**Continuums of Reproductive Choice:
Theorizing Doula Care**

by Jessica Dwyer

A thesis submitted to the Faculty of Graduate and Postdoctoral Affairs
in partial fulfillment of the requirements for the degree of

Master in Social Work

Carleton University
Ottawa, Ontario

©Copyright 2012
Jessica Dwyer

Library and Archives
Canada

Published Heritage
Branch

395 Wellington Street
Ottawa ON K1A 0N4
Canada

Bibliothèque et
Archives Canada

Direction du
Patrimoine de l'édition

395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file Votre référence

ISBN: 978-0-494-91595-0

Our file Notre référence

ISBN: 978-0-494-91595-0

NOTICE:

The author has granted a non-exclusive license allowing Library and Archives Canada to reproduce, publish, archive, preserve, conserve, communicate to the public by telecommunication or on the Internet, loan, distribute and sell theses worldwide, for commercial or non-commercial purposes, in microform, paper, electronic and/or any other formats.

The author retains copyright ownership and moral rights in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

AVIS:

L'auteur a accordé une licence non exclusive permettant à la Bibliothèque et Archives Canada de reproduire, publier, archiver, sauvegarder, conserver, transmettre au public par télécommunication ou par l'Internet, prêter, distribuer et vendre des thèses partout dans le monde, à des fins commerciales ou autres, sur support microforme, papier, électronique et/ou autres formats.

L'auteur conserve la propriété du droit d'auteur et des droits moraux qui protège cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

In compliance with the Canadian Privacy Act some supporting forms may have been removed from this thesis.

While these forms may be included in the document page count, their removal does not represent any loss of content from the thesis.

Conformément à la loi canadienne sur la protection de la vie privée, quelques formulaires secondaires ont été enlevés de cette thèse.

Bien que ces formulaires aient inclus dans la pagination, il n'y aura aucun contenu manquant.

Canada

Abstract:

Doulas are becoming an increasingly acknowledged presence on the maternity care landscape. A doula is a non-clinical support person who provides information, advocacy, and emotional and physical support to a woman, and sometimes her partner(s), before, during, and after childbirth. Growing academic interest in doulas has centered on their apparent role in reducing medical interventions during childbirth, such as caesarean birth and the use of epidural analgesics. As such, the doula narrative has been effectively absorbed into the discourse of the “natural” childbirth movement.

In this study, I explore the contradictory discourses which characterize doula care; most obvious among these being an emphasis on “natural childbirth” and “good motherhood” alongside a stated interest in choice, inclusivity, and women-centred reproductive health care. I ask how these contradictory discourses interact within the doula movement, and how they might impact relationships between doulas and clients and between women and health care systems.

Acknowledgements:

A warm and heartfelt thank you to Dr. Sarah Todd, my supervisor, for her guidance, mentorship, insight, and patience. I learned so much from you Sarah, not just from your brilliant mind, but also from the compassion and kindness you showed me. Much gratitude also goes out to Dr. Hugh Armstrong. Dr. Armstrong's support and thought-provoking questions and suggestions were always appreciated. A big thank you to Sue Brady, for keeping me in line; Susan Braedley, for helping me in the initial phase of this project; and to committee members Dr. Diana Majury and Dr. Adje van de Sande.

I would like to thank my "thesis buddies" Elizabeth White and Hannah McGeachie who were always there to provide motivation or commiseration. My gratitude also goes out to other friends and family, who reviewed drafts, made me dinner, provided encouragement, or rubbed my shoulders. Thanks Heather Holland, Karen Lawford, Emily Dwyer, Rachel Horsley, Sara May, Sara Krynitzki, and Brad Kukurudz.

A big thank you goes out to my long suffering daughter, Sharky. She tried her best to sabotage the thesis process at the beginning, but in the end I think she's proud of her mama (and very, very happy it's over). A special debt of gratitude is owed to my parents, Maureen Wilson and John Dwyer, who made this thesis possible by taking care of the aforementioned daughter and nourishing me with food, love, and encouragement.

Finally, I am so very grateful for the time and insights provided to me by the doulas who participated in this project. You know who you are. I am awed by your passion and dedication to your work.

Table of Contents

Introduction –	1
Background –	4
Theoretical Perspective –	15
Methodological Approach –	16
Recruitment and Selection Processes:	19
Data Analysis:	21
Limitations –	22
Chapter 1:	24
Doulas as Workers: For Love and Money	24
Doula Work as Care Work	24
Remuneration and Work-Life Balance	33
Professionalization and Regulation	42
Chapter 2 –	54
Doula Care and the Constitution of Womanhood	54
The Discourse of “The Natural”	54
The Nature of Sex and Gender	55
Doulas and the discourse of the natural?	56
Childbirth and Empowerment	68
Chapter 3 –	77
Doula Care and Discourses of Reproductive Choice	77
Choice, Agency, and Empowerment	77
Links between choice-making, control and empowerment	85
Choices and Rights: the mother-baby dyad	91
Conclusion-	97
Bibliography	106
Appendix A- Interview Guide	112
Appendix B – Letter of Information	115

It is unheard-of, uncivilized barbarism that any woman should still be forced to bear such monstrous torture. It should be remedied. It should be stopped. It is simply absurd that, with our modern science, painless childbirth does not exist as a matter of course.... I tremble with indignation when I think of ... the unspeakable egotism and blindness of men of science who permit such atrocities when they can be remedied.

ISADORA DUNCAN, *My Life*

the knowledge of how to give birth without outside interventions lies deep within each woman. Successful childbirth depends on the acceptance of the process.

SUZANNE ARMS

Childbirth is more admirable than conquest, more amazing than self-defense, and as courageous as either one.

GLORIA STEINEM, *Ms. Magazine*, April 1981

Introduction –

Doulas are becoming an increasingly visible presence on the maternity care landscape.¹

A doula is a non-clinical support person who provides information, advocacy, and emotional and physical support to a woman, and sometimes her partner(s), before, during, and after childbirth. Growing academic interest in doulas has centered on their apparent role in reducing medical interventions during childbirth, such as caesarean birth and the use of epidural analgesics. (Hodnett, Gates, Hofmeyer, & Sakala, 2009; Sosa, Kennel, Klaus, Robertson, & Urritia, 1980; Lantz, Low, Varkey, & Watson, 2005; Kennell, Klaus, McGrath, Robertson, & Hinkley, 1991) As such, the doula narrative has been effectively absorbed into the discourse of the “natural” or “alternative” childbirth movement. Depending on one’s philosophical starting point, this discourse might be characterized as radical and feminist, or rigid and conservative. Two recent developments; the founding of doula programs at anti-abortion associated “crisis pregnancy centres” (CPCs)², as well as the emergence of “abortion doulas” who advocate for doula care across the reproductive health continuum; indicate a lack of homogeneity within the doula movement.

In this study, I attempt to situate doula care within the trajectory(ies) of feminist theory. I explore the seemingly contradictory discourses which characterize doula care;

¹ I have not found an estimate of the percentage of births that in the US or Canada that are attended by a trained or untrained birth companion. Hodnett et al (2009) suggest that 50,000 women have been trained as doulas.

² “Crisis Pregnancy Centers” provide services such as pregnancy testing, “pro-life” counseling, baby supplies, and sometimes medical care, to women facing unexpected pregnancies. Munson characterizes CPCs as belonging to the “individual outreach” stream of the pro-life movement as they concentrate primarily on individual relationships as the strategy to preventing abortion. (Munson, 2008, p. 113) A quick Google search found a number of CPCs that either house doula programs, fund doula programs, or refer their clients to doula programs. First Place Pregnancy Centre in Ottawa (formerly known as the Pregnancy Distress Centre) runs a doula program.

most obvious among these being an emphasis on “natural childbirth” and “good motherhood” alongside a stated interest in choice, inclusivity, and women-centred reproductive health care.

Chapter one explores the idea of doulas as workers. I argue that doulas draw on discourses that are similar to those of other care workers in explaining their role. Most significantly, I show that doulas understand their work as motivated primarily by feelings of love, and that this is perceived as being a fundamentally different motivation from other types of workers. At the same time, I suggest that doulas are concerned with many work-related aspects of their role such as remuneration, professionalization, and work-life balance.

This sense of tension is echoed in chapter two, which explores the relationship between doula-hood and womanhood. In this chapter, I argue that narratives of ‘the natural’ are important to understanding doula discourses. I suggest that doula discourses emphasize and de-emphasize the idea of ‘the natural’ in different circumstances, sometimes articulating an essentialised version of womanhood and childbirth and at other times rejecting the very existence of ‘the natural.’ Alongside the idea of ‘the natural,’ I suggest that doulas understand the experience of childbirth as being fundamentally important in the constitution of womanhood and motherhood.

Chapter three explores the ideas of choice and empowerment in doula care. I find that doulas hold the themes of choice, agency, and empowerment as central to their role and identity. While many doulas argue that they will support any choice, what emerged from my interviews with doulas was a sense of tension around how and why certain choices are made and whose interests these choices should serve.

The ultimate purpose of this paper is to contribute to the body of research around women's health generally and doula care specifically. As a social work student, I am interested in the discourses that inform women's relationships with their bodies and women's experiences of choice, agency, and access to health and reproductive services. As a person who identifies as a reproductive rights activist, I am interested in how social movements are able to mobilize different discourses to move forward particular political strategies. The dearth of research (particularly qualitative) on doulas creates an ideal space in which to explore the themes, tensions, and contradictions that characterize this corner of the reproductive health movement. This issue is important to structural social work because it concerns who has access to reproductive information and support, how that information is framed and presented, and, ultimately, who has access to which reproductive choices.

Background –

Doulas³ provide more than just hand holding and a gentle presence during labour. Their role often extends throughout the entire childbearing year (from pregnancy to post partum) and involves an interwoven set of skills which are intended to be flexible and responsive to the needs of individual clients.⁴ Doula care is relationship-based. Doulas usually meet with their clients numerous times during pregnancy, are on-call to provide support during their entire labour and childbirth, and meet with them several times post partum. Doulas may provide a navigational role to their clients within the health care system, recommending particular health care providers (including non-traditional health professionals such as chiropractors, massage therapists, and lactation consultants) and providing information in order that their clients are able to make more informed choices about procedures and practices. Doulas are often available in an on-call fashion throughout pregnancy to answer questions related to pregnancy and childbirth and to refer their clients to other resources. During the course of labour, doulas provide reassurance to their clients and their partners. They may use techniques including massage, positioning, manipulation of the environment, touch and voice cues in order to help women cope with labour and childbirth. During the post partum period, doulas provide breastfeeding information and referrals, emotional support and referrals for post partum mental health services, and may perform domestic tasks such as cleaning, cooking, or laundry. The doula acts as a bridge between the birth “event” (be it a medicalised caesarean birth or a midwife attended home birth) and the rest of the

³ During the course of this thesis I use the word “doula” to describe a “birth doula.”

⁴ Description of the role of the doula taken from interviews with Szollos, Holland, Horsley, and Martensen as well as from BPCP (2008), and Simkin (2009).

woman's life. As such, the doula represents a tangible acknowledgement of the connection between physical, emotional, cultural, and spiritual health.

While the term "doula" emerged in the 1980s by most accounts (Papagni & Buckner, 2006), the concept is much older than that. Most historians agree that, prior to the 20th century, labouring women had other women (usually friends or family) provide them with emotional, social, and physical support during childbirth.⁵ (Benoit, 1997; Bourgeault, 2006; Papagni & Buckner, 2006). Papagni and Buckner (2006) call this practice a "social childbirth philosophy." "Women labored and gave birth at home and were attended by lay female friends, relatives, and traditional midwives." (Papagni and Buckner, p.1)

In the first half of the 20th century, childbirth in North America went through a fundamental shift. It was relocated to the hospital, redefined as a medical event, and placed under the care of physicians. The professionalization of medicine was integrally related to this shift as medical doctors pushed many women (including midwives) out of traditional healing roles. (Shroff, 1997; Mitchinson, 2002) "The demise of the midwife in Canada can be loosely understood as the purging of female expertise in childbirth and its replacement by a scientific model of childbirth management....propounded by and practised almost exclusively by men." (Nestel, 2006) The medical monopoly over childbirth became interwoven with colonization as First Nations and Inuit midwives were de-legitimized, and policies were enacted to evacuate Aboriginal women from remote communities to larger tertiary care centres to give birth. (Jasen, 1997) The exclusion of female health care providers was linked to financial, professional, and patriarchal goals.

⁵ In much of the world labouring women never stopped being supported by other women, including midwives. This shift has happened primarily in North America, although a more technological and biomedical approach to birth is being exported to other parts of the world. (Davis-Floyd and Sargent, p.5)

As childbirth came to be recognized as the domain of the physician, it was also redefined as a “medical” process as opposed to a normal physiological event. As a medical event, childbirth no longer just happened, but had to be managed by the physician. The pain of childbirth was mitigated by an evolving series of drugs and drug cocktails including chloroform, a mixture of morphine and scopolamine (twilight sleep), Demerol, and spinal epidurals among others. The exit of the baby from the vagina was facilitated by forceps, vacuums, episiotomies (cutting of the perineum) or caesarean sections. The process of medicalising childbirth necessitated a shift of location from home to the hospital. In 1900 almost all births in Canada took place at home; by 1940 hospital births accounted for 45.3% of all births in Canada (Mitchinson, 2002, p. 173); and by 2001 only 2.1% of births took place out of the hospital. (PHAC, 2009, p. 114)

These factors are relevant to the discussion of doulas for a number of reasons. By assuming control over childbirth, medical doctors placed childbirth within the sole purview of biomedicine, de-contextualized from cultural, social, emotional, family and community factors. Relocating childbirth from home to hospital and decreasing access to social support during birth were symbolic assertions that it is possible to separate physical health from other aspects of a person’s life. In this sense the (re)emergence of the doula was threatening to medical doctors because doulas re-inserted cultural, social, and emotional needs into the health equation thus questioning the legitimacy of the biomedical conception of health and health care.

