for a doula program at a specific hospital, rather than privately, are successful or just another way doctors are co-opting alternative birth movements reflect this dichotomy.

In the Hospital

Because the majority of American women give birth in hospitals, doulas mostly work in hospitals as well. All of the doulas I spoke with had worked with both obstetricians and midwives, and while many preferred to work with midwives, they often added that midwives can favor interventionist practices just as much as doctors. Conversely, it was noted that some doctors practice obstetrics with a midwifery model of care. Of 25 doulas, only eight had not attended homebirths. All worked in hospitals, including one doula who was part of a novel hospital-based doula program in which the hospital trains and hires doulas to work for their patients. Such a program suggests the

changing nature of birth in America, though it has yet to find its counterpart in other New Jersey hospitals.

Within the hospital setting, the role of the doula can best be defined as a liminal position. Oftentimes, doctors and nurses do not know how to treat the doula. Experiences among the doulas interviewed for this study varied from being ignored by hospital staff to being treated like a family member. One doula, Eileen, lamented that she was often mistaken for a client's grandmother, and Dianna, a doula who originally worked in Brooklyn with a local Head Start Program, stated she was often believed to a be a relative or cousin of her predominately Latina clients, which enabled her to attend births in hospitals that might otherwise restrict the presence of non-related support persons.

At training and in my interviews, introductions were an insightful topic. Upon arriving at a hospital, a doula can be welcomed, ignored, or responded to in a negative way. Regardless of the greeting, however, the doulas I spoke with indicated that it was their responsibility to remain cordial and friendly with a reticent staff, particularly because the staff did not have to like the doula, but they did have to be kind to the doula's client. In particular, Lauren, who is both a doula and massage therapist, summarized her experiences with introducing herself to hospital staff as such:

> I carry this big, bright orange birth ball. When I walk in with it to like St. Barnabas they're [the staff] like, "What's that? What are you going to do with that?" And I just joke around with them. I'm like, "I don't know. We could play catch with it, she could sit on it. Makes a great extra chair, you know?" There are some doulas that bring coffee and doughnuts to the nursing staff. I don't do that. I've been treated rudely by nursing staff, but what I just remind myself is that I don't work for them. They can be as rude to me as they want. It's not going to affect the rest of my life. But what I want is them to be good to my clients. And if I get confrontational with them, that's not going to help it.

Another doula, Jessica, said that nurses and doctors were never directly hostile to her, but some took on a particular tone of voice that, according to her, emphasized their "authority." She stated:

> You can tell, there's a tone like, "I'll just take the baby for a minute. I just need the baby for a minute and I'll get her right back to mom." Or they sort of get into like, "We need to take the baby to the nursery now. It's been an hour, the mother's had the baby for an hour." They sort of assert an authority in their voice. And then I kind of back down. So I try to befriend them, the minute I walk in the room like, "I've heard great things about the nurses here. I really admire the work that you do. I know it's not easy and you guys are really overworked and I really admire it." The last birth I went to, I stopped off at Trader Joe's because there was plenty of time before they were going to start the pitocin and I was going to be there right at the beginning, and I brought this little desert plate of like petit-fours for the nurses. I handed them to them right when I walked in at the nurse's station and I said, "Here, this is an appreciation for all of the hard work you guys do." Everybody was nice to me that night, so it really goes a long way.

In both of these instances, the doulas spoke about backing down from the hospital staff. In the hospital, the territoriality is clear. Rather than intervening with an unnecessary intervention, doulas are required and expected to remain quiet. It is easy to understand that, because doulas are not medical professionals, they should not directly refute the recommendations of a caregiver. At the same time, women who have attended hundreds or thousands of births may have the ability to claim a certain amount of authority in understanding birth processes and experiential knowledge of particular interventions. As difficult as it may be for a doula, and many spoke about feeling "drained" by their work when dealing with negative birth experiences, they uphold the hierarchy of cultural authority within hospital walls by deferring to hospital staff.

Furthermore, despite considerable understanding of the processes of birth, doulas are unable to directly influence their clients' decisions. This genuinely falls within the realm of "empowering" a client. However, in a doula's prenatal visits, couples are often asked to fill out "birth plans," a document detailing the preferences of the mother in terms of whether or not a natural birth is desired and what to do in the event of complications.[11] If the clients of a doula discuss with her that they want a natural birth with no interventions, to uphold this decision, the doula may only encourage her clients to ask questions. As an advocate, the doula cannot directly interfere with and is encouraged to not question directly the directions of a woman's caregiver (DONA 2008).

Arising from these behavioral expectations is the "urban legend of the terror doula." During the time that I was conducting my interviews, the *New York Times* had recently written an article about a doula who severely interfered with her clients choices by throwing herself on the bed to stop a procedure (Paul 2008). The doulas I interviewed also expressed a conception of a nightmare doula who steps on everyone's toes in the hospital, refutes medical advice, and speaks for her client. As stated above, doulas should not offer medical advice because they are not medical professionals. Nevertheless, many of these characteristics, such as backing down from authority and passively refuting unnecessary medical interventions, can also be seen as typically "feminine" traits. I also believe that the "terror doula" is more of an urban legend than a reality. While I was not able to attend any births, from what doulas themselves told me about their interactions

[11] Though birth plans are somewhat standard and are taught in doula training, a significant number of the older doulas that I interviewed stated that they no longer used birth plans. They reasoned that birth plans may make a woman feel that she has more control over her birth experience than she really has; having space for changes and adaptation is more beneficial to a client.

with hospital staff, particularly the personal distress suffered from difficult births, as well as interviews with doula clients, I did not see any of the characteristics of the "terror doula" present in the women interviewed. While it is unnecessary to refute that at any period in time, a doula may overstep her proscribed boundaries, it appears that the overall conception of a "terror doula" may serve as a means by which to remind women who provide labor support to know their place in the hospital status quo.

As such, the "terror doula," according to some of the women interviewed, may leave behind negative conceptions of doulas as hospitals where staff and, particularly, doctors will develop a poor understanding of and hesitancy to accept the doula. The "terror doula" also has the potential to divide doulas as well, especially when one may or may not be acting out of line. Michelle told me that she did not "want to talk negatively about [her] doula sisters," but, "There are crazy people in the world and there are women who are adamant about natural childbirth. They're like, 'She said in her interview that she wanted natural childbirth, and that's what she's going to do.'" Erin, a doula and registered nurse, said that there is a particular doctor that she works with who assumes she tells her clients not to accept pain medication. "I've told him more than once that it's not the case, it was her choice, not mine. But he doesn't listen and isn't swayed from his own opinion." In both of these situations, conceptions about how doulas act interfere with their experiences in the hospital. The solution is never to put more pressure on hospital staff, but to prove that doulas stay out of the way and do not breach certain behavioral expectations.

Along this line, doulas were very quick to state that "not all doctors," just as "not all midwives" reacted negatively to labor support persons. While such statements are accurate—it would be very difficult to genuinely argue that a whole group of people acts in a certain way—it also reflects the cultural authority given to medical professionals in America. Doulas had many criticisms of the medical community, yet many appeared to feel that these criticisms should also be followed by praise or a clear statement reflecting the doula's understanding that biomedicine and interventions *are* indeed helpful and important. Lauren, for example, commented that, "There are plenty of good doctors. I'm going to go on the record [*leans in towards the recorder*], there are a lot of good OBs who are respectful to women, but there are some who are not. Sometimes they'll start talking about their weekend plans, or they'll start talking to the nurses, not even to the laboring woman." A young doula, Anne, stated, while talking about the difference in how obstetricians and doulas talk to clients:

> They're just all about, "What can I get you? What can I give you?" But not in a nice way. It's like, "Let's speed it up" or "The baby's not doing well," when the baby's really fine. So, definitely, there's a big difference. And I don't look at them in opposition. I don't. It seems like I do. They know a lot more than I do, they've been doing this a lot longer than I have, but they just come at it from such a different place.

Because doulas are lower on the scale of cultural authority, it is important for them to credit doctors and medical professionals who may have been trained in such a way that their practices may be *more* damaging to a laboring woman, i.e. using the supine position, as ultimately being the most powerful and helpful.

Similar issues of "blending in" with the predominant birth system in America are also apparent in doula-client interactions. By nature of the clientele doula's receive,

doulas are more likely to work with obstetricians in hospitals, though midwife, in-hospital births are becoming more common in this area, according to the doulas interviewed. Because doulas are unable to influence their client's decisions, and serve, primarily, as an advocate or educator, the priority becomes the client's satisfaction with her birth. Doulas are not objectively seeking to lower overall statistics of cesarean sections or epidurals, but aim for each individual client to have an optimal birth experience, one at a time. Thus, despite the fact that doulas are a challenge to the biomedical birth system in just stating that women need support during, what should be considered, a normal, healthy body process, some doulas feel that they are not political, or do not believe that being a doula involves a certain amount of "activism." For example, one doula, Virginia, recognized that there was a type of "grassroots activism" to being a doula, in that she often talked to people about the books she was reading, or hoped her clients would spread their positive birth experiences. However, she countered this statement by saying:

> But I'm very careful, both as a Bradley instructor and as a doula, especially when I'm talking to people who are not of the same philosophy or who I don't know. I don't want to come on too hard and heavy because what ends up happening with anything, when you become too gung ho, then people can't hear you. You're almost frightening to them. And so the word doesn't spread well that way. So I try to listen first and then talk, or I try to feel it out if I can. Not that I wouldn't enter into a discussion with whomever about it, but if I'm sensing that they're totally in the other camp, and I'm sensing that they can't hear, I'm not going to discount what they believe in. I'm not going to yell louder so that they'll hear me. That's not going to happen.

Where some were hesitant to express their feelings about biomedicine, others felt that there was a double standard in speaking with women about their births, particularly if they had, what they believed to be, an unnecessary intervention.

> Let's say we just met, and you said, "I scheduled a cesarean. They said my baby was going to be big and since he was so big, breastfeeding just didn't work for me. So I ended up giving him formula and he's totally fine." But, if I'm meeting you and I say, "I'm completely opposed to drugs" or "I had natural childbirth," you say, "Oh my god, are you kidding me? That's crazy." People have no problem telling someone who had a natural childbirth that it's ludicrous. It rolls off the tongue. If I said to you, "Why would you have surgery to deliver you baby?" people don't do that. So, first of all, in my feminist bone, I wish we would all just support one another. But there's this huge double-standard where it's okay to criticize natural childbirth and women who breastfeed, but it's not okay to criticize women who have cesareans and bottle-feed.

In the statements above, there is a sentiment of constraint portrayed by the doulas. While both women recognize that there is a problem, i.e. wanting to get the public at large to understand natural birth processes and the need for labor support, both feel that they cannot use "criticism" or raising their voices to get the point across. This can be held in contrast to the fact that the biomedical community felt justified in issuing court-ordered cesarean sections on women who refused consent, for religious or personal reasons up until 2005 (Jordan and Irwin 1987; ACOG Committee on Ethics 2005). More sharply contrasted is the fact that despite ACOG's statement that they discourage elective cesareans (ACOG 2006), doctors and hospitals continue to ban VBACs and/or deny women the right to VBAC, as shown by the 2005 "Listening to Mother's Survey" (*cited in* Block 2007: 77). This relegation to the background of a real debate between natural birth advocates and the biomedical community has led doulas to identify and connect to

their clients' birth choices and negative birth experiences in a very intimate, and private, way.

Because the client's perception of the birth is top priority for the doula, doulas are likely to take on clients who are electively choose to have interventions, such as scheduled cesareans or epidurals, as part of their birth experience. Every doula I spoke with preferred natural birth, regardless of their personal birth experience. It was commonly believed that the medical profession had gotten too used to older protocols that are now understood to not be helpful to women in labor. Furthermore, doulas who had interventive or medical births often felt that was happened in their birth was best only for them, stating "each birth is unique." They also believed that their medicalized birth experiences, wanted or unwanted, helped them to relate and share experiences with clients who may be opting for interventions or who may need interventions during the course of their labors. Eileen worked as a doula for 11 years before returning to a job in a media-based field and had a diversity of experiences with clients, particularly because she felt that she "wanted to do the most good…[which] comes from a situation where they really need help because they're not going to get what they want otherwise." She elaborated:

> I made a point of not bringing my own personal judgments to the people I worked with. As long as I felt that they were going to love this child, I would have no problem with working with them. I did have people who planned on having an epidural the second they walked in the door and we worked on that. I shared information with them and respected whatever they wanted.