Doulas emerged in the context of the critique of the medicalisation of women’s bodies and bodily processes, characterized by the emergence of the “feminist health movement(s)” and the “alternative birth movement(s)” (Ruzek & Becker, 1999). Both

movements endorsed a rejection of (male) medical control over women's bodies, and a move toward the "de-professionalization" of health care – through consciousness raising groups that encouraged women to become experts about their own bodies, self-help groups, and an emphasis on "traditional" care providers such as midwives (Ruzek & Becker, 1999; Tuana, 2006).⁶

The philosophy and practice of doula work is founded on feminist principles that were developed as part of the women's health movement. In fact, "health has been a crucial vehicle for the development of feminist theory dating back at least to the eighteenth century" (Annandale E. , 2009, p. 4). From the 1960s to the 1980s the feminist health movement developed a critique of the medicalisation of women's bodies, pressed for more information about the drugs used on women, agitated for reproductive choice, established women's self-help groups, and founded woman-focused health centres and freestanding birth centres. These feminist activists understood the "strategic importance of the medical system for women's oppression as well as for their liberation" (Kuhlmann, 2009, p. 136).

Informed choice (as opposed to informed consent) became a cornerstone of the feminist health movement, epitomised in the midwifery model of care. Vicky van Wagner (2004) links midwifery and the women's health movement on the issue of choice. "The women's health movement used 'choice' as a powerful slogan, particularly in relation to access to safe abortion and to 'changing childbirth'" (van Wagner, 2004, p. 16). The ability to choose among a range of childbirth options was a key rallying point for 2nd wave women's health activists. Women agitated for increased (and legalised)

⁶ Examples of this kind of feminist health activism include the production of texts such as "Our Bodies Ourselves: A Book By and For Women" in 1973 by the Boston Women's Health Book Collective, and The "Birth Control Handbook" produced by the McGill Students' Society in 1970.

access to midwives, homebirth, and support for their choices to have unmedicalised births and to breastfeed. Feminist concepts and organisational techniques were employed by the women's health movement to give women access to a range of options related to pregnancy and childbirth (Shroff, 1997, p. 18).

Central to the approach of the women's health movement was the desire to "demystify and democratize" medical knowledge (Morgan, 1998, p. 113). Feminist actors argued that the medical system held power over women because of its control over 'scientific' knowledge about health. Across Canada and the United States, women set up consciousness raising and self-help groups that addressed both mental and physical health issues. These groups addressed topics ignored by the male dominated medical profession such as female ejaculation, the structure of the clitoris, breast self examination, contraception, and the female orgasm (Tuana, 2006). Women's groups bought speculums and undertook cervical examinations in "self-examination groups." Nancy Tuana described the women's health movement as a way to "...take our bodies back from the institution of medicine and reframe our knowledge and experiences of our bodies in ways not configured by sexism and andocentrism" (Tuana, p.5).

Part of the process of empowering women in the context of the medical system involved gaining access to basic medical knowledge, and reframing it in a manner that was accessible to the majority of women. A significant activity of the 2nd wave women's health movement was the publication of feminist health texts such as *Our Bodies Our Selves* that informed women about their own bodies and bodily processes. Doulas can be considered another medium that medical knowledge was "reframed" and repackaged to women. A key aspect of doula care is providing information about pregnancy, childbirth

and baby care that women can use with which to make informed decisions. This process of gathering and passing on information can be considered a rejection of "...the medical 'ownership' of obstetric technology and technical procedures" and the idea that obstetricians ".... should be seen as possessing authoritative knowledge, and consequently as holding legitimate decision-making power" (Beckett, 2005, p. 267).

Access to reproductive choice was a key element that galvanized the feminist movement and the women's health movement in Canada. This aspect of the movement encapsulated the desire for access to and information about birth control and abortion, but also the right to accurate and truthful information about drugs and treatments prescribed to women. In 1969, women's distrust of the medical system was ignited with Barbara Seaman's release of *The Doctors' Case Against the Pill*. In her book, Seaman exposed the health risks associated with the Birth Control pill and argued that doctors had been withholding this information from their woman clients. Feelings of anger and renewed activism resulted from this experience (Morrow, 2008). One of the most influential actions of the Canadian women's movement was the 1970 "Abortion Caravan Rally" which travelled from Vancouver to Ottawa in support of abortion rights. The women's movement used the language of individual rights to argue for access to abortion on demand (Shaver, 1994, p. 70). The "Canadian Association for Repeal of the Abortion Law" was established in 1974 and argued that access to safe, legal abortion was a fundamental human right.

Doulas fit into this trajectory of feminist health activism. Feminist activists argued that childbirth was more than just a physiological process, but that it had psychosocial, emotional, and cultural significance. While doulas were not specifically

addressed by 2nd wave feminist health activists, they emphasized the need for women to take the power back in the realm of childbirth. Acknowledging social and emotional needs was an integral part of this attempted shift in power dynamics. As Klaus et al implore, it was the lack of “humanity” in the mainstream medical paradigm of childbirth that encouraged the return of the doula (Klaus 2002, cited in Hodnett, Hodnett, Gates, Hofmeyer, & Sakala, 2009, p.2).

The limited research that has been conducted on doulas has tended to emphasize the impact of the doula on obstetric outcomes and newborn health (Sosa, Kennel, Klaus, Robertson, & Urritia, 1980; Zhang, Bernasko, Leybovich, Fahs, & Hatch, 1996; Kennell, Klaus, McGrath, Robertson, & Hinkley, 1991; Hodnett, Hodnett, Gates, Hofmeyer, & Sakala, 2009). The first studies of the obstetrical impact of continuous female support during labour were conducted in Guatemala in the 1980s. Researchers found that women who were assigned (what we would now call) a doula to stay with them and provide emotional support throughout labour and childbirth had shorter labours and smiled at, talked to, and stroked their babies more than the control group (Sosa, Kennel, Klaus, Robertson, & Urritia, 1980, p. 597). Since the 1980s, numerous studies have been conducted to assess the impact of continuous labour support on birth outcomes. A meta-analysis conducted by the Cochrane Collaboration in 2009 looked at 16 trials, over 11 countries, and over 13, 000 women in various settings and circumstances (Gilliland, 2002). They found that women who had continuous labour support were more likely to give birth without interventions (caesarean birth, forceps, vacuum); were less likely to use medications during child birth; and were more likely to be satisfied with their childbirth (Hodnett et al, 2009, p. 2). Numerous studies have shown that the biomedical

impact of the doula is significant. Klaus et al. (2002) found that the use of a doula would reduce the use of pain medication by 31%, reduce the use of oxytocin⁷ by 50%, reduce the use of forceps by 24% and reduce the number of caesarean section births by 45% (Klaus, Kennell, & Klaus, 2002). Physical effects notwithstanding, more recent proponents of doula care argue that their most important benefit lies in their role in increasing women's sense of autonomy and control during childbirth and pregnancy. As such, these doula advocates make room for the value of doulas even among women who may choose to have a medicated childbirth or a caesarean birth. Penny Simkin, the "grandmother" of the North American doula movement, has published a number of studies that explore the impact of birth memories on the long term well-being of mothers. Interestingly, Simkin's studies have shown that medical interventions and procedures, and even the experience of pain did *not* impact women's perceptions of their birth experience. Rather, positive and negative memories were correlated with the degree to which "...they felt they were in control of what happened to them" (Simkin, 1991, cited in Gilliland, 2002, p. 763). The importance of women's sense of agency or autonomy is picked up by Heather Holland who describes the relationship between the doula and pregnant woman as one that is open to the creation of "relational space." That is, the doula does not "empower" the woman, but the relationship between the doula and the woman makes a space for empowerment available (Holland, 2009).

The centrality of the themes of 'choice' and 'control' is reinforced by the oldest and most recognized association representing doulas. DONA's (Doulas of North America) position paper on the birth doula states that, "The doula's goal is to help the

⁷ Pitocin (synthetic oxytocin) is used to induce or augment labour.

woman have a safe and satisfying childbirth *as the woman defines it....* It is not the role of the doula to discourage the mother from her choices. The doula helps her become informed about various options, including the risks, benefits and accompanying precautions or interventions for safety” (DONA, 1998, p.1, emphasis mine).

Anne Lenzi, an American doula who identifies as a ‘radical doula’ expands on the link between doula work and choice. “Birth activism is just one more branch of the broader tree of free choice to me. It is still shocking to me that the biggest battleground of free choice is what rights we have over our own bodies, as if we cannot be trusted to make the proper decisions when we are the ones who must live in our skins each day” (Lenzi, 2009). Lenzi represents a newer branch of the doula movement; identified as ‘full spectrum doulas.’ These women take the doula model as a foundation and provide emotional and physical support, encouragement, and advocacy to women who have chosen to terminate a pregnancy. Mary Mahoney, founder of New York City’s ‘The Doula Project’ came to doula work from a background of reproductive justice activism. Her doula work was rooted in a desire to understand the “full span of reproductive health experiences...I became a doula because I’m dedicated to creating positive reproductive health experiences for all women, whether they choose to carry their pregnancies to term or not” (Mahoney, 2008).

The pro-life movement focuses on birth control and abortions, we go deeper. We ought to be able to decide when, and how we will conceive and with whom, who and what practices will be part of our pregnancy, what we allow into our body, where we give birth and with whom, how we feed our children, etc. Our intelligence, agency, and subjectivity are central. The health of the next generation depends on the psychological, physical and spiritual health of the mother today, our levels of stress, support networks, confidence and joy (Williams, 2008).

Many of these doula activists emphasize the centrality of agency and choice in their definition of doula work.

An alternate reading of the women's health movement exposes a more conservative undercurrent: the discourse of the "alternative birth movement," for example, has been criticized for a romantic and essentialised view of women, the veneration of women's roles as mothers, reverence for that which is deemed "natural" and special attention to the sphere of the home (Beckett, 2005). Books such as La Leche League's *The Womanly Art of Breastfeeding* and Ina May Gaskin's *Guide to Childbirth* emphasize the inherent knowledge that women possess by virtue of being women, and highlight the importance and value of heterosexual relationships.⁸ "In trying to reclaim choice and control for women in labour, the alternative birth movement has in some ways replaced the "story" of childbirth as "medical" with a "story" of childbirth as "natural" (O'Reilly, 2004); however well-intended, this newer "story" can also serve to constrict and constrain birthing women" (Holland, 2009, p.10).

In some ways elements of the doula philosophy can be made to fit with more conservative values that essentialise women as mothers. Miriam Perez, author of 'Radical Doula' explains that the reverence toward natural childbirth, and high value placed on motherhood can feed into a value system which is not supportive of a range of reproductive choices. While "full spectrum" doulas often situate their motivation to become doulas within a personal history of reproductive justice activism, other women say that it is a sense of connection and value of the "unborn" foetus that draws them to

⁸ These two books are included on the CAPPA required reading list for labour doula certification.

birth work. A poster on a religious blog discussing doulas states, “I pursued becoming a birth doula as an outgrowth of my pro life convictions” (Saggies, 2007). An Alberta doula who is quoted in an article titled “Giving birth the Pro-life way” connects her profession as a doula with her Catholicism. “My role is to make every childbirth the most rewarding and positive experience...I’m very pro-life...if parents have a positive birth experience, they are much more able to accept life... (Hoang, 2000). The link between doula work and the pro-life movement highlights a complex understanding of agency, empowerment, and choice within some parts of the doula movement.

No research has yet interrogated how doulas feel or respond when a woman makes a decision that is at odds with her own sense of morality, or what she feels is “right” to do in a particular circumstance. One “story” is that the doula’s role is strictly to protect the woman’s interests and desires. Another “story” is that the doula’s role is to help the woman fit into a particular narrative around pregnancy, birthing, and motherhood. How does the doula respond when her client asks for help advocating for an elective caesarean birth, or finding a doctor to circumcise her infant, or buying herbs to dry up her milk supply? How does the doula respond when the woman asks for support during a late term abortion after an ultrasound showed severe foetal abnormalities? All of these are situations that *could* be faced by any doula, but which are not part of the “above ground” doula discourse.

Theoretical Perspective –

I will take a post structural feminist perspective in exploring doula care. Post structural theorists reject the classical notion that there is an “essence” of humanity (Chanter, p.267), or an objective and identifiable “truth.” Instead, they emphasize particularity over universality and point to the role of discourse in constructing particular understandings of reality. From a post structural perspective, language neither reflects nor expresses meaning but actively shapes and constructs it (Weedon, p. 75). Binary categories (woman/man, good/ bad, natural/ technological) are considered problematic by post structural theorists. The idea of simultaneous, multilayered, and contradictory discourses will be employed in this exploration of doulas. Similarly, the idea of continuums of understanding will be employed as I problematise the concepts of “natural” versus “medical” childbirth and “pro-choice” versus “pro-life” philosophies.

Post structural theory rejects the “grand narratives” of modernism which “guarantee some forms of knowledge as legitimate and morally ‘right’” (Annandale & Clark, 2008, p. 21), therefore rejecting the notion of a single cause of oppression. As such, post structuralism is sometimes at odds with some feminist perspectives which understand oppression to be located within the institutions of patriarchy. Annandale and Clark state that much of 2nd wave feminist theorizing refers to “...the way that women’s social experiences (including health and health is mediated by institutions of patriarchy...and dominated by the idea that “we can ‘lift the veil’ and see ‘reality’ beneath” (Annandale and Clark, p.19). Rather, post structural theorists identify power as diffused and embedded in different experiences. “...Power must be analysed as

something which circulates, or rather as something which only functions in the form of a chain. It is never localized here or there....power is employed and exercised through a net-like organization....” (Foucault, 1980, p. 98).