Rather than encouraging a healthy woman to have a natural childbirth, doulas opt for respecting the wishes of the mother, regardless of whether this includes a scheduled

cesarean or homebirth. This approach does provide mothers with agency in their decisions regarding their birth experiences, as opposed to doctors or medical professionals who may not provide all of the information necessary for women to make a genuine "informed consent" decision. Many doulas complained of, what one of them called, the "dead baby card." This refers to some doctors' use of fear-based incentives to encourage a mother to choose an intervention. Jennifer said, "I've seen it time after time, doctors laying on the guilt for not complying with what they want you to do. Like, 'Oh, we have a healthy baby now, but I can't guarantee a healthy baby if you persist in doing whatever it is you're doing.'" As doulas take on clients seeking medicalized births, and continue to lack the ability to voice objections to medically unnecessary interventions, the disappointment and/or frustration with the American birth paradigm leads to a heavy identification with clients' birth experiences on the part of the doula, which takes a particularly heavy toll on the emotional state of individual doulas.

Jessica is a doula, lactation consultant, and birth education teacher. The day I spoke with her was a particularly hectic one. There was a storm the night before, which had knocked out her power for most of the day; when the power was back on, she was dealing with a previous client who was unhappy with her post-partum care. Particularly open, Jessica shared a specific instance worth quoting at length that highlights the emotional drain doulas feel when their clients go through what would objectively be called "negative birth experiences" from a doula perspective, or a difficult birth, despite a doulas' attempt to allow more time for the mother to make a decision, or even to have prepped the family before labor began:

> I had a client who was pushed into a c-section for her third baby. Her first two were totally natural. Because they [her medical team] said, "On the ultrasound today, this baby is measuring nine pounds, four ounces, and your biggest baby was seven, 14, the guidelines suggest that we do an elective c-section because there's a high risk of shoulder dystocia." The baby was born and he was eight pounds, ten ounces. So he was big, but she really could have pushed him out. She felt like she would be selfish in not listening to their guidance. I was so hoping she would do something else and I was like trying to talk her through it, like, "Let's look at the pros and the cons," but not injecting my own judgment into it at all. And I was the only voice in the room saying, "Here are the cons," and in the end, she opted for the c-section. I think she's pretty upset about it. Ultimately, she knows it was her choice, but she said to me, "Jessica, I really think I could have pushed that baby out. Maybe I shouldn't have done it." When she said that I said, "It was a really hard decision to make, but at the time, you made the one that seemed best." That's how I have to frame it, not like, "You should be so angry at that doctor, he never should have bullied you into that c-section." But what could I do, you know? Am I going to like belabor the issue with her? How does that help? I really feel awful, but there wasn't anything I could do. My conscience is clear; I said everything that was on my mind. But it's really hard for me. She's not having anymore kids. So I'm in a tough place. I'm in a tough place

In this particular instance, the doula experiences emotional stress because she was unable to influence her client's decision. Her client feels selfish if she attempts to go forth with an unmedicated childbirth. Birth weight is notoriously inaccurate, doulas insist, and Jessica attempts to offer both sides of the argument to her client. She is unable to state outright that she wishes she would not have a scheduled cesarean, but would attempt vaginal delivery, before deciding upon the option of a c-section. Jessica's client is enveloped in the patriarchal medical model—her own wishes for her birth experience are considered selfish in the face of, what may be skewed, medical advice. In the end, however, whereas it is the medical team's responsibility to ensure that their patient has proper, unbiased information, according to Jessica, only one person was offering information on the negative side effects of an elective cesarean. As such, the medical

team should be reprimanded for not living up to its responsibility of informed consent. However, it is Jessica who is concerned, confused, and appears to feel guilty, because her client may regret aspects of her birth experience.

Furthermore, this disappointment cannot be shared with a doula's client. Rather than taking the negative emotions of a disempowering birth experience and using them against an unfair medical system, doula's generally attempt to reframe a client's perspective on her birth by noting the positive aspects of delivery. While helping a woman who has had a negative birth experience view it in a positive light may reduce chances of post-partum depression, it also reduces the political impact that doulas and dissatisfied consumers, i.e. mothers, can have on hospital protocol. Consumer demand played a large part in the introduction of fathers into the delivery room. Birth was also recognized as a consumer commodity, particularly among the doulas interviewed in this study. When women do not have the language and/or mental categories to vocalize their dissatisfaction with traumatic birth experiences, their venues for change and validation are limited. When a doula helps a woman through what could be a difficult birth experience, she enables that woman to work through any unpleasant emotions. While beneficial on an individual level, it is difficult to determine whether or not this technique causes a change in the overall cultural conceptions of American birth.

Before Jessica shared her story about her previous client, she said, "even if there is so little positive about the situation for our [the doula's] perspective, we have to frame it in this really positive way for them so they feel good about it," adding, "we're not telling them the truth and saying, 'Your doctor should never have done that.'" She is not

alone in this sentiment. Doulas often stated: “Whatever the actual event is, it’s not as important as how they [the mothers] feel about it” or “I figure they’ve made their choice. I figure they’re intelligent enough to make their own choice.” Lauren in particular spoke about her experience as a doula at one of her cousin’s births:

> Once you climb up into the bed and assume the fetal position, you’re in trouble. And, in this case, her water broke and she had no cervical ripening and no dilation, she was locked shut. She went through two days and they did Cervadil on her. The contractions are harsh and she spent an entire night of passing out asleep and waking up screaming, moaning with each contraction. And meanwhile, she was in the bed, so when she was almost fully dilated, the baby was so high up, he was totally molded into the back of her pelvis, If only she had just gotten up out of that bed while she was doing all that laboring. But do I say that to her? No. I said, “You were strong, you toughed it out. It was a long hard labor, but look at your beautiful baby.” The hardest part of my job is letting it go. Reminding myself over and over again, “This is not your birth. This is not your birth.” If they choose to go to St. Barnabas when they want a natural water birth, you cannot stop them.

Prior to speaking about her cousin’s labor, she also stated, “My goal is that women feel good about their birth, so I just fill their head with the things that they did positively.” Despite the fact that doulas are achieving their goal of providing a positive birth experience for each client, it appeared that many doulas felt “drained,” and some stated they cried after negative birth experiences. Most often, they said they called other doulas to share and work through negative experiences. I take this to be a sign that doulas are the one’s bearing the brunt of the traumatic aftermath of unnecessary medical interventions, whereas doctors and nurses are not receiving the same kind of feedback. If, however, the negative emotions incurred during difficult birth experiences cause the doula to feel so powerless and/or frustrated that she might “throw in the towel,” as Susan,

a hospital-based doula said almost happened to her after dealing with a difficult doctor, the prospectus for change will be altered as well.

Doulas are also present as what can be termed "fictive kin." If the historical precedent for the doula can be found in the social births of early America, as well as in non-Western communities, theoretically the doula could present a return to birth as a community-based life event. This transformation from pathological birth to social birth is not unfamiliar to doulas. In fact, one of the more radically-leaning doulas interviewed felt that all normal births should be taken out of the hospital altogether, stating, "It's a family event, like getting married or graduating college." Lauren mused on the diffuse nature of American family life today when she said, "With the spreading of families across the country, or even sometimes not across the country, parents are working later in life or traveling later in life, women have less support. I think we have to give up on counting on extended family and start building a support network of other women."

Nevertheless, as the hospital sells anesthesia and episiotomies, doulas are in the business of commodifying emotional support during labor. While the cost of hiring a doula may range from $500 to $1,000 in New Jersey, a doula income is limited. As one doula joked, "it [becoming a doula] sounded like a nice way of becoming poor." However, with experience, over half of the doulas interviewed experienced a moment in their career when they realized that they were running a business, and a large emphasis was placed on getting paid as a means for valuing "women's work." Thus, despite the strong, emotional bonds doulas form with their clients, especially seen through the way doulas incorporate client birth stories with their own, the doula-client relationship is seen

as a business relationship. In doula training, students were specifically advised to ensure that relationships with clients were cut off at a certain point. While most of the doulas interviewed stated that they did not have a specific "cut off," nor were they particularly concerned about being harassed by an overly zealous ex-client, payment did enter into the picture. Eileen talked about how her practices as a new doula differed from her later years:

> I would go way too early, which is a tendency with newer doulas because it's so exciting because you just want to be there for every little thing and do everything you can. But you're not really taking into account your own energy level and your own schedule, let alone the financial aspects of it. It's a set fee, and if you're there with them for 24 hours when they really only needed you for 11, it's a very big difference. It becomes very hard to earn a living when you're giving as much as that if you're doing it for financial reasons.

Naturally, then, the doula-client relationship varies greatly from a traditional, kin-based support network. Factors of money, time, and client satisfaction enter into the labor support process. As will be discussed later, it is not uncommon for doulas to design payment plans or suggest volunteer or doulas who are in the process of certification to clients with a limited income. Without diminishing the "labor of love" of doulas, in the process of monetary exchange for labor support, birth remains a commodity event, rather than a genuinely social occurrence.

Race and class

What is a large criticism of biomedicine can also be applied to doulas: unequal access to care. Of the 15 doulas I spoke with in person, only one was non-White. Out of 25 doulas, all but one went to college, with over half having received post-graduate education. The one doula who did not receive an undergraduate degree was also the

youngest doula interviewed and who had attended college for roughly two semesters before deciding to pursue acupuncture and labor support. While I did not specifically ask about income, based on the homes of and/or the previous careers of the doulas I spoke with, they largely belonged to middle- to upper-middle class socio-economic demographics. Previous jobs included attorney, professor, nurse, actress, social worker, and marketing, among others. Only two of the 25 doulas did not have children themselves, and those same two were also unmarried.

In addition to a relatively homogenous demographic among North Jersey doulas, factors affecting the use of doulas by women include lack of insurance coverage, lack of access, and what could be termed "cultural capital" factors, to use Bordieu's term. While the doulas I interviewed felt that their clients came from a variety of backgrounds, they also often commented that it was an older, "Whole Foods-y," first time mother, or VBAC, that mostly comprised their clients. In interviewing five doula clients, only one was non-White. None of the women I interviewed had insurance coverage for doula-use, and all fit the mold of either older, first-time mother or VBAC candidate.

Because DONA declares its vision to be "A doula for every woman who wants one," and almost every doula interviewed echoed this sentiment in our conversations, access to a doula is an important priority, from both a geographical and economic perspective. With over 6,000 certified doulas, and more than 100 birth doulas in New Jersey, doulas are becoming more and more accessible. A more prevalent problem, however, is payment. Most insurance companies do not cover labor support costs and while some doula clients have had success in getting reimbursed for doula costs through a

flexible spending account, it is extremely rare to not pay for doulas services out of pocket. Doulas use a variety of payment options, ranging from barter and sliding scale to flat fee payment plans. All the doulas I spoke with primarily use flat fee rates and will suggest other options for potential clients who appear to be in financial straits. At Michelle's home, for example, she pointed out the statue on her front lawn given to her, along with some other pieces of art, from a client. Some theoretically gave up using sliding scales because it "only seemed to confuse people," though in practice they would alter their prices to meet the needs of a client, if necessary. Others, however, confer lower-income clients upon volunteer or doulas-in-training who are often cheaper than more experienced doulas. This second option seems contrary to the doula perception that clients often "click" with prospective doulas. A majority of the doulas interviewed felt that women just knew when the doula was right, akin to chemistry or a connection between two people. Other doulas spoke about prospective clients who had called, asked about pricing, and never called back. With these cases, it is impossible for the doula ever to know if they did indeed utilize labor support in their birth experience.

It should be noted that three of the doulas I interviewed did either volunteer doula work or volunteer birth education work. In particular, Anne worked as a volunteer doula near Philadelphia for a community-based doulas organization. Shaina offers pre-natal yoga classes at the YMCA in two major cities in New Jersey, whereas Samantha tries to incorporate one pro bono doula client per year. Because labor support is a business, these cases were less the norm, yet confer a sense of diversity in the approach women take to being doulas and how they view their responsibility and service to a larger community.

Related to questions of payment and pricing is the valuing of women's work. In a capitalist economy, one of the prime ways of conferring value to an action or occupation is through how much one gets paid. Historically, and currently, women receive lower salaries than men. For doulas, paying for labor support confers legitimacy to a profession that may seem unnecessary to critics. Upon hearing that I would be receiving doula training and would like to stand in for a doula or co-doula at a birth, Christine emphatically told me, "Make sure they pay you. Recognize that what you're doing has value." Whereas payment becomes a vehicle through which doulas tie labor support and larger, cultural acceptance, an under-appreciation for female-dominated fields relates directly to gender constructs and politics in American life.

While almost every doula interviewed considered herself a feminist, with the rest preferring terms such as "humanist," many believed that the feminist movement left the issue of birth behind.[12] While Natalie, a doula who also majored in Women's Studies in college, felt the question, "How can you fight for birth when you're also fighting for women to be able to terminate a pregnancy?" limited feminist involvement in birth rights issues, other doulas felt that feminism had overlooked the birth process in general, or was on the wrong side of the issue. Donna was one of the most experienced doulas I spoke with. While her politics were deeply influenced by her Christian background, particularly regarding sexual abstinence, she seemed to feel betrayed by the feminist movement when discussing the topic in our interview session. She said, "Where are all the feminists screaming about this? [The feminists] are on the wrong side of it, they say, 'A woman

[12] The words "feminist" and "humanist," in this instance, were taken to mean someone who agrees in social and political equality between men and women.

should have the choice to take drugs.' No, a woman should have the choice to birth the way God made her to birth and she's getting less and less of that choice now." While this statement is historically inaccurate (see BWHBC 1976; Kline 2005), this conception of feeling left out of the feminist debate has led many of the doulas I interviewed to believe that they are neither part of the medical system, nor part of a valid counter-culture movement.