Inherent in a post structural approach to research is the idea that “...objectivity must be carefully rethought. An account...is always situated. It is an account from somewhere, and some time, and some one...written for some purpose and with a particular audience in mind. It is always...a partial and particular account” (Gannon & Davies, 2011, p. 72). My biases with regards to this subject are quite glaring. I have worked within the “feminist health movement” for over a decade, most recently in the role of coordinator of a program that links volunteer doulas with marginalized women. I am a doula, a mother, and I identify as “pro-choice.” I recognize value in a holistic view of health and the body which acknowledges social, emotional, cultural, and physical dimensions. I am critical of the biomedical approach to health which has neglected individual and community needs beyond the presenting physical problem. At the same time, I am wary of the construction of the “natural” as the binary opposite of the “technological” (or biomedical), especially as it relates to women’s health.

Methodological Approach –

In this study, I explore the interrelated discourses that constitute doula practice and identity. In designing the study, I was particularly interested in the seemingly contradictory discourses which characterize doula care; most obvious among these being an emphasis on “natural childbirth” and “good motherhood” alongside a stated interest in

choice, inclusivity, and women-centred reproductive health care. I was curious about how these discourses co-exist within the doula movement, and how this might impact power relationships between doulas and clients and between women and the health care system.

My central research questions were:

How have the discourses of choice, agency, inclusivity, and woman-centeredness evolved and emerged in doula care? How are these discourses constructed by particular doulas in different situations?

In what ways do discourses about “good womanhood/ good motherhood” and the “protection of the unborn” create tension with discourses of female agency and reproductive choice within the doula movement?

How do doulas construct, mediate, or reproduce particular power relationships in various settings? What might the implications of this be on women’s access to reproductive information and reproductive choices?

This study involved qualitative interviews with eight Ottawa area doulas. I chose to use a qualitative approach because I was interested in a more rich and in-depth analysis of doula practice and identity than would have been possible in a quantitative study. I wanted to provide doulas with an opportunity and a framework to explore their motivations for being involved in the doula movement, to examine how doula care resonated with their own deeply held beliefs, and to explain the meanings and contradictions behind their doula identity. I hoped, and continue to hope, that this piece of research will serve as a stepping stone for a more nuanced conversation among doulas and other birth professionals on the discourses that inform their work.

I chose to use a semi-structured interview technique because I wanted to make room for the research participants (the doulas) to actively shape the research and include

areas not thought of or omitted by myself as researcher. I had hoped that a semi-structured technique would allow participants to "embody [their] voices, minimizing... the voice of the researcher" (Blee & Taylor, 2002, p. 96). In some ways this approach was successful. For example, the research participants emphasized several themes as central which I had not highlighted prior to beginning the research. Key among these themes was doula work as *work* and the challenges of the work-life balance. In some ways I was surprised by what the doulas did *not* describe as important. For example, I had expected doulas to talk more about their relative status compared to other health care providers, but the doulas that I spoke with seemed not to emphasize this as important.

In my approach to interviewing, I drew on the work of feminist researchers such as Ann Oakley. Oakley is well known for her challenge to the positivist ideal of researcher objectivity, arguing that instead of viewing women as "objects of the researcher's gaze"; researchers should conceptualize the interview "as an encounter between women" (cited in Gannon and Davies, p.178). This approach emphasizes a less formalized, and less hierarchical interview process in which power imbalances between interviewer and interviewee are acknowledged and attempts are made to lessen them. Of key importance to this interviewing method is the idea that the researcher cannot (and should not) separate him or herself from the research itself. "...[I]n most cases, the goal of finding out about people through interviewing is best achieved when the relationship of interviewer to interviewee is non-hierarchical and when the interviewer is prepared to invest his or her own personal identity in the relationship" (Oakley, 1993, p. 229). In many ways this approach to interviewing felt natural to me. Rather than asserting what would have been a false sense of neutrality, I often felt comfortable sharing my opinion

or experiences on a certain subject when I was asked. The fact that several of the interviewees were known to me prior to this research project probably helped to make the interview environment feel even more friendly and informal.

Recruitment and Selection Processes:

Participation in this study was open to any Ottawa-area birth doula who had received some sort of birth doula training (either through DONA, CAPPA, ALACE or Mothercraft) and who had attended at least one birth in the role of a doula. Because of my past involvement with the doula community, and the small size of the community, it would have been impossible to exclude all doulas that I knew personally from the study. Nonetheless, in order to minimize unequal dynamics in the research relationship, any doula who had participated in a Birth Companion Program volunteer training which I had co-facilitated was excluded from the study.

I first recruited doulas by circulating an email through the email list serves of two Ottawa doula organizations, the Ottawa Valley Doulas (OVD), and Mothercraft's Birth Companion Program. Four doulas responded to the original posting on the list serve. One doula from this list had to be excluded because she had attended a training which I had co-facilitated. I used a "snowball" recruiting technique in which I asked the doulas who responded to the initial request to recommend other doulas who might be interested in taking part. I contacted the recommended doulas directly via email or facebook personal message. One doula that I contacted directly by email requested that I send her the interview guide before agreeing to be interviewed, which I did.

The eight doulas who agreed to be interviewed represent a range of the doula spectrum. Four doulas were actively practicing doulas who provided their doula services for pay. Two doulas were “retired” from paid doula work and only occasionally provided doula services on a volunteer basis. Two doulas provided doula services primarily as volunteers. The doulas interviewed captured a broad range of experience, having served between twenty clients and over eight hundred clients each. All of the doulas had been practicing for over one year and had their own families, some of them grown.

I arranged to meet the doulas for interviews by email. In several cases the interviews had to be re-scheduled; once because of a snow storm, and several other times because the doula had been called to a birth. I gave the doulas the option of meeting at their home, at a private room at Carleton University, or at another location of their choice. Most of the doulas chose to have me come to their home, though one doula requested that the interview be conducted at my home, and three doulas requested that the interview be conducted at their place of work.

I prepared an interview guide which included a set list of interview questions⁹, but the conversational style of the interviews often meant that the guide was not strictly followed. The interviews lasted between 60 and 90 minutes. I obtained written and verbal permission to tape record each interview and made field notes of my observations directly following each interview. I then transcribed each recording verbatim. I gave each research participant the opportunity to review their transcript, but none chose to do so. One research participant sent me an email following the interview which included

⁹ See Appendix A

some additional information which she wished she had stated in her interview. The research participants were not reimbursed for their participation in the study.

Data Analysis:

The tape recorded interviews generated over one hundred pages of transcripts. I familiarized myself with the data by reading and re-reading the transcripts with the intent of allowing major themes to emerge organically. I then used NVIVO data analysis software to help organise and code the data. I went through the transcripts line by line and assigned each line or group of lines to a specific category, or “node.” I organized the “nodes” into overarching themes and then subthemes. These themes and subthemes became the basis of the analysis of this study.

It was at the data analysis phase that the tension between the voice of the research participants and my voice as researcher became most apparent. As I coded and assigned meaning to units of data, I was conscious of the fact that I was imposing my own interpretation on top of the thoughts and feelings of the doulas that I spoke with. In many cases it is likely that the doulas would disagree with the way in which I have interpreted their words. It is possible that they might disagree with the central arguments that run through this paper. I acknowledge my own privileged position in this conversation in that I framed the subject, I ultimately selected which pieces of numerous conversations were important, and I have analysed and presented these data without consultation from the research participants. I do this with the full recognition that this paper represents *my* interpretation and analysis of the conversations which were shared with me by certain

doulas in a certain moment in time. I hope that this thesis will incite other doulas and academics to disagree with me, to contradict me, and to offer alternative interpretations of these and other data as part of a fruitful and ongoing dialogue.

Limitations –

This research project is centered on the qualitative interviews of eight doulas. As such, the results of this study will not be generalisable to the doula movement as a whole. Rather than producing quantifiable data, a qualitative research study adds richness and depth to the body of research on a given subject. A deeper understanding of an issue requires both “numbers and stories” (Patton, 2002, p. 4). This research project also touches on people’s feelings about reproductive rights. Because binary labels such as “pro-choice” and “pro-life” can tend to reinforce a sense of polarity, I chose to conceptualize reproductive choice as a continuum rather than as a dichotomy. This approach helped to reinforce the idea that discourses do not have discrete boundaries, and that individuals represent and enact a plurality of discourses.

My status as an “insider” in the doula community may have affected the way that the research participants responded to my questions during the interviews. It is possible that they may have felt compelled to answer questions in a way that they thought I would approve of. I hope that my description of the research project, as well as my emphasis on an informal and non-hierarchical style of interviewing will have helped to mediate this possibility.

The following chapters do not represent an attempt to expose an “authentic” feminist (or anti-feminist) nature of doula work. Rather, I hope to explore the multiple

layers of discourse that inform doula work and the relationships that flow from it. It is my hope that the process and products of this research will contribute to a richer understanding of the idea of “choice” in health care. While I hope that this research will add to an ongoing academic dialogue on the subject, I also hope that it will help to start a more nuanced conversation among doula practitioners and clients on the meanings and implications of “choice” in doula work.

Chapter 1:

Doulas as Workers: For Love and Money

While many doulas and scholars would argue that women have always supported other women in labour and childbirth; it is only since the 1980s that these women started to call themselves “doulas” and began charging for their services (Meltzer Norman & Katz Rothman, 2007; Papagni & Buckner, 2006). The exchange of money for services changed the status of the doula from helpful friend or relative to *birth professional*. Yet, despite the fact that most doulas receive payment for their services, they express ambivalent feelings about the “work” aspect of their identity as doulas. This chapter will explore how the themes of gender, caring, compensation, and professionalization coalesce within doulas’ discourses of work. I will argue that many of the tensions that co-exist in doulas’ conceptualization of themselves as workers are similar to those experienced by other “care workers” such as nurses, social workers, and child care providers. Drawing on these themes, I will argue that the doula discourse around work is both *essentialist*, in that it reinforces doula work as naturally female, and *radical* in that it constitutes doula care as occupying a space outside of mainstream medicine and traditional work relationships.

Doula Work as Care Work

In the following section, I argue that doula discourses around “work” constitute doulas as care workers. Paid care work is a category of work which is in many ways quite distinct from other forms of paid work (Meaghre, 2006; Noddings, 2002). Care work involves such intangibles as “...nurturing, enabling, maintaining dignity...” (Meagher, p. 46), and

building relationships between the “carer” and the “cared for” (Noddings, 2002). As will be explored further in this chapter, theorists of care work have noted that care workers generally describe their motivations for engaging in care work and the benefits that they receive from their work quite differently than other workers. Most meaningfully, they emphasize the intrinsic benefits of their work (often using language like ‘love’ or ‘fulfillment’) rather than material rewards. Gender analyses of caring labour have highlighted that the great majority of care work (paid and unpaid) is performed by women and is often seen as an extension of the feminine, or motherly role. The conceptualization of caring work as naturally female and motherly affects what is expected from care workers as well as how they are remunerated for their work. Deborah Stone, cited in Meagher’s work on paid caregiving, notes that the “Golden Rule” of care work seems to be ‘Do unto others as you would do unto your own kin’ (cited in Meagher, p. 35). In other words, caring workers are expected to extend their familial or motherly love to those who they are engaged in paid caring relationships with, and they are expected to do so for little or no pay. That the identity of paid carers as “workers” is blurry seems obvious. As will be seen in this section, the discourse on work captured in my interviews with doulas conforms to this understanding of care workers.

Doula care is rarely referred to (in both academic and non-academic literature) as “work.” While the emphasis on the “cared-for” (the pregnant and labouring woman) has raised the visibility of doula care more generally, the lack of attention to doulas as workers has made their own needs and interests largely invisible. The doulas that I spoke with expressed a sense of ambiguity around the idea of themselves as workers. Most of the doulas that I interviewed were hesitant to speak of doula care in the language

of work. In interviews, I noticed that when I used the term “doula work,” doulas would often reply with terms such as “doula care” or “doula practice.” For example, when I asked Ellen, a doula who described herself as “retired,” about the biggest challenges associated with her previous work as a doula, she responded, “My husband always said – there’s nobody else that could leave home at 2 in the morning and be gone for 40 hours and come home and be so happy and so joyful and have had no sleep and worked a week’s worth of work in one stretch and still be happy. And I was. And I always kind of felt guilty because it never felt like work.”

I suggest that Ellen’s notion of work is consistent with much of the literature on care work, most particularly in the sense that *loving* the work renders it *not work*. That Ellen felt “guilty” about enjoying something for which she was paid suggests an idea that paid work shouldn’t be enjoyable. Melzer Norman and Katz Rothman argue, “This traditional and essentialist view, wherein money and love are oppositional and incongruous with womanhood and/or femininity, is a common thread in doulas’ beliefs about their work, about themselves, and about feminism in general” (Meltzer Norman & Katz Rothman, 2007, p. 266). I would agree with Melzer Norman and Katz Rothman that there is a distinctly gendered dimension to this way of distinguishing between “work” and “not work.” One would find it difficult to imagine a lawyer, fire fighter, or surgeon expressing guilt over their salary regardless of how much fulfillment they received from their work.

Other literature on care work has further developed this theme. Like Ellen, virtually all of the doulas that I spoke with emphasized the intrinsic rewards of their work. They described a sense of joy and satisfaction at being able to provide nurturance

and support and in being able to play a role in an important and intimate moment in a family's life. England and Folbre have argued that, in caring work, the emphasis on the intrinsic benefits of the work become part of the "payment" for the work and actually justify continued low wages (England & Folbre, 1999, p. 44). In other words, in exchange for your services as a (child care worker, nurse, social worker, doula) you receive a salary (however small) alongside the opportunity to be part of the happiness and fulfillment that is connected with the work.