Another conflict between the feminist movement and the doula camp that doulas did not remark upon, but was suggested, is the traditional "feminine" characteristics that doulas may embody in the birth room. Providing support, doulas are secondary actors in the delivery room. They can be called passive receptacles for a woman's needs; they listen, they mold to the desires of their client, they get paid little, they are strongly associated with motherhood, and they are often mothers themselves. The Women's Movement that arose in contrast to the feminist movement in order to address issues that directly affected women of color was a powerful historical development, showing the predominantly white, middle class women that they had their own stereotypes and prejudices to overcome. Subsequently, because of the dire status of the abortion rights movement, particularly during the presidency of George W. Bush, motherhood and reproductive rights regarding birth have developed a negative connotation. Motherhood is for the fifties, so to speak, and why should feminists worry about birth if birth control is taken care of? The doula is a traditional role, and a very feminine one as well. Though some feminists have taken up the issue of birth, it has yet to gain the same popularity as discourses on reproductive rights have in the past. With the creation of advocacy groups

such as the National Advocates for Pregnant Women, it appears that the topic of pregnancy is becoming more thoroughly integrated into current feminist struggles.

3.
Resistance

Resistance and power are both related to self-conceptions, cultural values, and relative influence a person has over the events occurring in his or her life. Power can be defined as a socially accepted ability to influence a total possible variety of actions in a person's life. The biomedical establishment, particularly obstetrics, represents, in the Gramscian sense of the term, a power-bloc in which doctors, through cultural conditioning that engenders consent and through legal means that prohibit certain ways of birthing, draw boundaries around options for birth. The influence of power and, particularly, who holds power, exists on a constantly changing continuum of interpersonal and micropolitics, that can be seen in the ambiguity of the doula's role in the previous chapter.

In James Martin's *Gramsci's Political Analysis*, hegemony is defined as leadership under a particular group or class that "struggle[s] for ideological domination whereby people are encouraged to interpret their experiences in ways favorable to certain sets of power relations" (Martin 1998: 2). As such, cultural hegemony denotes a group of persons who, upon certain axes of social identification, maintain "ideological domination" that perpetuates their position in the more influential points of self-identification. For example, whereas many of the doulas I interviewed would identify as White and/or upper-middle class, which denotes a more powerful position in American society, they also identify themselves as birth activists who are struggling to incorporate woman-friendly birth practices into the hospital-based obstetrical system.

Resistance occurs on many levels, both in terms of mass politics and in the realm of the politics of everyday life. Whereas some doulas are devoted to the political aspects of birth activism, such as fighting for paternity leave or post-partum care, other doulas seek to change the culture of birth "one woman at a time." In these instances, they follow John Fiske's interpretation of resistance as "the art of making do" (Fiske 1989: 4), which he uses in reference to the construction of popular culture. In relation to birth activists and doulas, there are many instances of "making do" in the delivery room, in which a doula and her client attempt to control the space by taking medical tools and/or protocols and using them to their advantage.

Fiske further develops his idea of resistance by defining two competing groups in any given culture: that of social force, which includes the resistance of those who lack power, and the power-bloc, which he defines as "a welding together of different components for a specific purpose" (Fiske 1993: 10) and thus cannot be seen as a category or group, but a "disposition and exercise of power to which certain social formations, defined primarily by class, race, gender, and ethnicity, have privileged access (Fiske 1993: 10)." The social force carries out its own struggle for control over individual lives through a variety of means that can be both highly visible, such as protests, or discrete, such as the creation of new meanings for words that originate in the lexicon of the power-bloc. Such methods of resistance are identified as "tactics," as defined by social theorist Michel de Certeau, who greatly influenced Fiske's interpretations of resistance. De Certeau differentiates tactics from strategies in stating that, "Because it does not have a place, a tactic depends on time—it is always on the watch for

opportunities that must be seized 'on the wing.' Whatever it wins, it does not keep" (de Certeau 1984: xix). As such, tactics are unbounded, spontaneous acts of resistance in which the social force appropriates power from the power bloc in a particular moment. Resistance or resistance tactics can incorporate methods such as the construction of locales in which people localize larger forces of power by claiming control of their space. The doula concept of "space," or "holding the space," is an example of such an effort.

Thanks to post-structural analyses of power, academics have taken Foucault and Gramsci's theories of power and hegemony and added a post-modern, multivocal aspect to struggle and resistance. In particular, Lila Abu-Lughod (1990) discusses the many layers of both power and resistance in her essay "The Romance of Resistance." Resistance is idealistic, it is testament to the strength of human character and willpower. However, in seeking to define instances of power and resistance in the daily lives of groups of people, it is important to understand that both operate on a variety of levels. Abu-Lughod states, "This may seem like boxes within boxes within boxes. But that is the wrong image. A better one might be fields of overlapping and intersecting forms of subjection whose effects on particularly placed individuals at particular historical moments may vary tremendously" (Abu-Lughod 1990: 332).

As discussed in the previous chapter, doulas are incorporated into the hegemonic system of American birth, or, it could be argued, they fail to maintain locales at particular axes in their self-conceptions and responsibilities. De Certeau summarizes this intellectual problem succinctly by creating a parallel between the indigenous groups of South America and the Spanish colonizers to all forms of tactical resistance today:

> Submissive, and even consenting to their subjection, the Indians nevertheless often *made of* the rituals, representations, and laws imposed on them something quite different from what their conquerors had in mind; they subverted them not by rejecting or altering them, but by using them with respect to ends and references foreign to the system they had no choice by to accept. They were *other* within the very colonization that outwardly assimilated them; their use of the dominant social order deflected its power, which they lacked the means to challenge; they escaped it without leaving it (de Certeau 1984: xiii).

This statement perfectly describes the liminal, *other* position of the doula as she acts within the system that she is fighting against. It is clear, then, that doulas operate primarily in the arena of resistance, resistance to popular conceptions of birth, women, and who controls mother's and their children's bodies. As such, they use a variety of techniques on the micropolitical level that push to change the culture of birth in America today.

Philosophies of birth

From critical medical anthropologists and birth activists, the obstetrical view of birth is most commonly described as pathological or technological. Birth is viewed as a problem and/or disease to be dealt with in the same way one would treat any other sickness. Such viewpoints are best outlined in the works of Robbie Davis-Floyd (1992) and Emily Martin (1992), in which they dissect metaphors for women's bodies during pregnancy as a cultural construction. Martin quotes Barbara Katz-Rothman in *Woman and the Body* in calling the baby and mother a "conflicting dyad" (Martin 1992: 64) in the hospital system, in which the interests of the two are discordant. Doctors are trained to distrust the bodily experiences of women and to place their utmost respect in the

technology and equipment of today's delivery room (Davis-Floyd 1987: 5-7). Further increasing the divide between mother and child, "only 55 U.S. hospitals could call themselves 'Baby Friendly' in 2006" (Block 2007: 153), according to UNICEF and WHO. The "Baby Friendly Initiative" is a set of guidelines created by WHO that suggest that hospitals "have a written breastfeeding policy that is routinely communicated to all health care staff," as well as "give newborn infants no food or drink other than breast milk, unless medically indicated" and "encourage rooming-in and allow mothers and infants to remain together twenty-four hours a day" (Simkin, Whalley, and Keppler 2001: 475). Indeed, though I was only able to interview two obstetricians, both defined birth as a normal, bodily event but were more wary of danger and complications than the midwives or doulas I spoke with ever expressed. While this is certainly attributable to the more high-risk cases that come through the hospital system on a daily basis, it is also embedded in modern medical training.

Doulas are fully aware that their view of birth is in staunch opposition to the "birth as pathology" model of obstetrics, which can also include some more medically inclined midwives. Primarily, the doula view of birth is centered on the belief in "normal birth." In the mainstream view of American birth, there is very little room for what can be called "normal." Because Americans are inundated with images of emergency cesareans and, as one doula said, go to the obstetrician not to find out how well a pregnancy is developing, but if there is anything going wrong, it is hard to define what would constitute healthy and average for mothers-to-be.

Doulas emphasize that birth is a transformational life cycle event. Many did not hesitate to relate it to popular conceptions of rites of passage, with one doula relating it to the American Indian vision quest. For Thalia, one of the more spiritually-focused doulas I spoke with, the vision quest was a symbol of complete trust in a person's ability to accomplish a difficult feat. She said, "The entire community trusts that they can do [the vision quest]. They go out into the woods and face themselves, face their fears. When they make it back, there is such a feeling of transformation; they are in awe of themselves that they actually did this. The entire community looks at them in a different way." For Thalia, the use of the vision quest metaphor symbolizes a woman's ability to understand her body and to guide it through the strenuous journey of birth. When women are able to be in control of their birth experience, then they will realize their strength as both mothers and women. For doulas, and their clients, it is the difference between "birthing your baby" and "being delivered."

The primary concern of the doula is contentment with a birth experience. However, this concern is directly tied to control and self-determination. Because a woman who uses a doula will have one to three pre-natal visits in which they can discuss their birth preferences, doula clients are more likely to be informed about the variety of interventions and medications that can be used in a difficult birth. While doulas are labor support persons, they are also educators. Fifteen of the 25 doulas I interviewed taught some form of birth education, but all were concerned with preparing their clients for any complications that may occur in the delivery room. There is a pragmatism to the doula approach toward birth education that can be defined, as Emily Martin stated, as "self-

defense in the hospital" (Martin 1992: 140). Because medical professionals cannot and do not always have the ability to offer genuine informed consent, doulas view it as their priority to educate women as much as possible so that they can make informed decisions during labor.

By providing full and accurate information, doulas challenge the birth system in which they operate. Though doulas are not theoretically able to ask a doctor to better explain a procedure or provide more options, a few defy this rule. Ellen, in particular, explained an incident in which her client's water had broken early and she had agreed to try to speed up the labor. Knowing that her client had hoped to avoid Pitocin, Ellen, asked the medical team if it was possible to use the alternative Cytotec, which would allow her client to continue to be ambulatory with only intermittent monitoring, whereas Pitocin requires constant fetal monitoring and, thus, confinement to the hospital bed. While she genuinely did not know some of the answers to the questions she asked about Cytotec, Ellen felt that it was important for the medical team to pause, stating, "Let's get some information on this. Is this another option she might have?"

More common, however, are doulas who attempt to create a safe space in which their clients can demand more information from their caregivers. Others will have previously prepared their clients for the possibility of sudden changes in the birth experience that they may not have expected and to keep alternate possibilities in mind. For doula trainees, a game that involves setting up cards with two opposing options, i.e. hospital birth or home birth, requires the player to give up one aspect of her ideal birth. After a card is turned over, the participants are surprised to see that, for example,

choosing an IV over no IV may lead to bed rest, which may lead to a slower labor, Pitocin, and so on. This "slippery slope of interventions," as doulas call it, is also conveyed to clients and their partners in prenatal visits.

Empowerment plays a large role in a doula attended birth. As stated above, control effects satisfaction with a client's birth. Women who feel out of control and who feel that things passively happened *to* her are more likely to be disappointed in their birth experience. Ellen stated poignantly that in "handing over complete responsibility you're also handing over the potential of complete blame." If a woman is an active participant in the decision making process, she is less likely to "point fingers" if, indeed, there is a poor outcome. One unique example of the effects of a lack of control on a woman's birth came from Susan, whose client had decided that she wanted an epidural during her birth experience. However, the baby's heart rate crashed into the 60s for three minutes and thus, she was not able to receive the epidural, which could have exacerbated the situation. Ellen continued to describe her experience:

> There is nothing scarier than when you get swooped on like that. When you've got every light on you, you've got six nurses, everyone's poking you and touching you and they're trying to set up a delivery table and they're turning on the baby warmer. Thank god everything settled, she settled, the baby settled, everything was fine. But when the baby was born, she just was very shocked and very much like "I really wanted an epidural, I can't believe I didn't get my epidural." Even when I saw her a day later, she was much more relaxed about it, but she still hadn't completely coped with the idea that it wasn't exactly what she wanted.

Doulas say that a woman will always remember her birth experience and such a lack of control could contribute to unhappy memories. While Susan's client eventually dealt with her "imperfect" birth experience, other doulas have helped clients who

suffered from post-partum depression, though they felt the disorder was much less common in their practice because, they said, women who have doulas are less likely to feel alone and under-supported.

Joan, a client of the relatively new doula Maria, hired a doula because of a very negative first birth experience. Having requested an epidural, the procedure was improperly performed and the anesthesia numbed the top half of her body, rather than the bottom half. The result was a numb chest and a lack of pain relief. While she stated that she "wasn't pleased with either birth experience," she also felt that things could have happened differently during her first birth, whereas the second happened as it was meant to. Her displeasure with her first birth was apparent when she spoke about screaming while pushing, and then while receiving an episiotomy. "The doctor started sewing me up and I was screaming and she asked, 'Can you feel that?'" Highly sarcastic, she expressed disappointment in not bonding with her baby right away because of the difficulties involved with the epidural. In comparison, while she was having difficulties with her husband after her second child, who felt that she preferred the doula's care to his own, she spoke much more happily about her more recent caregivers, whom she felt "supported and understood by…so even when she wasn't there because she was in the room next door [taking care of another patient], I didn't feel abandoned. I was just like, 'See, this is why I have a doula.'"

The doula view of birth is also able to incorporate a more holistic analysis of a woman's life history into her care. Whereas doctors and midwives focus on health, doulas are concerned with emotional well-being. As such, issues such as eating disorders,

sexual abuse, and reproductive histories are of interest to doulas. None of the doulas I interviewed directly asked women about their histories, but most commonly provided space on a questionnaire offered during prenatal visits in which a woman could share any extra information that might be helpful for the doula to know. A significant amount of research into this subject has been conducted and doulas were apt to cite the work of Sheila Kitzinger and Penny Simkin who have written about the subject.

Though doulas did not ask for this information directly out of respect for the woman's privacy and self-protection, they felt that there were "signs" that might suggest a history of abuse. Most specifically, "plateau"-ing in the middle of labor is identified as an emotional blockage that doulas attempt to help the mother work through. Sometimes, this blockage is related to a woman's fear of becoming a mother, specifically in relation to work, whereas in other instances, doulas found that the pressure of a baby's head in the vaginal canal may bring back memories of sexual abuse. Many doulas suggest epidurals for such women, so as to avoid to pain; other women seek to reclaim their bodies by "owning" their births. Either way, doulas' attention to women's histories give a humanity and respect to laboring women that doctors may not have the time or insight to provide for sexually abused or psychologically traumatized patients.

Localization of knowledge

In any culture, there are forms of knowledge that are given more cultural and social authority than others. In the case of doulas and the biomedical system, the medical profession is more highly legitimized. A glance at popular culture, with all of its

television shows that center around doctors, both fictional and "real," magazines regarding health, and the emphasis on science and empirical knowledge in schools, all show an extreme regard for the scientific method and its application to everyday life. In the wake of the American respect for biomedical knowledge, other forms of knowing are delegitimized and disregarded. The midwives I interviewed acknowledged that they had many fewer patients than their obstetrical counterparts, and doulas who birthed with midwives often stated that family and friends thought they were using alternative care providers because they lacked insurance, or were just foolish.

For doulas, experiential knowledge plays a large role in the foundation of doula techniques and approaches to birth. Among a certain minority of doulas I interviewed, particularly those who were also registered nurses, the short time frame in which doulas are trained was looked down upon, or regarded as insufficient. Indeed, after participating in the doula training course myself, I felt relatively unprepared for the role of labor support in a birth. The hands on experience in doula training, while invaluable, is also minimal due to time constraints. At the same time, doulas are non-medical professionals who do not make decisions that would directly affect mother or baby without the help of a midwife, nurse, or doctor. Furthermore, the doula knowledge base is strengthened by repeated experience, hence the utmost respect for "mother doulas" who have attended hundred of births and are thus regarded as being very knowledgeable in labor support, as well as doula communities.

When asked if their friends were doulas or if a doula community or "bond" existed, most doulas said yes, though more objective evidence pointed to the contrary. At

the time of my research, some community-based doula groups that met on a regular basis had dissolved. However, doulas often pointed to conventions and community message boards, particularly the MotherLove Doula listserv, as particularly helpful in making them feel both part of a larger doula group and in getting more information and advice when stumped for how to help a particular client. Susan said to me during our interview:

> I never had a doula mentor. I was just winging it, you know? There were a couple of doulas that I talked to who would give me information, but I never felt like anyone took me under their wing. I've kind of done this on my own. But thank god for the DONA message boards. They have been phenomenal; they are my lifeline.

When I began my interviewing process, the first three doulas I spoke with suggested I join the MotherLove Doula groups, run by a "mother doula" in New Jersey. On any given day, I received between zero to 15 messages regarding news articles, questions about breastfeeding and medications, referrals for VBAC-friendly doctors, as well as introductions from new doulas. I even posed a question to the doulas of the group, many of whom I already knew personally by then, for referrals to obstetricians to interview for this study. Responses are fast and based on the personal experiences of the doula responding, creating a grassroots knowledge base that is shared among group members. For example, one of the more recent questions sent through the listserv was regarding a doula whose client needed to restart medication for multiple sclerosis while breastfeeding. In response, fellow members offered advice from a sister who worked at a women's health center in Boston, a conversation with a neurologist friend, and advice as to alternatives for treatment, such as dietary changes. By building networks, doulas create

their own database of information that utilizes articles from the medical establishment, as well as personal experiences that add other doulas in supporting clients.

Doulas also rely heavily on their own experiences in the labor room when dealing with both clients and doctors. By using personal evidence to support, or challenge, possible medical interventions, doulas subvert the hierarchy of knowledge and authority. It should be reiterated that doulas do not offer medical advice. However, they will offer birth stories from previous clients and, what could be called, the collective memory of doulas who have shared birth stories from their clients. Lauren spoke of an incident with a couple in which the electronic fetal monitor was giving an abnormal read. Here, she offered her knowledge of internal monitoring in a way that both refutes the medical establishment's preference for constant EFM, yet also supports possible intervention.

> If a medical intervention is suggested, I lay out, "This is why they want to do it and then I give them [the client] my experience like, 'I've seen this before and this is usually the result.'" For example, the external belt monitors? They don't read accurately. But if those things are going off like crazy, there's an internal fetal monitor that they screw into the baby's scalp. It's scary to think that there's something being put into your baby's skull, but it is directly on their pulse line and it gives them a 100 percent accurate reading of how the baby is doing. I've seen it used about 7 times, so in all the cases where the external monitor says the baby's having a problem and they're starting to think they might need a cesarean, and they put in the internal monitor instead, the internal monitor has said the baby's perfect. So when they say they want to do an internal monitor, but [the mother] hasn't had any pitocin or drugs, and now they're saying they want to do an internal monitor, a lot of couples freak out. I tell them, "Look, you're right, it's invasive. You bear the risk of putting it in the wrong place. But it's going to give them a more accurate read on your baby. You can tell them you don't want to do it, but this could save you from having a cesarean because they trust this." And those women then go on to have an unmedicated, natural, vaginal birth, which is what they want.

Thus, for Lauren, if the ultimate goal for the mother is an unmedicated, natural birth, some interventions may prevent the ultimate in unnatural intervention: the cesarean. Using her experience, she offers her personal knowledge base to her clients that both refutes the cultural authority of caregivers by providing a more holistic picture, and also reestablishes trust in medical interventions when needed.

One of the more creative ways of drawing upon a personal knowledge base occurred when Michelle had a client whose midwife was unavailable the night she went into labor. A midwife that the couple had not met because they transferred late to the practice attended their birth. Michelle said, "She was about to go straight to Pitocin, so I sort of conferenced with the mom and the dad and said, 'I think it's a bit like if you're ever abducted by anyone, you should try to let them see you as a human being, so let's chat her up a little bit, ask her a bit about herself.'" They asked the midwife about her family, if she had been taken away from anything since it was late at night, until they "turned a corner and it was okay."

More commonly, however, doulas deal with plateaus, i.e. emotional blockages that may make a woman's labor stall anywhere between 4 and 7 centimeters. Though such plateaus often signify the need for augmentation or possible cesareans for medical professionals, doulas and some midwives see these instances as hurdles that can, for the most part, be overcome by patience and emotional support. The majority of doulas I interviewed had at least one experience of a stalled labor due to an emotional blockage. In some cases, a mother doubted her ability to have a natural birth; in others, she was dealing with body image issues from previous eating disorders. For Virginia, a Bradley

instructor, the "natural alignment plateau" is the perfect time for positive thinking. She said, "Most of the time, I just tell my moms, 'Let me tell you right now, you are not failing. You are succeeding.' It's a morale thing." Samantha, another "mother doula," says that getting stuck at 6 or 7 centimeters can, in certain situations, be a possible "marker of sexual abuse." "If you get somebody who has not been anxious throughout their whole pregnancy and you ask them what they're anxious about, you [often] get answers like, 'I'm anxious about being a mom' or 'I'm afraid there's something wrong with my baby,'" though vague answers sometimes point to past abuse.

In either instance, a doula supports her client by "boosting morale" or validating a client's desire for an epidural when she is having a hard time relaxing her pelvic muscles. Because many doctors rarely get to see a natural birth from start to finish, it is unlikely for them to understand the ebbs and flows of labor, particularly when they are bound to the clockwork of Friedman's curves, which estimates 1 centimeter dilation per hour of labor (Martin 1992: 59). For doulas, the experience was highly common and thus refutes the medical establishment's assumption of constant progression in dilation. These experiences also form a localized base of knowledge upon which both experienced and new doulas draw.

The doula birth experience

Doula resistance can also occur on a more personal level. It is not uncommon for a doula to have had a negative birth experience and have that birth experience directly affect her decision to become a doula. In analyzing the transcripts of the interviews I

conducted with doulas, I found that there were two main reasons or events that led becoming a doula and, quite often, the two overlapped. First, women who had a negative birth experience cited reading and literature as an activity that "opened [them] up" to the birth world. Second, other women found that they had been doula-ing friends and family before they were even aware of what they were doing. A sense of destiny comes up quite often in interviewing both midwives and doulas, though women who react to a negative birth experience by educating themselves are just as likely to feel that they had always been interested in birth themselves.

Two doulas in particular had negative birth experiences that led them to advocate for themselves in their subsequent births and directly affected their decisions to become doulas. It was not uncommon to hear women say, "I did not want another woman to go through that." One such woman was Lauren, a doula with two young children of her own. A bubbly and energetic personality, she immediately went into a lengthy discussion of her first birth when I asked her how she became a doula. Raised with the understanding that birth meant "you go to the hospital, you go to the OB, he gives you your drugs, and you have your baby," she found that when she went into active labor, she was utterly unprepared. "I looked at my husband and I went, 'Help me.' And he gave me a blank look. It's not that he didn't want to help," she said, "He just didn't know what to do."

Subsequently, she received an epidural to cope with the pain. At the end of the birth, she needed an episiotomy that, as she said, made her feel like she was "hit by a bus." "Physically, I was a mess. I could barely stand. I could barely sit. I couldn't urinate on my own because I was so bruised." Later, when her son was in the hospital for an

adverse reaction to a vaccine, she realized that there was "something about the human ability to heal other people." Upon leaving the hospital room that her son was in, the machines he was connected to went haywire. When she returned, everything calmed down again. After repeating this scene a couple of times, she started thinking more about alternative care practices, such as acupuncture, nutrition, and natural childbirth.

A well-educated college graduate, Lauren had been completely unaware of this alternative view of birth and when she was pregnant with her second child, she said to herself, "I have to find a way out of this. I'm not doing what I did last time." While watching television one day, she saw an episode of *A Birth Story*, a television program that documents women through their pregnancies and deliveries. "On the episode I saw, this one woman had a doula. And she was like this huge German woman that just held the woman up while she was giving birth. And I was like, 'Oh my God, that is what I need.'" Though she did hire a doula, and switched to midwifery care, for her next birth, Lauren was still not in control of her labor process. Past her due date during the holiday season, she was talked into taking Pitocin and later decided to get an epidural for her second birth.

> They couldn't get [the epidural] in and I'm wild from pain from the Pitocin. Finally I'm like, "What do you need from me to do it?" He's yelling at me, which is compassionate for a woman in labor, "You have to sit up and curl over." So I did it, and when I turned onto my back because they needed the medication to get level, she was crowning. I had gone from a four to a ten in 30 minutes. So everyone comes a running and her head delivers and she gets stuck. It's a condition called shoulder dystocia. So the midwife says to me, "You have to turn over on your hands and knees." And everyone's like, "She's got an epidural in and her baby's head is hanging out, how's she going to do this?" So I just did it and she came right out, but she wasn't breathing.

Strangely calm during the situation, Lauren said her doula told her husband to "call to" their baby. The baby responded and the situation was under control. At the end of the experience, though, Lauren's midwife spoke to her about the shoulder dystocia and explained why she used the Gaskin Maneuver, going onto her hands and knees, to deliver the baby. When Lauren told her midwife that her son had been born with a broken collar bone, her midwife was shocked. Breaking the collar bone and cutting an episiotomy is a typical response from obstetricians dealing with shoulder dystocia. "She looked at me like, 'That's vital information. How could you not have told me that before?' But my OB from my first birth denied that it was broken, though a pediatrician and chiropractor confirmed the break later." With this realization, Lauren said, "I went home and immediately looked up Ina May Gaskin and read *Spiritual Midwifery*. And then I just started reading about doulas, doulas, doulas." Thus, by taking her negative, and scary, experiences, Lauren was able to empower herself to challenge the medical establishment by getting a midwife and then, furthermore, to become a doula who supports other women in labor.