Because carers tend to be motivated by a genuine concern for their clients' well-being, caring becomes to some extent its own reward, and to that extent carers' wages can be set lower than those of workers with objectively comparable skills (Folbre and Weisskopf 1998). Further, because they care, carers are not as prepared to jeopardize their relationship with those for whom they care in pursuit of their own self-interest as other workers may be to undermine the product of their more alienated labors; this difference may make paid carers more vulnerable to exploitation (Himmelweit, 1999, p. 33).

The doulas that I spoke with reinforce Himmelweit's argument, consistently emphasizing the relationship aspect of their work and describing doula work as distinct from other forms of work. Another retired doula that I spoke with, Ruth, described doula work as fundamentally different from other types of work, both in terms of motivation as well as remuneration:

I think (doulas) are passionate, informed individuals who are willing to make huge commitments to other people. To help them. Just to help them. And they get paid for it because it is a service that costs us personally, and it costs us financially to do it, but nobody is getting rich off being a doula. You are not choosing it in the same way that you choose to be a dentist or a chiropractor.

Ruth's suggestion that doulas don't pursue doula work for the same reasons as a person might, "choose to be a dentist or a chiropractor," characterizes doula remuneration as distinct from motivation. As such, it is consistent with the conceptualisation of care workers discussed above, in which care workers are "paid" largely through intrinsic, non-

material rewards. By distinguishing between doula care and other professions which could also be considered care work (dentistry and chiropractic), but which are remunerated more generously, Ruth puts doula care in a different category which is perhaps defined by its poor pay and great sacrifices. “Caring occupations should be seen as part of a whole class of occupations that are not fully commodified, in which workers have motivations that are not purely monetary and also care about the results of their work” (Himmelweit, 1999, p. 27). I would argue that the doula work discourse upholds a vision of doula care which is divorced from financial motivations.

The idea of being “called to” doula work was repeated again and again by doulas. Doulas described feeling “hooked” on attending births; that “it just kind of gets into your blood” or of doula work being “deeply ingrained” in the psyche. Charlotte said, “it’s the same with any vocational kind of work where you care for people. I suppose – you look at midwives, nurses, doctors – they are there because they are called to this kind of work really. How can you work that many hours, and have that much commitment and dedication if you are not called to it?” This sentiment is repeated by Patricia, who states that the pay for doula work is so low, that it must be a calling.

If you were to break down what it costs me to be on call or what I’m being paid to be on call for \$600 a birth for 5 weeks on call – There’s the birth, I’m doing an interview and then two prenatal meetings , two postpartum meetings – or more if they need help with breastfeeding ... *it’s something that you really have to feel totally called to specifically to do the work. You have to want to make those kinds of sacrifices.*

I argue that by emphasizing the idea of being “called” to doula work, an innate or “natural” dimension to doula care is highlighted. In doing so, doula work is constructed as fundamentally different from other kinds of work.

Doulas' own characterization of their work as motivated by love and caring and a sense of "calling" rather than by money is strongly reminiscent of the early twentieth century debates around the professionalization of nursing (Morton, 2002, p. 201).

Florence Nightingale referred to nursing as a "*dedicated calling more akin to a religion* with little importance attached to status and reward" (Witz, 1992, p. 131). Indeed, the doulas that I spoke with consistently referred to their work in the language of caring labour using words like "love," "care," and "support" to describe their role. As with the literature on care work, doulas often made the distinction between work that was done "for the love of it" and work that was done "for the money." This is exemplified by Charlotte's assertion:

I think doulas shouldn't be in this work primarily as a business. If you don't have the heart – if you just wake up one morning and say I want to make money and I want to have a good business and I want to do something I really like – I think I'm going to be a doula.... I think that is a misguided rationale for going into the work. You have to love the work that you do first.... You bring your heart to your work and that's the first thing that you bring to work as a doula. And it has to be the leading – the leading piece that comes into your work.

I suggest that Charlotte's statement reflects a general unease around charging for (and paying for) care. Because care work is seen as rooted in familial love, the discourse around care work can reinforce the sense that there is a fundamental incompatibility between love and money. "We see love as sacred-and caring most effective when it is done for intrinsic rather than extrinsic reasons. The principle that money cannot buy love may have the unintended and perverse consequence of perpetuating low pay for face-to-face service work" (England and Folbre, p. 46). Zadoroznyj's work on Australian postnatal care workers also articulates the discourse of "care" as "...naturally emanating from social relationships (rather than as) 'work'" (Zadoroznyj, 2009, p. 274), resulting in

a “deeply felt ambivalence about what is and what is not too personal to pay for or do for hire” (ibid. p.269).

While in some ways the characterization of caring work as motivated by love rather than by money carves out a space for a different way of looking at work, it also makes it difficult for doulas (and other caring workers) to advocate for adequate compensation, no matter what that might look like. In particular, the ways in which love is placed in opposition to money in doula discourses, any step toward greater remuneration can be seen as a step away from love and caring.

(Caring) occupations, whether they require a weekend-long training or postgraduate work, are based on very essentialist notions of womanliness, of *naturally nurturant* womanly behaviour. To charge for being womanly, to charge for being motherly, flies in the face of the conventional ideology of gender. And for most doulas, there is much value in conventional gender ideology. These are women for whom being womanly, loving, supporting, and nurturing is a job description (Meltzer Norman & Katz Rothman, 2007, p. 267).

Intimately connected to the idea of care work being rewarded intrinsically, is the idea that caring work is an extension of women’s “natural” mothering and family roles. This association is perhaps hyper-realised in the case of doulas. Doulas are associated with the home/ private sphere (they often labour with women at home before going to the hospital), with reproduction, with mothering, and with gendered domestic tasks (like washing dishes and doing laundry). In addition, the characteristics of an ideal doula - patience, passivity, compassion, love – are themselves gendered feminine. Meltzer Norman and Katz Rothman make this argument bluntly,

Essentially, doulas are women hired to be women, to demonstrate every conventional gendered tactic, strategy, stance, and emotion you can imagine. They are there to be supportive of women in labor. They are there not to provide care, but to display care; they are decidedly not “caregivers,” or “providers,” a role left strictly to the obstetrician or midwife. They are hired for expertise in

birth, but not permitted to act on that expertise in anything but their caring support (Meltzer Norman & Katz Rothman, 2007, p. 251).

Some doulas that I spoke with rejected the connection between their doula work and 'the feminine,' especially rejecting the link with the mothering role. For example, Hazel stated explicitly, "I'm not doing this because I want to be somebody's mother," identifying her work as health care or health promotion rather than as an extension of the motherly. Other doulas used the concept of "mothering" as a way to describe *how* they supported women in labour, emphasizing a sense of selflessness, love, and unconditional support that characterises how they interact with women in labour.

I would argue that discourses of care work that elevate the "motherly role" of the caregiver are relevant with respect to doula work. Several theorists of care work have argued that paid care work has been largely modeled after unpaid caring relationships within families, such as the care of a mother for a child. These theorists have argued that society's expectations of caregivers tend to flow from this ideal of family relationships (Himmelweit, 1999; England & Folbre, 1999; Meaghre, 2006). Put simply: good mothers care for their children selflessly because it is in their nature to do so. Good care (paid or unpaid) is modelled after good mothering, therefore good caregivers care for their clients selflessly because it is in their nature to do so. This pattern holds true in the context of doula care work. In fact, the particularly intimate nature of doula care may elevate the familial feeling. Often this connection is stated explicitly; doula care is regularly described as "mothering the mother."¹⁰

¹⁰ See: (Klaus M. , 1993; Peck, 2005)

The essentialisation of care work as naturally female has the effect of closing doors to different expressions of femininity, of motherhood, and of caring. It also has the effect of devaluing the work undertaken by care workers such as doulas. Many of the skills that tend to be associated with women (like those that are linked with doula work) are assumed to be “naturally” female, and not learned (Armstrong, Armstrong, & Scott-Dixon, 2008, p. 93). As such, doulas are particularly vulnerable to the devaluation of their skills and their work. The devaluing of doula work both reflects and reinforces the poor status of “the feminine” more broadly. “When people overlook women’s skills, devalue them, give them low ratings, it is not a technical glitch, but a reflection of the status and power women have not had in the world” (Gaskell cited in Armstrong, Armstrong and Scott-Dixon, 2008, p.93).

To this point this chapter has explored the ways in which doula discourses are discourses of care work. Doulas tend to emphasize their natural affinity with doula care, and elevate aspects of their jobs that are most often considered “feminine” or “motherly, such as unconditional support and love, patience, and passivity. The inherent contradiction within paid doula work is that our model of caring work is founded in a model of familial love (itself constructed through gender norms and expectations), thus there is always something sacrilegious, or unsettling about paying for this kind of love. The following section of this chapter explores the ways in which “work related” themes such as compensation, work-life balance, professionalization, and regulation integrate themselves into doula discourses of work. The tensions that are expressed throughout

include conflicts between the needs of the doula versus the needs of the client, and the doula as “selfless woman/ mother” versus the doula as worker.

Remuneration and Work-Life Balance

The subjects of professionalization, remuneration and regulation of doula care emerged as salient themes in my discussions with doulas. The doulas’ emphasis on professionalization, remuneration and regulation indicates that, on some level, doulas embrace a role and identity as *workers* with particular interests. As will be seen in this section, the doula discourses around work-related themes are sometimes friendly and at other times ambivalent toward imagining different ways of structuring doula care that might be more attentive to the needs of the doulas. In this sense, doulas’ discourses on professionalization, remuneration, and regulation echo the same tensions between carer and cared for, and ‘lover’ and worker that were highlighted above. In addition, these themes are helpful in exposing discourses of status, power, and gender that are constitutive of doula care.

Despite the emphasis on “love over money” in many of my conversations with doulas, compensation emerged as a dominant theme. Doulas were interested in exploring how much compensation they received, what they perceived as “fair” and “unfair” about their compensation, and how their compensation matched with other doulas. I suggest that the doulas’ interest in talking about compensation is indicative of the tension that they feel between the more intimate caring role of the doula and the more formalised and distant role of ‘worker.’ More broadly, I think that doulas’ push and pull between ‘caring

value' and 'monetary value' represents a broad sense of discomfort with how value is assigned in a capitalist society.

The theme of compensation is particularly complex with doulas because they are concurrently positioned inside and outside the health care system. Doulas operate primarily in the private system, charging a fee to their clients based on an agreed upon course of care. Past research on doulas has found that the fee structure simultaneously makes it difficult for doulas to make a living¹¹ and makes doulas inaccessible to most women who cannot afford to pay for them. In this sense, the topic of compensation has the potential to position the needs and wants of the doula in opposition to the needs and wants of the client of doula care. The structure of doulas as private, self-employed ancillary health workers creates a situation in which doulas have to market their services to potential clients and, in essence, are competing with other doulas for clients.

Interestingly, while the doulas expressed mixed feelings about compensation in general, there was a near universal sense of concern with newer doulas charging (what were understood as) high fees shortly after their training. For example, Rose stated; "I think that doulas should be able to charge what they want, but I have a big problem with these new doulas charging \$500 right after they finish their training." I suggest Rose's statement is indicative of a belief shared by most of the doulas that I spoke with that the *most valuable* skills associated with doula care are developed over time while practicing as a doula. In some ways this contradicts the assertion by Meltzer and Katz Rothman that doulas are hired 'just to be women.' In some ways it also conflicts with doulas own emphasis on the 'love' aspect of their work.

¹¹ Lantz et al. (2005) found that most doulas earned under \$5, 000 per year.

I spoke quite extensively with Patricia on the issue of compensation. The topic was of particular interest to her because she had initially hoped to engage in doula care as her full time career.

I'm realizing that it's just too many hours; it's too exhausting to make it a viable career option for me. You know, I'm thinking long term – I don't want to work that hard for \$40 000 a year, minus expenses. I'm not going to take home enough money. And the fact that you're on call for five straight weeks for any client – I go on call from 37 to 42 weeks - and you always have overlapping clients so you're never off call. So at any point I could get called away from doing something that I like. Anybody who thinks that they can do it for the money I think realizes very quickly – after 5 births, no I can't do this for the money – you just don't make much money being a doula. I haven't finished my taxes yet for this year, but including my other non-doula work this might be the first year that I break \$10 000, and that's with a lot of other work.

While Patricia was committed to continuing providing doula care for the near future, she found that the low pay and the stress associated with being on-call would preclude her from continuing it as a career. I would suggest that Patricia's feelings about compensation are illustrative of the tensions that inhabit doula discourses around work. On the one hand, Patricia accepts that "you can't do (doula work) for the money," while at the same time, her emphasis on the financial aspect of doula care acknowledges that compensation is a part of doula work.

Similarly, while Ruth no longer provides doula care on a fee-for-service basis, she echoed Patricia's feelings that doula fees are too low and argued that opportunities for garnering more income through taking on additional clients were minimal.

"(Interviewer) - *Do you think the compensation for doulas is fair?* No, because you couldn't choose to be a doula and actually sustain your life. It just is not possible, as an individual, to do more than 5 clients a month – even that is totally stretching it and your chance of not making it to a birth are fairly high." That doula care is structured in a way

that the compensation is inadequate to 'sustain your life' is worthy of analysis. I suggest that the combination of a number of factors: the devaluing of caring labour, relying on payments from private clients, an emphasis on the intrinsic rewards of doula care, and the construction of doula work as available only to those women who can afford it have worked together to create this situation.