Similarly, Susan began with a negative birth experience. A hospital-based doula, Susan has three children, all born via cesarean. With an on-again, off-again labor, Susan had her family with her in the hospital when the nurses told her that if she thought she might want an epidural, she should get one then because the better anesthesiologist was in at the time and would be leaving at eight o'clock. "I remember the thought process going on in my head, which was, 'Oh my God, I'm only four centimeters and this is really bad. They're telling me that she's the best and they must think I'm going to need to

have one.' I could feel the whole process unwinding in my head." While getting the epidural, Susan noticed that once the nurse put her arms around her, the pain went away. Nevertheless, the "train was rolling" and once Susan had dilated to ten centimeters, her team recognized that her son was stuck in her pelvis. Eventually, her medical team recommended that she have a cesarean because she had been laboring for a long period of time. Though a c-section was not what she wanted, Susan said she does not "resent" her doctor or her medical team, suggesting that they were not as educated in natural childbirth as they could have been.

For her second child, Susan originally planned to have a VBAC. Before hiring a doula, as was suggested to her by her second obstetrician, Susan tried to place realistic limitations on herself as to what she would be capable of doing. When she found out that her baby was over eight pounds, she felt she would not be able to push him out and decided to do an elective cesarean. However, elective cesarean in place, Susan went into labor two days before she was scheduled to deliver. Planning to go along with the change in plans, she could not figure out why the hospital staff was asking her so many questions about what she had eaten and if she was allergic to anything. Eventually, they said, "Well, you're going to have a c-section." Susan said, "I was like, 'No, I'm not. I'm in labor.' I was so excited to be in labor. And my doctor was so mad, I made him miss his son's event, and he checked me at one point—now this is after an hour of active labor—and he said, 'Well, you're four centimeters, but the baby is still high. I think you're going to end up with a c-section again anyway.'"

Emotionally distraught, Susan was trying to figure out how she could make a VBAC happen. Because of the stress, she was unable to "get on top" of her contractions. Eventually, her second child was born via c-section, too. She said:

> I had loving support, but I needed someone to say to me, "Stop this. Get your butt out of this bed and start walking." The hard part is, in hindsight, everything is 20/20. I should have listened to him and hired a doula because at the end of the day, I needed the doula to guard me against him. And finally, when they took me into the OR, they sat me up and I thought I was going to puke. I was like, "I think I have to push," and they're going, "No, you don't." And of course, you're sitting there, you're so vulnerable, you're by yourself and they did the spinal and they delivered [my child] via c-section. It was in the months that followed that I started getting mad. I was like, "This is not right. I walked into the hospital at 6:30, I was one centimeter and by quarter to eight, I was four centimeters. Come on." There was no reason for this and that got me think that there has to be a better way.

Susan attributes this particular experience to why she is a doula. That need for forceful support was something she lacked in her second birth experience. The anger that ensued led her to, finally, take control of her final birth experience.

Ironically, Susan's last birth, and most self-determined birth, was also a cesarean. One of the most unique cesarean experiences I came across in all of my research, Susan requested a skin-to-skin c-section with her doctor while she was living in England, to which her doctor agreed. Her stipulations were that she watch her birth, immediately have the child laid on her chest, and have no separation, to which the doctor replied that they would slow down or go fast according to her desires and that no one would speak over her. "It's your gig, it's your show. If you don't like somebody in the room, we'll send them out. If you don't like the music, we'll change it. This is about you," her caregiver told her. She got exactly what she wanted and, she told me, she does not tell her

clients about her experience because she does not want other women to think having a c-section is a good idea. “If you have to have one, you’ve got to figure out how to make it your own,” she told me. “To some degree, I killed my own demons by having a birth like that because she really was never apart from me and to this day, she’s very attached to me and I think it’s because we were never separated.” Interestingly, this activity could parallel the withholding of information that can occur with obstetricians. For Susan, the healthier alternative of natural childbirth prompts her to breach the doula desire to provide women with any and all applicable information.

Susan finished telling me about her births by saying “that was how I came to be a doula.” Though all of her births were highly medicalized, rather than feeling disempowered, she fought back. She found a way to make her cesarean her own and remained in control throughout the whole experience. As such, she offers her unique background and history to other women who come to her for labor support. By having had an epidural and a c-section, she understands what both of those experiences feel like and she is able to validate any of her clients that go through the same experiences. However, because cesareans are far from the doula ideal of birth, she struggles to not promote the kind of c-section that she had, despite the shift in power that occurred in her experience. Though she does not consider herself an activist, she proactively altered her final birth experience and crafted a positive memory for her and her daughter.

Tactics of resistance

Lila Abu-Lughod warned against seeing and romanticizing resistance where there is none (Abu-Lughod 1990). Though doulas may not directly confront the medical establishment while on their "turf," so to speak, there are many tactics and means by which doulas subvert and/or re-appropriate medical technologies and protocol. It is the art of making do in which meanings, tools, and personal relationships empower women to remain in control of their birth experience, which is contrary to the practices of the medical establishment outlined above. These methods can take on a variety of forms, such as loopholes, education, and semiotic changes.

It should be noted that the doulas I spoke with may not be comfortable with the term "resistance." Unique as a subject of ethnography, doulas have already reframed their worldviews and philosophies because of personal birth experiences and education. They are highly articulate about *why* they have become doulas and can provide deep answers for their actions. Doulas were not raised in the doula-culture, but consciously chose to become part of it. They hope to change the medical establishment; every woman I spoke with called, at the very least, for more humanity and individuality for women giving birth in America today. They recognize that malpractice and the cost of providing care inhibit the ability of the obstetrician to practice the way he or she desires; they support the growth of the American midwifery movement that has been growing in popularity, as demonstrated by television shows and movies, such as *Orgasmic Birth* and *The Business of Being Born*. At the same time, the clause "interventions do save lives" always entered the conversation, because it is true. Doulas and midwives often envision a birth world in which midwives assist normal birth and the only clients obstetricians receive are the

high-risk, abnormal cases. A homebirth midwife I spoke with laughed when she said, "The c-section rate for doctors should be 100 percent, because that's all they should do." Though some doula actions may contradict their words, and though many of the women I interviewed refute the claim that they are "resisting," I believe this is more out of respect for the medical system and highly attributable to the cultural hierarchy of medicine in American culture. Thus, doulas carve out a space for humane, woman-centered birth through covert means that may take some time and intimate knowledge to view as genuine resistance.

The most obvious and concrete form of physical resistance is finding loopholes in the hospital system. In most hospitals, women are expected to be on the electronic fetal monitor which can also require women to remain bed-ridden during labor. Because walking is incredibly helpful for dilation and pain-management, doulas suggest that for women seeking natural birth, remaining mobile is crucial. For women who are required to stay in bed because of EFM, doulas suggest frequent bathroom trips. Caregivers do not deny women the ability to use the restroom and it requires that women unhook themselves from the mistake-prone external monitors, stand, and walk to the restroom. In the restroom, women are alone and thus can try any position change they would like. Doulas keep women in the restroom, often, until the nurses suggest that they return to bed. If these trips occur often enough, they will aid in a woman's pain management in labor.

Doulas also advise their clients to labor at home, in a normal birth. What is often dubbed the "cascade of interventions" is believed to begin when a client arrives at the hospital. For women whose water breaks before consistent contractions, the moment they

arrive at the hospital, they are "on the clock." In most hospitals, a woman is given twenty-four hours from the time her water breaks to when she gives birth. The hospital's reason is to prevent bacteria from entering the birth canal, which is even more likely to happen when a woman undergoes repeated vaginal exams during labor. When laboring at home, women wait until they are closer to the active stage of labor so as to avoid any interventions that can occur along the way in a hospital or so that they can buy time under the 24-hour protocol. All of the doula clients interviewed for this study said they waited at home as long as they could, with the doula meeting them in their homes to help them through the early stages of labor. At home, a doula will help a woman walk up and down the stairs, breath through contractions, use the birth ball and/or shower for pain management. Of the five doula clients interviewed, three had completely natural births. For Sasha in particular, a first-time mother from Russia, she hired a doula because she knew she wanted a natural birth and she was unsure that her husband would certainly be there because he is a doctor. She said, "Another thing [Jessica] helped with was not rushing to the hospital. Without her, I would probably think, 'Okay, time to go.' But she pretty much knew that it wasn't the time yet."

This is also a method that many doulas themselves used when speaking of their own birth stories. In particular, doulas who gave birth before the natural birth movement said they stayed at home as long as possible to avoid routine interventions that were almost never challenged at the time. Erin, for example, was given 150 milligrams of Demerol without consent during her first birth. When she was fully dilated, she was transferred to the delivery room and told when her contractions were starting and ending,

resulting in a forceps delivery. For her, the experience was traumatic, and thus, for her second birth, she "made sure that the doctors were not going to do that to me. I arrived fully dilated and had her within less than an hour from my arrival at the hospital." By arriving fully dilated, Erin avoided the protocol of the period that included enemas, perineal shaving, and medications.

Once at the hospital, doulas often subvert medical norms by suggesting position changes and techniques that are unfamiliar to most obstetricians. As such, from time to time, a doula will suggest pain management methods to her client who will then either succeed in convincing the doctor to allow her to continue the method, or will be told to return to the supine position, as is standard. Periodically, a doula will introduce a doctor to a new technique or method that is more natural birth friendly that standard hospital procedures. Susan was particularly excited to discuss a beloved obstetrician who, though initially hesitant to accept her recommendation for a position change, ended up appreciating the non-interventionist methods of doulas.

> [The client] was ready to push and the doctor said, "Okay, get on your back." She refused. He's got his gloves on, and he's this very tall, very skinny guy and she's like, "I want to squat this baby out." He says, "The problem with that is that I can't see anything if you're squatting." I would fault him, except he was 6'4". So I say, "How about I put you on your shins, you could hold the back of the bed, push on your hands and knees." She got on her hands and knees, pushed the baby out in a couple of contractions. Afterwards, mommy looks up at me after the baby came out and she goes, "I'm tired, I think I need to get on my back now." [*Laughs*] I directed the whole show. The doctor was like, "That was so cool." And he's not a youngster by any means, but he asked, "Can I have your business card? That was great." And he has since referred me to another patient.

For Susan, her client's desire to squat her baby out led her to compromise with the medical team who was unfamiliar with such a tactic. This particular hospital was relatively small and, as she told me, they later remembered her as "that doula." Though the doctor would have preferred a supine position, both because of his height and his training, Susan was able to compromise and clearly showed the helpfulness of doulas and labor support. In particular, this client had also had a negative first birth experience and it was very important for Susan that her "mommy" was able to maintain control for her second child.

Both Donna and Maria had experiences in which doctors were suggesting cesarean sections and their recommendations for walking and changing positions altered the outcome. For one of Donna's clients, the birth team was open enough to help "move her in every position we could." She had dilated to eight centimeters, but after four hours of pushing, they were concerned that the baby would not fit through the pelvis. "Because she was a VBAC, I told her husband, 'You should be thankful that her team let her push that long,'" in addition to helping her on her hands and knees to open the pelvis for the posterior baby. Though this particular client had a second cesarean, Donna said, "I think she felt okay about it [the birth]. She was a trooper. She had no meds, she pushed for almost three or four hours…it was a pretty good experience." Maria, on the other hand, had a client which, she said, "had I not been there, she would have ended up with a cesarean."

> She had to be induced, they broke her water, and for a short time after, the baby's heart rate was not the best. She was lying in bed, so I suggested that she get up. So the doctor came in and was like "You can read the monitor, right?" and I said, "Yes." He said, "If that heart rate goes down

> again—" he didn't say, "I'll bring her in for a cesarean," he just made it clear. As soon as we changed positions, everything went very well, very smoothly. Eventually the doctor's partner came in to deliver, but just my presence there reminded him that this [cesarean] was not the route that she wanted to go.

Though the doctor in this instance was not changed by Maria's "intervention," her suggestions were, indeed, accurate. The expectation that she and her client rest idly, rather than risking an imperfect heart rate reading, was challenged by her understanding that lying down can constrict oxygen to the baby if he or she is in the wrong position. By standing, walking, and changing positions with her client, she directly challenged the intimidation tactics used by the doctor in the hospital and ended up with a natural birth for a client who was seeking to have an unmedicated birth experience. She also proved that further intervention and all medical responses are not necessarily the only ones in a risky situation.