Interestingly, when I asked doulas whether it would be possible to make a reasonable living as a doula, several responded that it would be a reasonable second income, or supplemental income. For example, Charlotte stated; "If you're the primary income earner in the family then it's really hard. *If you're the secondary income earner – or you have that supplement of a partner that brings in an income, then you don't have to make that much.* So I think the pressure comes off a bit then." Shania made a similar point, stating that doula work was, "...a reasonable second income. It is not a primary income. It definitely needs to be supplemented with other things. – teaching prenatal classes, private prenatal classes – or offering photography or something complementary to it is helpful. But, it is do-able." The structure of doula work as requiring full time commitment but only receiving part time compensation is reminiscent of the idea of the "family wage" in which the household is considered as a single economic unit with the male as breadwinner and female as social reproducer. The social implications of the family wage include a lasting gender division of labour in which women's work is more likely to be viewed as peripheral (Morris, 1987, p. 87). Perhaps more integral to this analysis; the family wage was based on an assumption that women would not want to seek paid employment (ibid). I suggest that the doula discourse around income as 'supplemental' constructs a situation in which it seems reasonable that doulas don't need

or want to be paid a living wage for their work. The discourse of “doula income as supplemental income” constructs doula work as female and ensures that women working in doula work are more committed to the work than they are to the money (Morris, 1987).

This sense of commitment to the work above and beyond the compensation was repeated over and over and is consistent with the literature on care work. Jennifer demonstrates this sensibility; “Often I felt like, yeah I’m doing a lot of work for very little, but – I didn’t mind it. It was always such a privilege to me.” Jennifer’s statement reflects the care work discourse discussed above in which part of the “payment” for care work becomes the opportunity to take part in the “love” of caring work. Beyond this though, several doulas suggested that the value of doula care was so intangible that it would be difficult or impossible to put a monetary value on the care. Ellen stated: “You can’t charge what we’re really worth. I’ve been at births for 50 hours straight....and the amount of work that you do prenatally and postpartum – that’s the kind of thing – you can’t charge, you can’t put a dollar value on it.” I would suggest that Ellen is saying two things here. Most practically, given the current payment structure of doula care, Ellen acknowledges that some clients either could not or would not pay an hourly wage for doula care. Shania expressed it succinctly, “the compensation for our work is not fair. But it’s hard to explain that to someone when they first meet you. We have to try to get them to hire us.” Also significant though, Ellen alludes to the idea that there is something else about doula care that itself is not commodifiable. I would suggest that this uncommodifiable piece is the “love” piece discussed so much in doulas motivations for their work.

Similarly, Ruth stated:

I am not a commodity, you cannot buy what I am going to give you. And there is a portion of this that is about buying in to that commodification. What we offer doesn't actually translate into dollars. So we are attributing some kind of financial value which doesn't in any way measure or match up to the real life costs of doing this. We are trying to replace a village with a paid service.

I suggest that Ellen and Ruth's statements are reflective of the tensions within doula discourses around ideas of care and commodification; value and capitalism. Ellen and Ruth both articulate caring work as something that is (or should be) outside of the market place, arguing that there is some intangible in doula care that cannot be translated into dollars and cents. England and Folbre assert that this hesitation to link care work with financial reward can be rooted in a sense of 'sacredness' in caring work. "Many people seem to think that caring motives are so sacred that it is offensive to talk about their exchange value. At issue is what can be commodified, where we should draw the lines around what may be exchanged for gain (Radin 1996)..." (England & Folbre, 1999, p. 46). I would suggest that Ellen and Ruth's resistance to the commodification of their work is reflective of similar debates in other forms of care work. The question that hangs in the balance is how, in a capitalist context, it is possible to acknowledge a sense of inherent value in caring work without at the same time placing the entire burden of that caring work on the ones doing the labour. In the words of Folbre and England, "(S)imple resistance to commodification is no solution, and we should be suspicious of any argument that decent pay demeans a noble calling. The notion that women should provide care out of the goodness of their hearts has traditionally reinforced low pay for caring occupations" (England & Folbre, 1999, p. 47). In other words, if doulas emphasize their work as 'invaluable' will it necessarily be unvalued?

With all of the doulas that I spoke with, whether volunteer or paid, it became quickly apparent that there was a great deal of personal sacrifice involved in doula work. This element of personal sacrifice seems to be largely due to the way doula work is most commonly structured, with one doula providing care for several clients per month. While the one-to-one relationship between doula and client is likely appreciated by the clients, it involves a great deal of surrender of personal autonomy on the part of the doula. The doulas' personal commitment to clients, as well as the clients' expectation of total availability on the part of the doula, can translate into doulas never having any time off call. In addition, like other self-employed workers, most paid doulas have little or no safety net in the case of injury, illness, or the fluctuation in numbers of clients. Because doulas' pay is so low to begin with, their vulnerability to loss of income is potentially higher.

Jennifer describes the extending reach of her doula work:

If you want to be successful and make enough money to earn an income from it – or even to be a supplementary income – um, it's very time consuming. I don't have regular scheduled hours. I feel like I work all the time. A phone call here, an email there. I don't have a set time where I feel like I can close my office and say ok no more phone calls; no more emails....I haven't even kept up with my own medical appointments or had regular dental care in years.

I asked Jennifer if she had an idea of what the personal sacrifice would be when she decided to become a doula.

I had no idea. No one does. I really think that a lot of people pursue being a doula because they themselves have had an experience that they want to share with others or because they feel very passionate about it and want to support those women. We don't realize how isolating it is. We don't realize how incredibly straining it is on your time and your resources, and not just you yourself, but your family and friends. I knew that there would be sacrifices, there is no doubt about that, but I'm very fortunate that I have such a great support for it to be successful. But yeah, I didn't know it was going to be as much of a sacrifice – in some sense.

Over and over, when I asked doulas how they managed time off, they responded that they never had any time off. Shania said, “I don’t have any time off or vacations. Every once in a while I have blocked a chunk of time – but seeing as you have to essentially plan 7-9 months in advance, it’s very difficult to do.” Rosa agreed, “(Interviewer) *Do you manage to carve out time for yourself?* No (Interviewer)...*never ever?* *Do you do one month a year where you don’t take clients or anything?* No. Because it’s not just one month. You don’t just have clients for that month. You also might be doing post-natals and prenatal visits. So to actually take time off is incredibly difficult when you are working alone.” Again, I understand Jennifer’s statement on the challenges of doula care to be reflective of the wider devaluing of caring labour, high ‘family-type’ expectations on care workers, as well as a fundamental conflict between the needs of the carer and the needs of the cared for when it comes to doula care. The particular structure of doula care (including being on-call and the inherent unpredictability of birth work) can heighten the sacrifices generally associated with caring labour. As will be explored below, the fact that doulas are self-employed adds an extra layer of vulnerability to their predicament.

The sheer amount of work, including work that is unpaid (such as going to interviews) was experienced as very draining for many doulas. Patricia explains,

You’re constantly having to go to lots of interviews – and I’d say I get hired a lot. I probably get hired 3 out of every four interviews...But still, you’re constantly planning for these, going out. I’m out usually 4 nights a week, and often on weekends as well. Just for prenats, for teaching, for interviews, for post-natals, appointments with clients that is. Even when my youngest is napping I’m doing paperwork for the business and I never have enough time for it. So then on the weekends that I’m not working or teaching, or I’m not at a birth I usually try and get a big chunk of time in the afternoon where I tell my husband – you have to look after the kids, I need to get some paperwork done, I need to get a bunch of emails sent out – I need something changed on my website. And then, you’re of course attending births on top of that – usually overnight which, it is hard – but it’s ideal in a way (so that I can be home with my own kids in the day).

In some ways, the situation described by Patricia is reflective of the literature of other self-employed women. The literature indicates that women generally choose self-employment as a strategy to balance work and family commitments (Budig, 2006). While non-professional self-employment tends to have a negative financial effect on women, this is seen to be offset by the ability to combine work and family responsibilities. Other studies have also shown that self-employment can place unforeseen pressures on personal and family life. For example, Butler and Modaff's (2008) piece on home child care providers found that the challenges of providing care for children all day, managing business finances, and not receiving any sorts of breaks often became overwhelming (Butler & Modaff, 2008). Budig argues that women may be willing to accept lower-pay and vulnerability in exchange for the perceived 'family friendliness' of self-employment (Budig, 2006).

Aside from the sacrifices involved with providing doula care to clients, doula work can be very financially unpredictable given the difficulties recruiting sufficient numbers of clients or outside factors which affect their ability to work. Patricia described the process of recruiting clients as a "feast or famine; "It's hard to get that many clients! Especially when you're first starting out. It takes years to get to that point where you can consistently get four births a month. And it's very much feast or famine. I had about 25 or 30 enquiries for last October, just October! And then I had nothing for November or December – I did finally get something but it took forever." Ruth described her sense of vulnerability when she had an injury.

I had an accident. I was off for eight weeks. I couldn't work. So that had a huge impact on me emotionally, financially, professionally. Not only the time that it took to heal, but also afterwards, because you are interviewing for months down

the way. So how could I interview for three months down the road, when I know I'll be healthy, when I'm completely incapacitated.

Again, the vulnerability that Ruth speaks of is reflective of the instability of non-professional self-employment more generally. "A large proportion of the self-employed are in very precarious economic situations receiving low remuneration and enjoying little in the way of employment security or employment-related benefits (Dale 1994, 44)" (Cranford, 2005, p. 5). I suggest that this vulnerability speaks of doulas' conflicts between their own needs and the needs of their clients. At the same time, it also structures doula care as the sole purview of women with partners who are employed. "The finding that married mothers, who have the cushion of a husband's earnings, take the largest hit in earnings for being self-employed indicates that self-employment may be a luxury for those mothers who can afford it" (Budig, 2006, p. 748).

Professionalization and Regulation

Professionalization emerged as a prominent theme in my conversations with doulas and their lives as workers. Integrated with this theme were the concepts of regulation and certification. While these concepts are not interchangeable, they were often considered together by doulas as they attempted to articulate what might be gained and lost from each. In many ways, the doula discourses around professionalization, regulation, and certification are intricately connected with ideas discussed above; the sense of tension between care and money, conflicts between the needs of doulas and the needs of clients, and the struggles that arise as a result of working both inside and outside the health care system.

Terence Johnson characterizes professionalization as a strategy used by an occupation to gain more status, remuneration and/or autonomy. Larson concurs that a professional project tends to involve a “collective process of upward social mobility,” and also suggests that there is a ‘closing’ aspect to professionalization in that it is generally associated with the assumption of control of a particular market of expertise (Larson, 1977 cited in Witz, p. 50). In the case of doulas, the potential rewards of professionalization could involve gaining greater status and legitimacy within the medical community, as well as increased remuneration and improved working conditions. Indeed, there is evidence of the efficacy of professionalization as an occupational strategy, even among lower paid groups. Speaking in the context of ancillary workers in health care, Armstrong, Armstrong and Scott-Dixon argue that, “Professionalization (and unionization)...provide a major explanation for the better pay and smaller wage gap of ancillary workers compared to others with similar work in the private sector...” (Armstrong, Armstrong, Dixon-Scott, p. 109). For doulas, a movement toward professionalization would also likely involve some sort of system of regulation. Larson argues that professionalization generally involves a regulatory aspect including, “a standardized system of training, licensing, and certification” (Larson cited in Bourgeault, p. 4). While doula care has an existing system of training and certification (through the national and international doula associations), there is no requirement for doulas to undergo any form of training or to become certified. As will be seen below, it is a sense of distaste with this idea that any person “off the street” can call themselves a doula that provides the most common ground among doulas around the idea of doula professionalization.

Ellen articulated a clear desire to be recognized as a professional and not just “some friend,” “I just really wanted to get it across that we were professionals and we should be part of the birth team and not just some friend that you bring in. That’s always been my standpoint.” I would suggest that Ellen’s assertion is linked to a broader attempt among doulas to raise the status of doula care. There is a degree of cloudiness as to how doulas’ status and legitimacy are recognized within health care settings. Certainly, the reaction of Ottawa hospitals to doulas in the face of potential spread of illness such as SARS and H1N1 would seem to indicate that doulas are of low status in the hospital. During the 2002 SARS outbreak, doulas were disallowed from Ottawa hospital birthing rooms and classified as “non-essential” participants. This policy was the catalyst for the formation of the “Ottawa Valley Doulas” organization which cites communication with hospital policy makers as a key objective (OVD).¹² The low status of doulas vis a vis other health care professionals was highlighted again in the reaction of some hospitals to doulas during the 2010 H1N1 outbreak. Doulas were barred from Ottawa’s Queensway-Carleton Hospital as well as other hospitals across North America. DONA issued a press release in support of the right of birthing women to choose to have a doula as support during labour.

Some hospital systems are forcing women to choose between their partner and their doula. This move is causing many women a great deal of stress and anxiety. It is illogical to believe that having an additional *professional* support person will significantly increase the risk to the mother or the baby. In the same way that we will continue to have nurses available to care for the mother’s medical needs, we must allow women to get the emotional and physical support they require. (DONA, 2009, emphasis mine)

¹² Since the SARS outbreak, representatives of the Ottawa Valley Doulas have been invited on the accreditation boards of both the Ottawa Hospital and the Montfort Hospital (Szollos, 2009).

These two events illustrate first, that doulas have relatively low status within the hospital, and second, that doulas desire greater status and respect within health settings and between health professionals.

The sense that doulas are not respected by other health professionals has been repeated through several pieces of research. For example, the survey of American doulas by Lantz et al. found that 41.6% of respondents listed their most frequent challenge being the “lack of respect and support from members of the medical community” (Lantz, p. 112). A 2006 qualitative study of patients’ views on the relationship between doulas and interpartum nurses had similar results, finding that four out of nine interviewees thought that their doula was viewed by their nurse(s) with “animosity and resentment” (Papagni and Buckner, p. 1). It is possible that these tensions in the hospital room can be understood as turf tensions that “are common when an emerging profession undergoes social definition” (Lantz, p. 115). Nonetheless, there are indications that some medical professionals are supportive of doula work. For example, the SOGC (Society of Obstetricians and Gynaecologists) along with partner groups issued their “Joint Statement on Normal Childbirth,” in 2008 which lists “continuous labour support” among their recommendations for normal childbirth. (SOGC, 2008, p. 1165) What the above references suggest is that doulas may have something to gain in terms of increased status vis a vis other health professionals through the process of professionalization.

Despite doulas’ occasional hesitance to think of their role in terms of work, and despite any formalized system of regulation within doula care, there are indications that a process of professionalization has already begun for doulas. Among the doulas that I spoke with, and in the written materials of the major doula associations, doulas often

refer to themselves as *professionals*. DONA (Doula of North America), which is the oldest and best known association of doulas describes doulas on its website as “....members of a fast growing profession.” (DONA, DONA International, 2009) The Canadian doula association, CAPP, refers to itself as a “professional association.” (CAPP, 2011) And the Association of Labor Assistants and Childbirth Educators (ALACE), describes a doula as a “trained and experienced professional.” (ALACE, 2009) Indeed, some of the scholarly work refers to doulas as professionals; “Labour support provided by the professional caregiver is based on specialized knowledge and skills as well as previous experience of supporting women during childbirth” (Bowers, 2002, p. 751). Similarly, while the doulas that I spoke with did not always use the language of professionalization, they articulated an understanding of their work as involving a set of skills, having value, and deserving respect.

In several cases, the doulas that I spoke with linked their allegiance to (or rejection of) the idea of professionalization with aspects of regulation, such as standards of practice or certification guidelines. For example, Rosa replied to my question about the subject of professionalization as follows, “If you ask me if I think of myself as a professional- well absolutely. And the reason that I think of myself as a professional is because I adhere to a code of ethics and standards of practice. And I make every effort to serve my clients in a way that will enable me to serve future clients.” While Rosa is clear in her assertion that doulas are professionals, her conceptualization of professionalism is sourced more in the standardisation of philosophies and behaviours rather than in an articulated desire for more status, mobility, or remuneration.

Ruth, a retired doula, stood alone in her suggestion that doulas were not professionals. Interestingly, her conceptualisation of professionalism was linked to Rosa's in that it centers on the lack of standardisation and regulation of doulas. Ruth argued,

I think we also have to be really aware that – although a lot of doulas are more informed than the hospital staff that they are working with – it is limited information. It is not medical information. So, while we have access to studies – not all doulas are very diligent at staying on top of that stuff. Old information is tossed around for long periods of time because it is not a professional institution. So because we're not having to re-certify, there's no overseeing body – if there was truly a professional association, where you had to be re-accredited, it would be different. But it's not. It's very loose. Not all doulas have equal information to start off with. They are not supervised. And there is no expectation that we will stay current. And you don't even have to be certified to practice. - so, is it a profession, not really. I mean, childbirth educators have a more diligent responsibility to stay current.

Ruth's assertion that doulas are not professionals is linked to her sense that doulas lack a collective body of knowledge, and do not have a standardised set of responsibilities and practices. As such, Ruth conflates the ideas of professionalization and regulation, and places more emphasis on professionalism as a shared set of knowledge and values rather than a strategy of upward mobility.

Ruth's position on the professionalization of doulas would concur more closely with Lantz and Holland, who both refer to doulas as "para-professionals." Lantz describes a para-professional as "someone with a lower level of training and/or credentials who works in tandem with another professional" (Lantz, Low, Varkey, & Watson, 2005, p. 110). There is no debate that the level of recommended training for doulas is quite minimal.

In some ways, it was shared feelings around the idea of training that most galvanised the doulas' perception of professionalization. Overall, the doulas that I spoke

with expressed a sense of having “earned the right” to call themselves doulas by virtue of the time and effort put in. Almost all of the doulas that I spoke with, and indeed all of the doulas who charged for their services, suggested that it was unreasonable for new doulas to charge the same amount as doulas who had significant experience. For example, Shania stated,

I’m very torn (about the idea of professionalization) because as it stands right now – there are these women who are taking this weekend course – because it is a weekend course to become a doula! I can come to the course having had an art degree and working waitressing, or I can come to the course having worked in nursing or developmental services or having a social service background. So you’re coming to the course with different backgrounds. But we’re not talking about a month worth of training, we are talking about a weekend. And afterwards people are leaving this training and they are saying they are worth the same amount of money as someone who has done over a hundred births.”

I would suggest that Shania’s statement is reflective of a shared sense among doulas that the most valuable aspects of the doula’s education occur outside of traditional classroom settings.

I argue that the doulas’ rejection of the equality of all workers who call themselves doulas represents both a desire for recognition of skills, values, and practices that are obtained outside of conventional settings, as well as an attempt to claim ownership over the concept of doula care. As such, this aspect of the doula discourse on work represents both an *opening* aspect (upward mobility) as well as a *closing* aspect (narrowing the idea of who can call themselves a doula).¹³ This sense of closure involves both the regulation of the “supply” of potential members to the occupation (or exclusion) as well as the control over the skills, knowledge and expertise associated with the profession (see Johnson and Larson cited in Witz pp. 41, 46 and 50).

¹³ The opening and closing aspects of professionalization are noted by Witz, p. 39.

The desire to protect doulas' image as professionals emerged particularly around the theme of regulation. When doulas supported the idea of regulation, it was primarily because of the role that regulation might play in protecting clients - and protecting the legitimacy of the profession, by ensuring an adherence to the doula scope of practice. Many of the doulas that I spoke with felt that doulas (or people who claimed to be doulas) who operated outside of the scope of practice could represent a threat to the safety of clients and a threat to the reputation of other doulas. Patricia makes this point clearly,

I am really hoping for regulation. I am getting really tired of hearing some of these stories of crazy people that walk off the street and call themselves doulas. It just happened recently at the Civic and it turned into a huge blow up. A woman walked in off the street – this woman had no training and was encouraging this woman who was at 33 weeks and in preterm labour to do a lot of things to move the labour along. So she had her bouncing on an exercise ball, doing lunges, and all these things to encourage labour to go which is totally inappropriate – they needed to be trying to stop labour. She was verbally aggressive with the staff – basically telling them that she knew more than them and that kind of thing. But this woman was not a doula! Otherwise she would have known better. I don't like hearing stories like that – that is the kind of thing that makes news.... They give a bad name to all of us. I would really like to see regulation.

I would suggest that Patricia's sense of frustration around "false doulas" practicing outside of the doula scope of practice represents both a sense of collectivity among doulas (who would "know better") as well as a desire to formally define what a doula *is* and what she *does*. Ellen echoed this sentiment,

There are doulas practicing in Ottawa that will do vaginal exams. And it's illegal! That's illegal! I have people say to me – there is a doula giving little white pills. And that's homeopathic. Those are the doulas that frustrate me and they are the very doulas that are against regulation, and I agree with that but we've got, we've got to protect this profession. In this profession there has been a lot of back lash, you know. And we could lose all of our professionalism if there are people going and doing exams and stuff like that.

While Ellen generally expressed hesitation around the idea of regulating doula care, her above statement articulates a link between doulas as professionals and the adherence to a specific scope of practice. It is obvious that, despite her reservations, she could imagine a role for regulation in protecting doula care and doula clients. Indeed, most of the doulas had heard stories about doulas who worked outside of the doula scope of practice, usually by trying to make recommendations about medical procedures, being “really just there to try and catch a baby,” or conflating their work as a doula with a previous profession, such as nursing. Many doulas felt that better regulation of doulas could help to mitigate some of those problems and would ultimately improve the professional image of doulas vis a vis the medical world and the public.

Even among the doulas who were generally supportive of regulation, there was a sense of concern that regulation would insert outside control into what is currently an autonomous profession. Doulas articulated unease around the idea that regulation could involve an increased amount of scrutiny at the hands of outsiders (see Burch, 1994).

Ellen explained,

I think (that regulation and public funding of doula care) would be great. But I think that what happens in these situations though is that the government starts getting involved and starts having some sticky rules and then you have that whole underground thing where you have people doing doula work who aren't covered by regulation but who are also not practicing within the confines of what a doula is.

While Charlotte was somewhat supportive of the idea of self-regulation, she saw outside regulation as potentially threatening to the autonomy of doulas “I don't want to see doulas get regulated basically, because I saw what happened to midwives. I am not a big fan of regulating midwifery.” I suggest that both Ellen and Charlotte understand

autonomy to be centrally important to the doula identity, and that the external regulation of doulas could be detrimental to the autonomous nature of the profession.

The idea that there is an “essence” of doula work that could be negatively affected by regulation was reflected in Heather Holland’s qualitative study of doulas and doula clients. Holland specifically addressed the feelings of this group about regulation and public funding of doula care. While research participants wanted doula services to be made accessible to more women and families, they also expressed concern about the “enclosure” processes related to regulation (and professionalization).

Participants frequently referred to what might be “lost”, how doula care might be “reduced” or have things “taken away” if it were to undergo regulation and public funding. Similarly, participants conveyed wariness about placing too many parameters on doula care (e.g., “as long as they don’t infringe on how we do things”; “as long as it doesn’t come with too many strings attached and take away from what it means to be a doula”) and fears about not being understood (e.g., “I think it’s good as long as the government still understands the essence of it...”)
(Holland, 2009, p. 136).

In many ways the doula conversations around regulation and professionalization echo the conversations that Ontario midwives had in the 1980s and 1990s. Prior to regulation, midwives were largely accessible only to those who could afford to pay for their services. The pay received by midwives was relatively low. A midwife was usually paid between \$400 and \$1400 per birth (AOM). This fee would have covered all prenatal and postnatal care, as well as being “on call” to be the primary health care provider at the birth. Prior to legislation a midwife would have had no vacation, pension, sick days, benefits, days off etc. While some midwives had positive relations with individual doctors, midwives’ level of status within the medical community was illustrated by their lack of legal status. The low status of midwives dates back to the medical doctor’s

professional project, in which midwives were characterised as, “dirty, ignorant, and dangerous” (Bourgeault, 2006, p. 46) and contrasted with clean, scientific, and modern doctors.

Many midwives (and feminists) worried that midwifery legislation would usher in a “medical model” of midwifery in which midwives became part of the mainstream medical system and began to answer to that system instead of to their clients. Ontario midwife Anne Maranta rejected the move toward regulation. “I firmly believed that the process towards legalization was patriarchally initiated and carried out... We are still considered a threat because we are able to empower by imparting information, supporting choice, respecting the decisions of individual womyn independent of their male counterparts” (Maranta cited in Shroff, p. 23-24).

Midwifery in Canada is self-regulated today because midwives wanted to avoid the consequences experienced in countries where they were regulated by outside bodies. Bourgeault describes these consequences as the medical control of the profession (lack of autonomy), limited scope of practice, and lack of access to client population. (Bourgeault, p. 147) As was referenced by Charlotte, it is clear that these concerns continue to play out in conversations with doulas around their work lives.

Conclusion

Despite the fact that most doulas that I spoke with rejected the conceptualisation of themselves as “workers”, much of our conversations were dominated with what I would call work related issues: compensation, training, competing demands of work and family

life, and challenges in negotiating for their own needs. The way that doulas spoke about their work was reminiscent of other women involved in caring labour. For the most part, the doulas believed that it was essential to be involved in doula work for the love of it rather than for monetary gain. The doulas that received monetary compensation for their work tended to receive little pay for the hours of work and in almost all cases the doula remuneration was considered “supplemental” to their partner’s income and to other paid work. Despite the low pay and considerable personal sacrifices involved with doula work, the doulas referred to their work as a “privilege.”

The doulas that I spoke with had conflicting ideas about the concept of professionalization or regulation. Most doulas thought about themselves as professionals, and almost all of them mentioned a sense of having earned the title of doula that went above and beyond the requirements of training and certification. For the most part, when doulas were “for” regulation it was because it would be good for clients, or good for the doula profession at large. In fact, more than one doula had negative associations with the idea of re-structuring doula care to improve work-life balance for doulas because of the potential effects it would have on the client’s experience of care. The theme of putting women first was an undercurrent in all of the discussions. As such, I would argue that discourses of femininity, the “good woman” and even “the good mother” are instrumental in the constitution of doulas as workers. It became striking how much the doulas downplayed their own needs, or challenged other doulas for putting their own needs first. In the “good doula,” “bad doula” split, there was an obvious and sometimes explicitly gendered basis. “Good doulas” display feminine traits, “bad doulas” were more masculinised.

Chapter 2 – Doula Care and the Constitution of Womanhood

As has been seen, doula care is partly constituted through a tension between the ideas of doulas as workers and doulas as carers. In the following chapters, I argue that doula work is also constituted through discourses of choice, agency, and empowerment as well as ideas of “good womanhood/ motherhood” and “the natural.” I use post-structural feminist theory to help to draw out the ways in which contradictory discourses intermingle to constitute doulas and doula care. I examine the ways in which the language used by participants has a tendency to emphasise or de-emphasise a connection with the discourse of “the natural.” I argue that doula discourses place more emphasis on the idea of experience than on outcomes.

The Discourse of “The Natural”

How has the “Discourse of the Natural” helped to shape feminist understandings of reproduction, sexuality and the body; and how have these understandings helped to shape and develop doula care?

The discourse of the “natural” is central to this inquiry. Interrogating the question of the “natural” has been a key part of how feminists understand the world (embracing or rejecting the idea of innate feminine qualities; regarding woman’s nature as inherently constraining or potentially liberating; highlighting or discrediting binary gender order and sex as a primary category of difference). As will be seen in this chapter, the discourse of the “natural” has been drawn upon to help to legitimize doulas’ work and, in some ways, helps to form a basis of the doula identity. This is partly because doulas have been connected primarily with the alternative childbirth movement (itself often allied with the

idea of “the natural”), but also because the dominant doula discourse has generally positioned doulas as a mediating force “against” technology.