Dianna was the only non-White doula that I interviewed. As a Puerto Rican woman who worked in primarily immigrant communities, she was in the unique position of acting as both doula and translator. Providing an excellent example of John Fiske's definition of "semiotic power" in which members of the social force appropriate the power to make meanings out of the power-bloc's lexicon (Fiske 1989: 10), Dianna often translated and softened the words of the doctors she worked with. "The doctors, a lot of times, did not speak Spanish, so they could say everything they wanted that was mean or horrible and I could just translate it and make it sound a lot better." During training, it is recommended to doulas that they speak to their clients in their primary language, if possible, because labor and primary language are dealt with in the same, primitive part of

the brain. For Dianna, she took the recommendation a step further. Rather than translating directly any words or phrases that could be disempowering or "mean," she offered her clients positive words and buffered them from rudeness of the part of the medical establishment.

Rather than reinterpreting or shifting practices and words in the hospital environment, mothers can also offer selective information to their doctors, so long as it does not risk the health of their babies. Doulas may advise their clients, for example, to choose the later of two possible due dates and possible times for the breaking of the waters. During one of the birth education classes I attended, a mother-to-be stated that her doctors had told her two different due dates that differed by roughly five days. Virginia, both birth educator and doula, suggested that she tell her doctors she wanted to go by the later date. The purpose of this technique is to avoid unnecessary inductions. According to the midwives and doulas I spoke with, 40 weeks of pregnancy is not a definitive length for carrying a child. In the past, doctors preferred to induce or cut a cesarean at 36 weeks; more recently, it is uncommon for a doctor or midwife to allow a patient to carry for more than 42 and induce before 39. Experientially speaking, the women I spoke with stated that even when a baby is "late," it may be for a reason. As such, doulas prefer to help their clients "buy time" by, if possible, going with a later due date to avoid induction, which often leads to other interventions, such as pain medication and/or cesarean sections. Due dates vary from baby to baby because each child has different needs. By reestablishing this individuality in obstetrical care, doulas both avoid intervention and allow a woman to trust her body and her ability to give birth "when the baby is ready."

Knowledge as power

Education plays a crucial role in preparing doula-clients for the hospital-based birth experience. In particular, doulas attempt to prepare their clients for any unpredictable decisions they may have to make during their birth experience. Though I have already analyzed this as a means by which doulas often support the prevailing birth hegemony by educating their clients because they cannot confront caregivers directly, doulas also subvert the limited information most women are given when meeting with their caregivers over the course of their pregnancies. By educating women, they are empowered to take control of their birth experience by feeling confident and knowledgeable enough to challenge the suggestions of their doctors that may or may not be medically necessary.

Karen used a doula for one of her homebirths. Now a relatively well-known birth activist, she came upon doulas after adopting a healthy lifestyle with her husband. Self-education, advice from her doula, and personal experience with her doula-supported homebirth has all led her to feel empowered and confident in her knowledge of her body. For her second birth, she was receiving prenatal care from a midwifery practice who knew that she would be birthing at home without them because they did not do homebirth. At one of her appointments, "They had hired some new midwife at their practice and this woman said to me that homebirth was dangerous and I would die if I had a baby at home." Instead of doubting herself, Karen said, "I looked at her like, 'You're crazy.' I just walked out of her office, stopped at the front desk, and said, 'Give me my records.

I'll never come back here again.' And I was totally confident." Her own knowledge and understanding of birth and, particularly, how she births enabled her to refute the unfounded advice her midwife was giving her and, she joked, "I did give birth to my son at home and I'm still here to tell about it."

Women giving birth in hospitals may have to contend with professionals who may not give the entire picture when suggesting medications or interventions. There are a slew of competing interests in any enterprise that range from economic to personal. For Lauren, when an anesthesiologist was sent to a client's room even though she told her doctor she did not want an epidural because of a fear of needles, the education that she had given her client enabled her to stand up to the misinformation the anesthesiologist offered her.

> [The anesthesiologist] started talking to her about what an epidural is, as if he were reading it, like half-asleep. She said, "But I've heard that if you get an epidural late it could affect the baby." He goes, "No, none of the drugs get to the baby." And I was just—that's an outright lie [*Laughs*]. But you can't say anything. I know it, but when you're in the hospital you keep your mouth shut. And he goes, looking at me, "I don't know what some people have been telling you, but an epidural is perfectly safe, there are no side-effects from an epidural." And I'm letting her fight her own battle. I'm standing by her side. She knows what she wants, and he was like, "Fine," and he walked out.

Even though Lauren was unable to contradict what the anesthesiologist was saying, the prenatal visits she had with her client provided her with enough information and confidence to stand up to the anesthesiologist. For hospitals with thousands of births going on each year, it is genuinely easier to have women on pain medication because they remain in the same place and they do not have as many physical, one-on-one needs. Pressure for interventions, particularly pain medication, can be very intense. It takes resolution and a firm knowledge base to refuse medical suggestion, especially during

labor, as no parent would ever want to harm their child by not providing the appropriate care. Education, however, gives them a firmer foundation upon which they can judge which may or may not be genuinely appropriate care.

According to the doulas I spoke with, it is not uncommon for a client to switch from obstetrician to midwife after meeting with the doula. Sasha, Jessica's client, had switched from an obstetrician who was a friend of her husband's, to a midwife during her pregnancy. It was a switch that she was very satisfied with, even though she received some backlash from friends and family because of the personal connection to the doctor. While the majority of doulas I spoke with acknowledged that midwifery care was gaining in popularity, a couple also mentioned that they had clients who switched from obstetrical prenatal care to midwifery care after calling them about hiring them for doula services. This reflects the fact that doulas are providing honest answers and accurate information about the type of birth a woman *can* have in a particular hospital with a particular care provider. Though none of the doulas I spoke with freely offered this information, if a prospective client asked their opinion, they did not hesitate to be honest based on their personal experiences.

More important than switching from biomedical care to midwifery is what doulas call establishing "philosophical alignment" with your caregiver. This means that for a woman who is seeking a natural, unmedicated homebirth, it is important that she have a homebirth midwife who believes that women can give birth on their own at home. For a woman looking for a hospital-based, less interventive birth, it is important that she have an obstetrician who views birth as a normal body process that takes patience and an

ability to see when danger arises, and how to treat it. Samantha had a client who called her at 35 weeks for doula services. Though she had not yet decided on hiring her, Samantha offered the prospective client a list of questions to ask her OB because, she said, "She's telling me what kind of birth she wants and she's telling me what hospital and doctor she's going to. I'm thinking to myself, 'There is no where you're going to have this kind of birth.'" When the client called her back to share her experience with meeting with her doctor, Samantha found:

> The first words out of her mouth were, "I need your help because I know I'm not going to get the kind of birth I want. And I said, "Phew." So I helped her find a supportive OB because she wanted an OB rather than a midwife. She transferred at 36 plus weeks to this OB and she had a beautiful, unmedicated birth, just like she wanted.

Even though Samantha's client still used an obstetrician, she found an OB that whose birth-view was similar to her own. For women who are not philosophically aligned with their caregivers, the birth experience becomes an uphill battle. In the case of Samantha's client, she was able to utilize the information that she was given to recognize the situation she was in with her first caregiver and to act on it, enabling her to have the birth she hoped for.

Another form of education that doulas use, which can also be termed self-education, is the creation of a birth plan. The doulas involved in this study were split as to the usefulness of birth plans. In short, a birth plan is a write-up of a woman and her partner's ideal birth, i.e. in a hospital with a preferred obstetrician, a few family members, minimal interventions, and contact with the baby immediately after birth. A woman can present a birth plan to her medical team before she goes into labor. It is also suggested

that she keep more than one on hand when she is in labor so that differing shifts of nurses can be updated as to her wishes.

Some doulas believe that birth plans encourage women to believe that birth can be controlled and actually planned for. Every doula I spoke with believed that birth is an individual and unpredictable experience in which what is meant to happen, will happen. This philosophy allows for any event to occur in any given birth and provides both doulas and family members with a buffer for dealing with any grief or disappointment in the birth experience. Thus, rather than offering the traditional birth plan, doulas are more apt to discuss a woman's preferences and then prepare her for any changes that could occur during the labor and delivery process.

The other purpose of the birth plan is to alert caregivers to a woman's preference. By preparing a birth plan, doctors, nurses, and midwives become aware that this particular patient has taken the initiative to educate herself and make choices regarding *her* birth experience ahead of time. A homebirth midwife that I spoke with said that, in her experience as both a doula and midwife, "[Medical professionals] roll their eyes and patronize women who have a birth plan and the nurses say, 'Oh, she's going to be a section. Ha ha,' at the nurses' desk when someone comes in with a birth plan." Though such reactions are clearly not true of all, or even most, medical professionals, because women in labor are very sensitive to the words they hear, it is important that their medical team support their goals. Rather than going into the hospital and hoping for the best, a doula client is prepared and has alerted her medical team of her own wishes which, hopefully, will result in a birth experience she will be content with.

Space

The primary mode of resistance in the hospital for doulas, however, is through advocacy and "holding the space" of her client. Genuine advocacy occurs when doulas create space in the medical establishment for her client to make informed decisions without being rushed or pressured. This also occurs when doulas maintain a particular atmosphere in the birth room. For example, during training, Patricia told us that she often turned the lights off in the delivery room in the hospital, shut the blinds, and put a doorstop on the inside of the door, so as to maintain privacy and respect for her client. This way, she said, when caregivers entered the room, they recognized it as their patient's space into which they were entering. She also made a point of positioning herself in front of the electronic fetal monitoring screen so that the doctors and nurses would not walk in and directly go over to the screen, but would first ask the mother how she was doing.

In terms of verbal advocacy, this same doula would ask her clients if they needed to pray before making any major decisions. She found that medical professionals were more inclined to agree to let a family pray, rather than allowing time for them to "think" about it. By maintaining this space both verbally and physically, Patricia enabled her clients to reclaim their authority in the birth process. In the hospital system, processes can be rushed. Doctors have increasing demands made on them both economically and time-wise. Hospitals also need to make money. As such, the atmosphere tends to be direct and to the point. By buying time and holding back the medical establishment, doulas are able to maintain the "sacred" space of birth.

Lastly, doulas use the one-on-one bond they develop with their clients to help maintain their desire for a natural birth. While very few of the doulas I interviewed still used this technique, two of the newest doulas I spoke with utilized "code words" and the doula training workshop also spoke of this method. A code word is a word a doula and her client pick during a prenatal visit that she can say to her doula if she decides she wants pain medication after opting for a natural birth. As such, she remains in control of when and if she wants pain medication, rather than asking for one after the repeated offers of hospital staff members. Anne, for example, explained her personal experience:

> [A friend of mine] was in the hospital and she had gone in with the plan to have a natural birth. Every five minutes the nurse came in and said, "Can I give you your epidural now? Can I give you your epidural now? Do you want epidural? Do you want anything? Do you want an epidural?" which is very common. When I was in the hospital with this woman, they knew that she had birth plans and that she had a doula and no desire for any medical intervention. Still, they came in and said, "Can I get you some pain medication? Can I get you an epidural? Can I get you this?" They think, "Oh, I'm just trying to be helpful," but they're just making it more and more difficult. So we use code words in the doula world and that if a woman really needs it, they know that they have the option of asking for it if it gets to that point, like a safe word.

When using a code word, a doula knows when her client has definitively made the decision to have an epidural. For Anne, when nurses ask patients over and over if they want an epidural, they start to doubt their desire for a natural birth. A woman may begin to wonder if it is strange or wrong to not accept medication. By creating a code word, she knows that she always has the option, but does not give into constant questioning by well-meaning hospital staff.

Long term changes

While doulas do advocate "one birth at a time," they also hope to change both of politics and culture of birth in America on a larger scale. Some doulas are more prone to political activism than others, though all recognize problems in the current birth system. Popular American culture tends to conceptualize birth as painful, fast, and as a pathology. Jennifer, a doula who studied Anthropology as an undergraduate, commented that in the media, birth is "presented in a very negative light. If you see any sitcoms, they're usually screaming, they're always flat on their backs. It's always a crisis and an emergency. Birth isn't really like that. It's not like, 'Oh, it's time, honey.' And we all run to the hospital. You never see a strong woman just laboring and bringing forth her baby." She also commented that birth is not seen as normal or natural and if homebirths are shown on TV, it's usually viewed as a comedic event.

Because doulas view birth as a normal body process, a cultural transition from birth as pathology to normal birth is something hoped for. From a subjective point of view, as a researcher, I was very aware of speaking about birth so openly in very public places. While I met some doulas in their homes, I also met others in diners, restaurants, coffee shops, and at events. Not one woman hesitated to speak about topics that, I believe, are generally considered taboo to speak about in public: menstruation, breastfeeding, female anatomy, etc. In discussing the topic of my research with friends and acquaintances outside of the birth world, many people, particularly men, reacted by joking about doulas and natural birth or appearing uncomfortable with the subject.[13] This

[13] I should add that quite a few women I spoke with about this topic often started talking about their own birth experiences and how they felt, what went wrong, what they hoped for, and so on. While many did not see the point of a doula, they did appear to be more open to the subject then some men.

gender segregation of conceptions of birth is also related to the cultural construction of birth. Shaina was a doula who focused much of her work on "new age" spirituality and a mystical, or romantic, view of womanhood. She stated in our interview that she felt both men and women were crucial in the birth process and that if boys were taught more about the "blood mysteries," there would be less violence toward women in American culture overall.