The Nature of Sex and Gender

Before I discuss the ways that my conversations with doulas highlight a relationship with the discourse of “the natural,” I briefly outline how debates around “the natural” have been used in feminist theory. These theoretical sign posts will be helpful in the later analysis of the qualitative data. A principal contribution of feminism has been the rejection of biological determinism by describing a difference between *sex* (usually thought of as biological) and *gender* (socially constructed identity). When Simone de Beauvoir introduced the second book of her iconic *The Second Sex* with “One is not born, but rather becomes, a woman,” she was asserting the idea that gender is socially constructed (though still loosely tied to sexual difference) (De Beauvoir, 1997). More recent feminist scholarship has stretched this analysis by asserting that bodies themselves are socially constructed. Pat and Hugh Armstrong explain, “Bodies...are a factor in all of women’s lives but these bodies themselves are embedded in social, economic and political structures that are continually influencing how bodies work, as well as how they are defined and valued” (Armstrong & Armstrong, 2002).

As the nuanced positions of de Beauvoir and the Armstrongs suggest, feminists’ relationship with the idea of the “natural” has not been static. Many first wave feminists viewed women’s embodiment as a type of prison. “Woman has ovaries, a uterus; these peculiarities imprison her in her subjectivity, circumscribe her within the limits of her own nature” (De Beauvoir, 1997, p. 13). As such, “*nature*” is something that women

*need to escape to be free.*¹⁴ A group of second wave feminists, largely in reaction to male medical control of women's bodies, embraced women's embodiment and celebrated the idea of an innate and powerful femininity. They argued that women's bodies and bodily capabilities had been denigrated and then taken over by men, and sought to re-gain ownership, both discursively and practically. One way that this ownership could be regained was through placing renewed value on women's nature and natural capabilities. In this understanding, *women's "nature" is devalued by patriarchal systems; it is necessary to attack these oppressive systems in order to raise the status of women.* More recently, third wave feminists have rejected the idea of "the natural" completely and argue that bodies themselves are historically, socially and discursively constituted. Donna Haraway argues, "There is nothing about *being* 'female' that naturally binds women. There is not even such a state as *being* female; itself a highly complex category constructed in contested sexual scientific discourses and other social practices." (Haraway, 1991, p. 155). Succinctly put, *the difference between the natural and the artificial is ambiguous. There is no such thing as "the natural."*

Doulas and the discourse of the natural?

Doulas are inextricably tied to the discourse of the natural and the theme of embodiment because so much of what they do involves working with women's bodies and women's bodily experiences of reproduction and lactation. In addition, doulas are linked with the discourse of the natural by virtue of their association with the alternative childbirth

¹⁴ That women's reproductive capacities were considered oppressive can be evidenced by first wave feminists who imagined external uteri which would free women from the burden of childbearing. Interestingly, these feminists were also activists for women's rights to pain relief during childbirth.

movement (sometimes called the natural childbirth movement) which itself was entwined with the second wave feminist health movement. The term “doula” appeared concurrently with the emergence of a feminist backlash against the “medicalisation” of women’s bodies and bodily processes (Papagni & Buckner, 2006). Feminist activists argued that the progress of scientific knowledge and development of medical technologies were experienced differently by men and women. Women were drastically more likely to undergo surgeries, medical science pathologised female bodies and bodily processes, women were prescribed drugs that emerged as dangerous, they were excluded as “neutral” research subjects, and they were kept in the dark about medical information that concerned them (Annandale E. , 2009). “Once again, and over and over, women are first medically conceptualized and then “diagnosed” as naturally sickly, blamed for being sick, treated as sick, and seen as irrationally pathogenic by nature” (Morgan, 1998, p. 103).

Thus the discourse into which doula care was born was one in which women and women’s bodies were positioned *against* medical technology. Unlike the first wave feminists who imagined how technology might help them to escape the imprisonment of their bodies, the feminist health activists of the second wave often saw their liberation (of their bodies at least) in the escape from the tyranny of the misogynist medical system through a return to “the natural”. In this juxtaposition of the (bad) technological, and the (good) natural; the discourse elicits an almost Lockesian return to a perfect and unpolluted “state of nature” in which women’s bodily processes can safely *be*.

Post-structural feminists have been critical of the second wave embrace of all things “natural,” and the un-interrogated rejection of the technological. This critique

emphasises that the natural childbirth movement can be experienced as restrictively and oppressively as the movement to medicalise childbirth was several generations earlier (Beckett, 2005). In some ways, the process of rejecting the patriarchal medical model of childbirth, the feminist health movement used much of the same language which itself had been deemed patriarchal and oppressive a generation before. By referring to a supposed innate female power (exemplified most purely in childbirth); and using words like “natural” and “normal” to describe the bodily; women and women’s experiences were essentialised. The discourse either excluded women who did not conform (by segregating them from ‘natural women’) or represented them as somehow inferior (Haraway, 1991). The continuing dichotomy in the metaphors of birth are evidenced by pop culture descriptors such as “too posh to push” to describe women who choose to give birth by elective caesarean and “martyr mommies” to describe women who choose to give birth without medication or medical interventions. The doula movement often finds itself caught between these competing discourses, at times drawing on themes of the natural, and at other times emphasising particularity, non-conformity, and choice.

Before beginning interviews with doulas I had anticipated that they would emphasise their role in supporting ‘natural’ approaches to childbirth, or at least would articulate a distinction between ‘natural’ and technological, medicalised, or surgical birth. In some cases this was true. In general, the doulas agreed that the understanding of their role was entwined with the idea of ‘natural childbirth.’ The source of this enmeshment was understood to be partly sourced in historical or discursive reasons, but also because the clients who sought their services tended to do so because they desired a childbirth with minimal medical interventions, or because they themselves had initially become

involved with doula care out of an interest in “less medicalised” childbirth. Despite these connections, the doulas that I spoke with largely rejected the use of binary language to describe childbirth. In fact, very rarely was the word “natural” used in any of our discussions. Ellen spent a lot of time problematising the very idea of “the natural.”

We have this idea that we are going to protect people from having a negative birth experience – but what is that? ...I try to impress on my clients the seriousness of what is about to happen. It's not that I'm trying to scare them, I just don't want them to buy into that whole – ‘women have been doing this for thousands of years, blah, blah, blah...it's natural blah blah blah’ What is natural? Or normal?

Ellen's statement reveals an understanding of childbirth that is keenly different from many of the second wave advocates of natural childbirth epitomised in authors like Ina May Gaskin or groups like La Leche League. I suggest that Ellen's discourse around childbirth is compatible with the views of Katherine Beckett who is critical of the second wave feminist emphasis on unmedicated childbirth insomuch as it serves to strengthen discourses of essentialised femininity. “...(C)hildbirth has no meaning or essence outside of its construction through this and other discourses....the idealization of ‘natural childbirth’ rests on the assumption that both women and childbirth have a true essence or nature that is respected by the natural childbirth movement but violated by the medical establishment...” (Beckett, 2005, pp. 258-259). Similarly, I would argue that Ellen's question *what is natural? or normal?* is in line with the post structural critique of the idea of ‘the natural,’ implying that ‘naturalness’ and ‘normality’ are themselves constructed concepts, and that there are no hard and fast lines between the natural and the technological, or the normal and the abnormal. Ellen's statement draws attention to the impossibly blurry line between ‘nature’ and ‘technology;’ asking the question: what

would tip the scale from a ‘truly natural’ birth to one that was intervened upon? Would a forceps delivery be ‘unnatural’, but the use of vaginal exams during the course of labour be ‘natural’? Would rupturing membranes to speed labour along be ‘unnatural’ but the use of homeopathic blue black cohosh be ‘natural’? Would the use of ultrasound technology be ‘unnatural’ but the engagement of the services of a health care professional be ‘natural’?

Similarly, I found that the doula discourses around the use of pharmacological pain relief technologies (which in the natural childbirth discourse would be named interventionist) was also nuanced. Again, given the emphasis on non-pharmacological comfort measures in doula trainings (and on doula websites), I found this somewhat surprising. Not only did none of the doulas that I spoke with have an automatic negative reaction against the epidural (which many of them acknowledged as a symbol of the unnatural or technological), but most doulas that I spoke with had advocated for an epidural for a woman at some point of time. For example, Patricia explained: “I won’t ever hesitate to really support a woman who says something about needing pain relief – usually if they’re getting to that point of pain, they can’t even verbalise “epidural” – all they can manage is “make it stop, make it stop.” Then I won’t hesitate to ask, would you like me to call the nurse for an epidural.” Ellen echoed Patricia’s comfort with supporting women to access an epidural as a tool to ease a difficult labour. She also juxtaposes this feeling with the more dominant characterisation of doulas. “I know of doulas, they want to throw themselves on the woman’s body if she gets an epidural, and protect her from the epidural. Well, frankly, epidurals come in really handy sometimes. Sometimes people cross that fine line between normal labour pain and suffering.”

What these statements suggest is that the doula discourse creates space for the idea that technology can be used for the benefit of women, and can, in fact, be empowering to women. Not only does this possibility underscore a distance between the discourse of natural childbirth and the doula discourse, but it represents a distinct shift from the second wave feminist conceptualization of technology (particularly high-tech obstetrics) as “inherently patriarchal.” (Annandale and Clark, 1996: 35). In doing so, it rejects the essentialising discourses which “treat some women’s use or appreciation of technology as indicative of a kind of false consciousness, a violation of their true (essential) nature” (Beckett, 2005, p. 259).

Interestingly, despite the space that some doula discourses can create for more fluid conceptions of “nature,” “technology,” and “womanhood” within the context of childbirth, other discourses tie it back to the notion of natural childbirth again. For example, many doulas that I spoke with suggested that they initially understood their role to be to support women to have childbirths with minimal interventions, and that at times they had experienced a sense of personal failure when a desired (i.e. unmedicated) outcome was not achieved.

Several doulas mentioned that the emphasis on “outcomes” in their doula training made them feel like, if they only did their jobs properly, they would be able to prevent certain unwanted occurrences. Patricia conveyed this sense of failure, “When I was first starting out, I always felt very useless at a birth... I really felt responsible for outcomes. If someone had a caesarean I was a bad doula. If someone was treated badly by a staff member I was a bad doula. I should be able to prevent these things, isn’t that why I’m here?” Ellen made a similar observation,

...a lot of new doulas go into this thinking that it's always going to be these really nice births, and it's always going to be a full moon, and we are going to put on our cape and our patchouli oil and go and chant or whatever – but birth isn't like that.... When I started out as a doula – I was younger and didn't have as much life experience – I remember, you get into the whole earthy-birthy thing, and you start worshipping Ina May Gaskin and you think, we're all going to chant under the full moon after we give birth and – and then after a while and somebody wants an epidural you think you have failed.

What Patricia and Ellen's stories suggest to me, is that there is a dominant, mainstream discourse of doula care which constitutes the role of the doula as *protective* of natural childbirth. That this role is accepted by newer doulas might suggest that many individuals who become doulas do so because of an existing interest in “less medicalised” childbirth.

The link between “natural” or unmedicated childbirth and doula care is reinforced again by doulas' understanding of their relationships with their clients. Several doulas that I spoke with asserted that, regardless, of their own personal philosophies, the clients that sought them out did so specifically because they desired a childbirth without medical interventions. Explaining the link between doulas and the idea of the ‘natural’, Patricia said,

The people who approach me usually want an unmedicated birth – usually – or at least the most minimum amount of interventions possible. And, they recognize that the statistics and the literature that is out there is very supportive of doulas and doulas consistently do help all of these things.... - I don't wander around and go to random women's houses and say – you are pregnant so you are having a natural childbirth because it is best for you and best for the baby and forget the pain, that's part of life, you need to suck it up and deal with it.

Patricia's statement is a reflection of doulas' current relationship with clients; namely, that doulas are often hired in order to support a woman in her desire for a minimally intervened-upon birth. The context of the doula-client relationship is

constituted by a discourse which continually connects and re-connects doulas to natural childbirth.

Interestingly, despite the aforementioned links between doula care and discourses of the natural, only one doula that I spoke with directly stated an allegiance to a certain type of birth. Ruth, a retired doula, argued that while doulas often present themselves as neutral when meeting with potential clients, they tend to be more philosophically aligned with a model of “natural” or “unmedicated” childbirth.

I have ideas about what is best. And I have things that I think that – as a birthing mom – unless there are mitigating circumstances, that I think we should all shoot for. I think every woman should try for a delayed epidural at the very least. And I think that probably all doulas in this community believe that – at the very least, unless somebody is in a traumatic situation, either emotionally or physically, should be shooting for that. Because we know that the science bears out that the less time you are in hospital...the less time you are medicated, the better off both mother and baby will be, given that things are going normally. So yeah, I think there are a whole lot of unspoken values that when doulas are debriefing together are clear, that when they are talking about things – talking about their clients, best case scenarios, the research, yeah those values are totally there. And I think doulas are lying to their clients when they say they are going to support them no matter what – ok we will support them, but is that support truly there?

Ruth’s discourse around “natural childbirth” serves several purposes. On one hand, it highlights a disjunction between doulas’ stated support of women’s choices in childbirth and a set of values which lifts one set of choices above others. On the other hand, this discourse serves as a counter-narrative to the dominant biomedical discourse of childbirth.

Despite Ruth’s assertion that a certain type of childbirth is preferable, her approach is more nuanced than simply “natural is best.” For example, she acknowledges the particularity of birth by mentioning the role of physical or emotional trauma in

guiding birth-related decisions. Nonetheless, by drawing on scientific discourses to argue that it is safest for women to birth without medications, Ruth implicitly asserts that *good (and rational) mothers* would choose a certain type of birth. Ruth's statement highlights the ways that doulas are often caught between competing moral discourses. Horton-Salway and Locke (2010) argue that; "There are often contradictory moral pressures on women around pregnancy, childbirth and parenting." with some choices (such as breastfeeding) characterised as 'moral imperatives'" (Horton-Salway & Locke, 2010, p. 437). Many doulas that I spoke with expressed frustration with a type of overly-moralising rhetoric that they argued was used regularly within medical systems to influence women's decision making. In the words of Beckett, "...obstetric intervention often results from misleading indicators of risk or narrowed definitions of normality, (resulting in a diminished capacity of women) to make meaningful choices regarding their birth deliveries" (Beckett, 2005, p. 255).