> I really believe that if we had more reverence and honor and respect for the all of creation, and we had rites of passage to honor transition to adulthood for boys and girls, when a 34 year old is pregnant, she would be less likely to believe that she needs a male to deliver her baby because she'll know that she can birth her baby. She'll know that blood is not scary, it's part of the life cycle, it's part of what makes her whole and well and healthy. But every person who's in front of me in prenatal yoga may have a history that I may or may not be privy to.

She further tied the cultural conception of birth as a pathology and man's work to, like Robbie Davis-Floyd, gender conceptions in American culture that "shame and blame" women's bodies and sexuality in general. To Shaina, for a woman to not trust her body during the birth process is directly related to the fact that she has never been told to trust her body. "Conversely, it's been, 'Suck in your stomach,' 'Hide yourself,' or 'Don't show cleavage.' She's been getting bombarded with images her whole life," she said. The goal is to help women to believe in the power of their bodies and their capability to overcome obstacles which, of course, can be translated as a metaphor for women in American society as a whole. As such, it is not surprising that doulas are not promoted more by the medical community. The goal of the power-bloc is to maintain its power.

Looking outside of the delivery room, doulas have also gotten involved with efforts regarding breastfeeding, paternity leave, and vaccinations, as well as networking

with alternative care providers. In particular, the doulas involved in this study also practiced massage therapy, acupuncture, and one was a Certified Lactation Consultant. Chiropractors are also an important ally for doulas and the natural birth movement. The use of doulas largely coincides with an alternative, more holistic medical view. As Anne said, the type of client she feels are more attracted to the use of doulas are "the Whole Foods-y type." She added, "They've got the disposable income available. They've already made the commitment in other parts of their life to try to eat organic or buy a hybrid."[14] Of the three chiropractors I spoke with, they all also stated that they took a more holistic view of the body and two had used doulas in their birth experience, whereas the other had not yet chosen to have children.

Chiropractors are most often called upon when dealing with pain during pregnancy or, in the case of a breach presentation, the use of Webster's Technique. Webster's Technique is a chiropractic maneuver that loosens and relaxes the muscles in the uterus, with the idea being that by removing tension, a malpositioned baby will be able to move with less resistance to the ideal position. Whereas the majority of New Jersey doctors would primarily respond to breach presentations with elective cesareans, chiropractors are offering a new alternative. As such, some doulas are forming alliances with certain pregnancy-centered chiropractors to both recommend their clients to and to be recommended to clients. In forming these bonds, doulas and chiropractors are offering women and their families a wider variety of options for pre-natal care and well-care. In the long run, both doulas and chiropractors attempt to empower women not only through

[14] She also added that there was a growing popularity for the use of labor support among the Orthodox Jewish community, to which she is connected through work and religious background.

the birth process, but for the rest of their lives as well. In terms of power, a woman who understands her body and feels that she birthed her baby, doulas suggest, will be more likely to have the confidence to stand up to her doctor or her child's pediatrician when a medical authority recommends a care plan that she may or may not agree with.

One of the chiropractors involved in this study tied her work to larger issues of pharmaceuticals and wellness in America. "Things that we [she and her partner] work on with kids, in addition to just regular overall wellness, are colic, ear infections, allergies and things like that. So for the moms coming in, that's really part of the education I want to give them so that they know when those things happen they don't have to run right to the pediatrician for drugs." Subsequently, two of the doula clients I spoke with had decided not to vaccinate their children and had also begun regularly using chiropractic support.

In shifting the cultural authority away from biomedical treatments to holistic care practices, doulas and their partners are slowly changing birth culture. While the message generally may only reach a privileged few, with the rise of community doula programs in low-income areas, as well as doulas-in-training who may work for free, accessibility leads to alternative conceptions of birth and health overall. Chiropractors are offering their clients information about doulas and natural birth, as well. With more exposure, and with an alternative message, doulas are subtly undermining a birth system that is not always the best option for every woman.

Subverting expectations

Though in the minority, some doulas are more apt to take a radical approach to birth. Rather than compromising, very few will only take natural births or home birth clients. One of the doulas I spoke with found herself more satisfied emotionally when she switched to become a homebirth midwife, rather than a doula who often worked in New Jersey hospitals. The overwhelming majority of the women I spoke with, however, disapproved of the more radical approach to doula-ing.

Many of the doula stereotypes I encountered arose from the conception of the radical doula that was adamant about non-medical births. Though this divided the doula community into different camps, I very rarely came across women who fit the description of the radical, "crunchy, granola" doula. Nevertheless, both the idea of such doulas and their actual existence provide a space for compromise between the doula community and mainstream caregivers. Susan framed it by saying:

> There are doulas who will not support women who think they're going to have an epidural; they will not go to c-sections. They won't go to certain hospitals, and there are certain hospitals I don't like, but I'll go anyway. I understand why they won't, but I still do it. So, I appreciate and applaud them for this effort that they're making because they are so left-wing about things and I think that you need people who are extreme to make change happen.

Thus, in comparison to the conception of the pushy or radical doula, moderate doulas who work with a variety of caregivers in a variety of settings are more likely to bring about changes in the medical system because they run contrary to popular misconceptions of the role of the doula.

Furthermore, almost all of the doulas interviewed encouraged or admired homebirth, while acknowledging that birthing where "she feels safest" is the best option

for any woman. However, by exposing clients to the option of homebirth as professionals in a position of authority, albeit local, doulas disentangle American women from the web of preconceptions about how one is supposed to birth. Michelle, for example, believes that women who experience difficulties or fetal demise during a homebirth are less likely to receive sympathy than a woman who gave birth in a hospital. "Whether said or not, people would be thinking, 'Well, look what she did, you got what you asked for.'" she said. Statistically, homebirth is as safe as, if not safer than, hospital births for women with normal pregnancies. Homebirth also removes the profit from maternity care and places the power directly in the hands of women who are more often "guided" by their homebirth midwives, rather than "managed" by doctors or hospital midwives.

Regardless of the type of client a doula takes on, by verbally supporting more radical doulas or by exposing potential clients to the option of homebirth, they subvert the prevalent expectation of pregnant women in America. While providing options and information, doulas also provide supplements of confidence that may enable a woman to believe that, indeed, she can birth naturally. As such, they undermine and resist the obstetrical monopoly on birth in America.

Conclusion

On December 11, 2008, *New York Times* blogger Lisa Belkin (2008) of Motherlode posted a story about childbirth activist and doula, Debra Pascali-Bonaro's new documentary, *Orgasmic Birth.* The film shows the unique cases of women experiencing pleasure, rather than pain, during their childbirth. Having listened to Pascali-Bonaro's rationale first-hand as to why it is more productive to call contractions "surges" and "waves" during labor, her film seems perfectly in line with stories I have heard from her fellow natural birth advocates and like-minded mothers, doulas, and midwives. For the readers of the *New York Times* (Belkin 2008), the announcement sparked a slew of comments, over 500, that ranged from disgusted to delighted, though few fell in the realm of ambivalent. Some of the comments included:

> Huh. I hadn't realized that I had been taught to "endure" childbirth rather than enjoy it. I always thought my body just responded as it felt appropriate. Somehow an orgasm just didn't happen while I was experiencing the most mind bending pain of my life.
>
> The Bible says in Genesis that woman are cursed with a painful childbirth. I find it hard to believe that this curse has been lifted.
>
> It's no more ridiculous than declaring that the earth revolves around the sun, or that deciduous trees lose their leaves in the fall. It's a fact, amply documented, and easily explained. I'm glad it's getting more notice–the culture of childbirth in the US is pathological with astronomical c-section rates (>25%) because people are so afraid of the pain. It puts everyone at risk. Pain is an extremely subjective experience, highly sensitive to expectation and context–it's time to push in the other direction.
>
> This is a truly pathetic topic for a documentary. While a few women may actually have this experience it really sounds freakish and does more harm than good in promoting a realistic natural birth to the majority of women.

Pop culture, uninhibited and broadly available, can be a hot-spot for the discovery of cultural perceptions. In the case of Belkin's "Orgasms During Childbirth?," the user-generated comments provide ample data on American perceptions of childbirth. Though it is impossible to discover whether these readers are doctors, lawyers, clerks, plumbers, or secretaries, the comments found below "Orgasms During Childbirth?" vary greatly. The overwhelming majority treat the topic with a healthy dose of skepticism, particularly when pitted against their own experiences. Others find the idea "gross." And still others believe that this is a positive movement toward a less frightening view of labor in American culture.

Of course, Pascali-Bonaro's documentary focuses on a highly specialized birth experience. A woman giving birth in an American hospital, with an obstetrician, and a, what is considered, normal expectation for pain during childbirth will have an experience greatly different from the homebirther laboring in her room with candles and a home-made CD mix. Neither scenario is better or worse. Each woman births according to her own needs and expectations. Though most all of the doulas I spoke with joked about the "crunchy," hippy-esque stereotype they attracted, there was always a bit of truth in the statement. The women I spoke with preferred to not vaccinate their children, attended yoga classes, shopped at Whole Foods, and spoke openly to their children about the process of childbirth. Of course, not every woman I spoke with participated in these activities, but trace amounts of an "alternative" view of women's health entered into these women's lives and conceptions of themselves and their families.

So what does it mean when the alternative view of birth, i.e. birth as a transitional and, possibly, sexual experience, is met with derision and scorn from average internet surfers? It is hard to refute the perception that natural childbirth and women-centered approaches to birth are entering mainstream media. Doulas and midwives have been breaking into television shows, op-eds, and major motion pictures steadily over the past ten years. Their appearances have been met with derision and scorn, optimism and curiosity. From the viewpoint of an outsider-turned-insider, it would appear that the modern birth paradigm if beginning to shift, if ever so slightly.

Birth junkies

With the knowledge we have gained from these alternative birthers and their supporters, we have learned the ways in which culture affects the practice of science. We have also learned the way grassroots organizing can challenge predominant paradigmatic viewpoints. The issue of birth is not only an issue of medical anthropology, but it crosses over into the intersections of feminism and science, capitalism and State-legitimized systems of knowledge. By studying doulas in particular, we are able to see birth from a perspective that is both counter to mainstream viewpoints and more enmeshed in popular conceptions of childbirth than a homebirth midwife could offer.

The arguments of the doula are simple: women-centered, individualized, holistic systems of childbirth. American women appear to be receiving the message, as shown by the increasing amount of doulas included in popular television shows, such as *Birth Day*. Even Ricki Lake's film, *The Business of Being Born*, caused a small stir in the news

media. Though many critics focused more on the film and images of Lake's actual labor than the content of the movie, feminist blogs and presses spread the word and the men and women who saw the film were exposed to a normalized version of healthy homebirths, midwife guided labors, and the role of industrialization in the creation of a not-so-traditional birth system.

Furthermore, this study in and of itself is unique for its focus on doulas. Often mentioned in passing as secondary characteristics of the natural birth movement, doulas seem to be hiding in the shadows of the more controversial resurgence of the American midwife. Doulas, however, have no medical counterpart in the same way that midwives are in direct conflict, at least from a consumer's viewpoint, to obstetricians. The actual presence and, via certification programs and doula-centered organizations, legitimization of labor support is historically unparalleled.

Of course, prior to today, it was indeed rare for a woman to find the opportunity and need to commodify the support of friends, relatives, and neighbors. Quite often, commodification becomes a dirty word, in particular, when dealing with the emotions. Karl Marx spoke of the disturbing aspect of the commodification of non-commodities as "being offered for sale by their holders, and thus acquiring, through their price, the form of commodities. Hence, an object may have a price without having value" (*quoted in* Martin 1992: 66-67). But birth itself, a non-commodity in the truest sense of the word, has taken on the metaphors of the industrial culture to which in belongs, in certain societies. As such, we return to Fiske's art of making do, where resistance and passivity co-exist in the grey area of personal politics.

As discussed above, doulas participate, in many ways, in the rituals of modern obstetrical practice, falling into the cracks of traditional gender politics and hospital hierarchies. Speaking of "economic crises," Antonio Gramsci wrote, "They can simply create a terrain more favorable to the dissemination of certain modes of thought, and certain ways of posing and resolving questions" (Gramsci 2000: 208). With the "maternity care crisis," doulas may not be fighting for a world in which every birth is a homebirth, regardless of desire or danger—and it is doubtful that anyone would propose this position—but they are enabling more radical views of birth to be disseminated in a system that, in general, does not favor the questioning of authority.

In drawing an example from Lila Abu-Lughod's "The Romance of Resistance" (1990), one can see the inevitable dichotomy between "giving in" and protestation. Abu-Lughod's Bedouin women follow the codes of their sexually segregated culture at a superficial level and, arguably, on the whole. With a more in-depth reading and analysis of how the Bedouin women of Egypt's Western Desert live, Abu-Lughod found "all sorts of minor defiances of the restrictions on activities and movements enforced by elder men in the community" (Abu-Lughod 1990: 317). These defiances included secret trips, smoking, songs, and resistance to marriage. Toward the end of her essay, Abu-Lughod asks, "How might we account for the fact that Bedouin women both resist and support power, the latter for example through practices like veiling, without resorting to concepts like false consciousness, which dismisses their own understanding of their situation, or impression management, which makes of them cynical manipulators?" (Abu-Lughod 1990: 323) She answers by suggesting that academics and researchers have developed a

type of hierarchy of resistances. Ortner echoes these findings with a subtle, nuanced conclusion to her own essay on resistance:

> These ambivalences and ambiguities, in turn, emerge from the intricate webs of articulations and disarticulations that always exist between dominant and dominated… subordinated selves may retain oppositional authenticity and agency by drawing on aspects of the dominant culture to criticize their own world as well as the situation of domination (Ortner 1995: 190-191).

For Ortner and Abu-Lughod, as well as de Certeau and Fiske, one does not need to first escape the hegemonic powers of a society before resisting. Resistance is deeply and complexly woven into the fabric of cultures and their systems of hierarchy throughout the world. American childbirth is just one example.

By now, it is clear that resistance is multifaceted and, in reality, no one form of resistance is "better" than another. When a doula suggests that her client ask if there are other options when advised to be induced a week after her due-date, outside of earshot of a medical professional, she is still resisting or, rather, enabling the resistance of other birthing women. There are numerous forms of resistance that range from the subtle to the audacious. Images of protesters and rioters are imbued with obvious cultural significance and romance. As the 21st- century progresses, we have seen that grassroots, "humble" protestations are just as apt, if not more likely, to create change within inhumane situations. Thus, it would not be difficult to argue that for each person who finds alternatives to hospital birthing to be "gross" punishment, another doula has just educated her next client on the possibilities of a woman-centered birth.

Appendix 1

Drew University
Statement of Informed Consent

I am conducting a research project for my Honors Thesis in Anthropology at Drew University. The purpose of this research is to gain insight into the doula profession and the American obstetrical system. With this research, I seek to contribute to the general knowledge of birth in the sphere of Anthropology and other social sciences. The insight this research will provide is also aimed to increase understanding and awareness of the role of doulas in childbirth in America and how this relates to American culture writ large. Specifically, this research will explore how doulas view the birth experience and how this view differs from the predominantly medical birth experience in which most American births take place. My methodology primarily involves open-ended interviews and participant-observation and research will be conducted from April 2008 to April 2009.

You will be asked to share your thoughts and experiences on the birth experience. Interviews typically last between one-and-a-half hours to two-and-a-half hours and will be conducted in a mutually convenient location. Your responses to a series of twenty to twenty-five questions will be recorded via a digital recorder or hand notes, depending on your preference. You will not be identified directly; I will use pseudonyms in the thesis to maintain confidentiality. The transcriptions and digital recordings of the interviews will be kept on my personal computer and only I will have access to them. Your name will not be released for any purposes. Your participation is voluntary and you may withdraw at any time.

I would be happy to provide you with a summary of my results. Any questions you may have at any time will be answered. If you have additional questions after completion of the research, you may contact me at evarlese@drew.edu or 973.408.5737. You may also contact my thesis advisor, Professor of Anthropology Marc Boglioli, at mbogliol@drew.edu or 973.408.3363.

I, _____, agree to participate in this study and may withdraw at any time.

Signature of Participant: _____

Printed Name: _____

Date: _____

Appendix 2

Doula questions:

When did you become a doula?

Why did you decide to become a doula?

Were you certified? What program? Post-partum?

How were your own birth experiences?

What is the role of the family in birth? The doctor?

Do you do any other birth-related activities? Which and why?

What is your most recent birth? Can you describe it to me?

Tell me about your clients. Is there a particular type?

Do you keep in touch with your clients afterwards? What about their children?

How do you interact with midwives? Obstetricians?

Would you ever consider becoming a LDN or midwife?

How do your children feel about your doula-ing? Family members?

Do you have many friends who are doulas? Is there a local community?

Doula literature? Films?

Can you describe the typical doula to me?

What is the ideal birth setting? What is the worst birth setting?

Do you feel that doulas should be covered by insurance companies? Have you ever been paid through an insurance company?

Have you ever used “creative capital” or bartering for payment?

Do you consider yourself a feminist?

Do you consider yourself pro-choice or pro-life?

What is your relationship to the father or partners present in the delivery room?

Did you have a doula? Can you tell me about your birth experiences?

Have any of your clients had c-sections or medicated births?

How do you think the media represents birth? Doulas?

Would you like your children to use doulas if they have kids?

What is your essential role in the delivery room? Where do you stand? How often do you communicate with the nurses, the doctors, staff, family, etc?

How do strangers and family members respond to your profession?

Do you feel being a doula is political? If yes, how so?

Have any of your clients had post-partum depression?

How important are reproductive histories?

What is your process by which you take on a client?

Do you see a difference in how OBs talk about birth versus how you talk about birth?

Is birth a feminist issue?

Appendix 3

Midwife questions:

How did you become a midwife?

What kind of program did you follow for certification?

What are your roles in the birthing community? (Do you do anything else?)

Do you do home births or hospital births, or both?

Was there a particular moment in your life when you decided you wanted to be a midwife?

If you could sum up your birth philosophy, what would it be?

What is your role in the delivery room? Describe a recent birth for me.

How many births do you do a month?

Are some births more memorable than others?

Do you have backups, partners, etc.? Are you associated with a hospital?

How often do you work with doulas?

What do you look for in a doula when you agree to work with her?

Do you have any experiences with doulas that stand out as particularly pleasing? What about negative?

What does a doula bring to the labor room versus when a mother chooses only to have a midwife and any other partners in the room?

How do you interact with doulas in a typical birth?

Have you ever worked with an OB? How do they differ from other birthers?

If you could choose an ideal labor, what would it be?

Do you have children? Did you use doulas and midwives for them?

How do people react to your profession?

Do you have many doula, midwife, birth educator friends?

How do your clients rate their experiences of birth after using a midwife? Midwife and doula?

What kind of transformation do you see in women who give birth?

Do you see birth as a feminist issue? In what ways?

Are midwives covered by insurance? How does this relate to the national debate?

Have you ever attended births in other countries?

Do you see natural birth in the media? How is it represented?

Tell me about aspects of birth that are overlooked in the medical community, if there are any at all. (Difference between births in the medical and midwifery communities?)

What is a typical client for you?

Do you think there are midwife stereotypes?

Does religion play a role in your practice? If yes, how so?

Why do you feel that most women go to OBs and don't have doulas and midwives? Socially?

Do you use "intuition" in your practice? How so?

Do you consider yourself a birth activist?

Appendix 4

Questions for OBs:

Why did you choose to become an obstetrician?

How long were you in school for?

Did you always know you wanted to be an obstetrician?

When a patient comes to you, what are the first things you go over when she becomes pregnant?

What kind of relationship do you have with your patients (i.e., how many times a month do they come in?)

Do you keep in touch with patients after their birth?

Can you describe a typical birth for me?

What do you focus on during birth (i.e., baby's heartbeat, mother's comfort or pain level, etc.)?

Have you ever worked with doulas?

What are your experiences with doulas?

Are they helpful or a hindrance?

Do you notice a difference in the outcomes of birth when you've worked with doulas?

If you recommend doulas to patients, what characteristics make a doula better or easier to work with?

Do you work with midwives ever? Do you feel that your view of birth differs from theirs or is it compatible?

Do you have many patients who choose to have natural births?

Do many of your patients choose to have medicated births?

How do you define a natural birth?

Do you see birth as a feminist issue?

Do you use “intuition” in your birth practice? Energy as a way to help the mother progress in labor?

Is there a standard by which you can judge the progression of a pregnancy?

Have any of your clients ever had post-partum depression?

How do you feel about breastfeeding? Do you promote it to your clients?

What kind of transformation do you see in a woman after she has given birth?

What’s the role of the family in the delivery room?

Do you feel insurance companies should pay for doulas?

How does malpractice affect your practice?

Are there any changes you would like to make in obstetrics? Why?

Do you support the natural birth community? Midwives? Homebirth?

What is protocol for c-sections?

What is your ideal birthing environment?

Appendix 5

Questions for chiropractors

How did you get into being a chiropractor?

What kind of training did you need?

In what capacity do you work with pregnant women?

In what capacity do you work with doulas?

Do you recommend doulas to your clients? If so, why?

What kind of information and advice do you pass along to your pregnant clients?

Are you ever in the hospital? Only prenatal?

What kinds of problems might a pregnant woman come to you for?

How do you feel prenatal care relates to the birth outcome?

Do you keep in touch with clients after their births?

Do you work with any particular doulas? What do you look for in a doula?

How did you hear about doulas?

Where do you see them fitting into the medical, birthing community?

What are your views on birth?

Are your services covered by insurance?

Explain the role of touch in birth, if there is one.

How do you find your clients?

Do you ever recommend doulas to clients?

Appendix 6

Questions for clients:

Can you describe your birth story/birth experience?

How did you hear about doulas?

How did you find your doula?

Did you talk to any other doulas before choosing your doula? If so, why did you decide not to choose them?

What was her process for taking you on as a client, i.e. questionnaires, contracts, prenatal meetings, etc.?

Did you meet with your doula before the birth? If so, how many times and why?

Did you take childbirth education classes? If so, what kind? Did they help?

Did you have a natural birth? If so, what made you choose natural birth?
If not, were the interventions planned?

Can you describe specifically what your doula did for you while in labor, i.e. massage, comforting words, position changes, etc?

Did you or your husband or partner have any concerns about using a doula?

What was the role of your husband or partner in the delivery room? Were there any family members or friends present as well?

How did you feel after you gave birth?

Have any of your friends used doulas?

How would you rate your satisfaction with your birth team, i.e. midwife/obstetrician, doula, family support?

Do you think having a doula affected your birth experience?

How do you feel about being a mom now? What was the transition like?

Would you recommend using a doula to other mothers-to-be?

Would you consider using a post-partum doula, or are you using a post-partum doula? If so, please describe.

If you plan on having more children, will you use a doula again?

When choosing a midwife or obstetrician, what were the most important characteristics that they had?

Appendix 7

Code of Ethics for Birth Doulas:

DONA International's Code of Ethics sets high standards
Our Code of Ethics helps us to practice with integrity by clearly defining our ethical responsibilities to clients, colleagues, the profession and society. It requires us to maintain high standards of personal integrity and professional competence and practice.

I. RULES OF CONDUCT

A. Propriety
The doula should maintain high standards of personal conduct in the capacity or identity as a labor support provider.

B. Competence and Professional Development
The doula should strive to become and remain proficient in the professional practice and the performance of professional functions through continuing education, affiliation with related organizations, and associations with other Labor Support Providers

C. Integrity
The doula should act in accordance with the highest standards of professional integrity.

II. ETHICAL RESPONSIBILITY TO CLIENTS

A. Primacy of Client's Interests
The doula's primary responsibility is to her clients.

B. Rights and Prerogatives of Clients
The doula should make every effort to foster maximum self-determination on the part of her clients.

C. Confidentiality and Privacy
The doula should respect the privacy of clients and hold in confidence all information obtained in the course of professional service.

D. Obligation to Serve
The doula should assist each client seeking labor support either by providing services or making appropriate referrals.

E. Reliability
When the doula agrees to work with a particular client, her obligation is to do so reliably, without fail, for the term of the agreement.

F. Fees
When setting fees, the doula should ensure that they are fair, reasonable, considerate, and commensurate with services performed and with due regard for the client's ability to pay. The doula must clearly state her fees to the client, and describe the services provided, terms of payment and refund policies.

III. ETHICAL RESPONSIBILITY TO COLLEAGUES

A. Respect, Fairness, and Courtesy
The doula should treat colleagues with respect, courtesy, fairness, and good faith.

B. Dealing with Colleagues' Clients
The doula has the responsibility to relate to the clients of colleagues with full professional consideration.

IV. ETHICAL RESPONSIBILITY TO THE LABOR SUPPORT PROFESSION

A. Maintaining the Integrity of the Profession
The doula should uphold and advance the values, ethics, knowledge and mission of the profession.

B. Community Service
The doula is encouraged to assist the DONA International vision of "A Doula For Every Woman Who Wants One" by making reduced cost or no cost labor support services available when possible.

V. ETHICAL RESPONSIBILITY TO SOCIETY

A. Promoting Maternal and Child Welfare
The doula should promote the general health of women and their babies, and whenever possible, that of their family and friends as well.

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