I argue that Ruth's discourse around "best" childbirth needs to be understood within a context in which the biomedical narrative of childbirth is dominant. By rejecting doulas' 'neutrality,' Ruth is positioning herself, and other doulas, as part of a counter-narrative which represents an alternative way of understanding of childbirth. To put it bluntly, if the dominant 'story' of childbirth is that it is fraught with danger, and that women's labouring bodies require medical surveillance, management, and interventions; the 'counter-narrative,' in which Ruth would include doulas, is that childbirth is a normal bodily process, and that women do not necessarily require any medical interventions to give birth. As such, Ruth's rhetorical strategy would align itself with what is suggested by Beckett; '(B)irth activists' emphasis on the 'normality' and 'naturalness' of birth is

best understood as part of an effort to contest medical control of birth and to challenge the increasingly narrow definitions of normality that prevail in hospital settings” (Beckett, 2005, p. 254).

There are opening and closing aspects to this kind of discourse. It opens possibilities for less medicalised birth within a context in which interventions are often presented as “normal,” necessary, or morally essential. At the same time it closes possibilities for choices that are made for reasons other than a knowledge of scientific information or emotional or physical trauma. This discourse constructs a dichotomy between ‘good’ and ‘bad’ choices. Have I made a ‘bad’ choice (or at least, not the ‘best’ choice) if I choose to use epidural analgesics because I find the idea of pain frightening? Is my choice reasonable only if my pain is excessive? Or if my pain reminds me of a rape that I experienced in childhood? What if a woman intuitively decides to have an epidural before experiencing pain? I argue that, while it is important for a counter-narrative to the medical discourse on childbirth to exist, it is possible to exist without falling to moralizing discourses or discourses that essentialise women or women’s bodily processes.

Interestingly, while I did not find that doulas engaged the discourse of “the natural” as a primary way of explaining childbirth, several doulas that I spoke with employed it to describe the doula’s role. Doulas’ particular relationship with women’s bodies and reproductive capacities ties them to the concept of biological womanhood even without explicit reference to the discourse of the natural. This relationship articulates a conception of womanhood which is necessarily tied to the body and which highlights reproductive labour as central to women’s lived experiences. In many ways,

doula care can't help but to emphasize the, "...ubiquitous and tenacious connections among being female, giving birth, and mothering" (Ruddick, 1989, p. 37). That the discourse of the natural is so soundly embedded in the doula discourse serves to tie the concept of the physical body with that of a gendered (or sexed) "essence."

Indeed, several doulas that I spoke with emphasised a sense that there was a female "essence" of doulahood. For example, Jennifer identified the idea of honouring birth as a *process* as particularly female.

There is something about accepting process as a thing in itself that seems to be a female capacity. That's not necessarily to say that men can't or don't do it – there are some men that do...it's not like it's a natural way to be in the world. But as a generality, it seems to be that this is a much more female way of being in the world, and it's that –accepting that birth cannot be about the moment of pushing a baby out.

I understand Jennifer's statement to be linked to the idea of counter-narratives or alternative narratives referred to above. This is to say, Jennifer is emphasising the way that doula care is different from the medical model. She juxtaposes the idea of birth as 'pushing the baby out'(male/medical) with a more holistic and process-oriented description (female/natural). In doing so though, I would argue that Jennifer is employing a strategy in which the values assigned to gender categories and characteristics are questioned, but the existence of those categories and characteristics are left relatively intact. Beckett drew on this idea in her analysis of the alternative childbirth movement and its "...tendency to celebrate women's reproductive capacities and invert the categories through which women have historically been denigrated" (Beckett, 2005, p. 258). The danger of this approach is that, not only do the categories (themselves used as tools of oppression) remain uncontested, but space becomes limited for operating outside of the categories.

Other doulas drew on the essential “femaleness” of the doula in their descriptions. For example, Patricia felt very uncomfortable about the idea of a male doula: “...I think for me personally, I can have those kinds of moments in front of another woman knowing that she really gets everything that I am feeling – even if she hasn’t had a baby herself, just the fact that she has the same anatomy.” Patricia’s statement suggests that she feels that there is something unnatural about the idea of the male doula. Part of this sense of discomfort is around the idea of relying on a male for emotional support. Patricia also attributes a biological basis to sense of emotional connectivity that might emerge between a woman and her doula when she refers to “the fact that she has the same anatomy.” Again, Patricia is assigning value to characteristics which have historically been constructed as “female” without questioning the binary structure of gender and gender characteristics.

Just as the doulas that I interviewed described doula-ing as “naturally female,” they often described the existence of doulas using the language of “the natural.” For example, Shania said,

I believe there were always women, other women around the woman giving birth. It was either the women of the house, or it was a wet nurse, or it was someone local – there were sisters and mothers. Women around other women giving birth – that’s always been there. What I think has happened as a society as a whole, is that we’ve become so disjointed with family that we don’t have our mothers and sisters involved with – you know – the whole giving birth thing.

Many of the doulas that I spoke with believed that the medicalisation of childbirth had disrupted a natural model of childbirth in which women are supported by other women, and understood the re-emergence of doulas to represent something of a return of childbirth to its “natural” state. Again, I would argue that Shania’s understanding of the

‘natural’ history of doulas suggests both a rejection of the ubiquitousness of the medical model of childbirth (and the separation of body, mind, and spirit that is inherent to the model) and an adherence to an essentialised female; loving, caring, and connected with reproduction.

The doulas that I spoke with both emphasised and de-emphasised aspects of the “discourse of the natural” as they spoke about doula care. While most doulas agreed that, all other things aside, they would find a “natural” (or unmedicated) birth preferable, they all saw a place for birth technology (such as epidurals). Their role was articulated as less about preserving or protecting the “natural-ness” of the childbirth, and more about supporting the labouring woman to negotiate challenges that emerged during childbirth. In general, the doulas didn’t create a picture of an essential, or natural labouring woman – instead choosing to emphasise the particularity of each woman and each childbirth. However, when doulas reflected on themselves and their roles as doulas, they were much more likely to use essentialising language, and to describe womanly-ness as an important characteristic of a doula.

Childbirth and Empowerment

Why is the experience of childbirth important? How does the experience of childbirth constitute women as women and as mothers?

The above section explored the ways that doulas draw on or reject ideas of naturality in constructing the ‘story’ of childbirth and womanhood. This section will emphasise the ways that doulas understand the experience of childbirth as constitutive of womanhood, and motherhood, and personal empowerment. Indeed, the doulas that I spoke with often characterised childbirth as a fundamentally important moment in a

woman's life, and understood the experience of childbirth as profoundly influential to a woman's self-identity and identity as mother. As childbirth is linked with motherhood (Ruddick, 1989, p. 37), and mothering is central to the social organization of gender (Chodorow, 1978, p. 6), the potential links between the experience of childbirth and constructions of womanhood/ motherhood are evident. In many ways the doulas' tendency to highlight the importance of the experience of childbirth serves as a counterpoint to the emphasis on the natural – the notion of experience is based on particularity and situatedness whereas a focus on the natural reinforces universality and essentiality.

All of the doulas that I spoke with understood childbirth to be a uniquely important experience for women. They often used the words “sacred,” “life changing,” or “key life experience” to describe childbirth. Charlotte explains how she understands the lasting impact of the memory of childbirth,

Sometimes I'll have women come who want to be doulas and it's been 20 years since they had their first baby and we'll start talking about the significance of birth. And we'll talk about the memories that women have of their first birth. Sometimes a woman will cry in a workshop because it's the first time she's actually had the time to remember the birth and to allow herself to feel those feelings. And, it's 20 years later and she can remember things so clearly. That's where Penny Simkin put the study – ‘Just Another Day in a Woman's Life’ – you know, is it just another day in her life? No it's not. The experience is significant. You can have a woman who is in her 80s and she can still tell you about their birth experiences. And very clearly they can remember. So it is a significant event. It is unique. It's not the same as everything else.

I suggest that Charlotte's understanding of childbirth reflects a belief that the experience of childbirth is constitutive of women as women and as mothers. Charlotte describes the experience of childbirth as so impactful that it is able to shape a woman's feelings, emotions and sense of self over the course of her life.

Similarly, many of the other doulas that I spoke with also understood a strong and consistent link between experiences during childbirth and later parenting. This link was most often articulated around the themes of control and empowerment. Jennifer said, “(Childbirth) affects how the woman feels about herself – about her self worth. It can change a woman’s life. I’ve seen a woman who came from a very trodden down life, who had experienced a birth where she became so empowered through her birth that it changes the direction of her life.” Similarly, Rosa said,

If you can become empowered during birth then you can become empowered around all kinds of other things. One day it is going to be your kids’ schooling, after that it is going to be your kid’s psychiatrist – whatever! Once you learn to do it once, you know the steps to take. But so many of us don’t learn those steps until very late in life. We just follow along like sheep until somebody wakes us up and says – you know, you do have an option here.

Thus, for Rose and Charlotte, the experience of “empowerment” in childbirth helps to constitute women and mothers who are “empowered” in other aspects of their lives.

While the doulas that I spoke with articulated a link between an empowered experience of childbirth and later feelings of empowered motherhood, they also described a lasting negative impact of “traumatic” births, or births where they did not feel in control. After her own difficult birth, Ruth felt particularly disempowered, “I dealt with a lot of personal disappointment and questioning around who I was and my entitlement to motherhood. And really feeling like all the information didn’t help much at all.”

Similarly, Jennifer elaborated on her own difficult birth and challenges bonding with her daughter,

I was just so exhausted, so traumatized, the lack of dignity, it was just humiliating, the whole experience was humiliating from the get-go. From the time they shave you and stick an enema up you – and don’t even tell you what they’re doing. Oh, it was so awful – the whole birth experience was humiliating,

so yes, I think we can at least start off the bonding well, there might be something down the line that you don't do well in parenting, but you could say – I was a really good mother, I really gave birth to you well, I gave you every opportunity to have a good, safe birth.

Here Ruth and Jennifer make explicit links between negative experiences of childbirth and later challenging experiences in parenthood.

Emphasizing a distinction between outcomes and experience, many of the doulas that I spoke to described wanting the mothers to have a “good birth experience;” this “good experience” was thought to lead to positive parenting relationships and positive self identity on the part of the mother. The good experience was not defined as fitting with a pre-conceived plan, but with being able to make their own decisions and feel supported along the way. Patricia said,

For me, I sum it up in happy mom, happy baby – because that implies their health, which yes of course is very important, but we also want a great experience for both mom and baby. And neither one of them is going to have a great experience if something happens to one or the other and they're not healthy. So I say happy mom, happy baby. And, yeah for sure people have made different decisions – but so long as at the end of the day they are happy with their birth, and everyone is healthy, it is not up to me.

Jennifer made a similar statement, and contrasted her desires for the women that she works with her own experiences in childbirth, “For me, the most important thing is that the mother has a good birth experience. My birthing experiences were in the mid seventies. It was a nightmare, especially the first one. I think I almost didn't have a second child. It was so awful, so impersonal, so traumatic... So in terms of care, the most important thing is that the mother have a good birth experience. That's all that I think about.” For Patricia and Jennifer, childbirth is not just an event that happens, but an experience that is formative of womanhood and motherhood that is born out of it. The doula discourse articulates a link between happy childbirth and happy mothering,

traumatic childbirth and traumatic mothering, empowered childbirth and empowered mothering.

Drawing on the work of Heather Holland, it is possible to see how a lasting sense of empowerment could be drawn from the type of social support that is often provided by doulas. Holland draws on the work of Fox and Worts (1999) to argue “...that a young mother's empowerment during labour and control over her birth experience can be positively impacted by strong social support, which is precisely what a doula can provide” (Holland, 2009, pp. 105-106). Anti-oppressive social work practice described the process of empowerment as something which can have a long lasting positive impact. In this context empowerment “is viewed as a means of transforming unequal power relationships between groups and is the "process and outcomes that occur for people when they begin to access various types of power, both internal (such as personal strengths) and external (such as social networks) that they can then use to improve their lives (Barnoff & Coleman, 2007, p.37)” (Holland, 2009, p. 30).

As part of the link between social support, the experience of childbirth, and personal empowerment, doulas emphasized the impact of telling “birth stories” following childbirth. The doulas that I spoke with largely rejected the idea of the “perfect” birth and described a central part of their role to help mediate against these unmet expectations following the birth. I argue that this emphasis on birth storytelling and rejection of the idea of the “perfect birth” is part of the doula discourse which emphasises the particularity of the experience of childbirth over the universality of the “natural.” Hazel said, “It’s really horrible that women are made to feel inadequate, to feel like their best wasn’t good enough. There is no such thing as a “perfect birth” at least not the story book

version that you might have had in your mind.” Hazel’s statement is echoed by Crossley; “(T)he ‘natural discourse’ towards childbirth may create idealistic expectations that are totally at odds with the reality of the actual birthing encounter. The tension arising as a result of this discrepancy between expectations and outcomes may have unfortunate negative psychological and emotional consequences, especially for first-time mothers” (Crossley, 2007, p. 543).

Several doulas that I spoke with told me that birthing mothers often wanted to “debrief” after a birth in which technology was engaged in a way that was unexpected. Sometimes these debriefing sessions centered on potentially traumatic events, but often the doulas described helping clients to feel comfortable with the decisions that they made during labour and childbirth. This suggests that birthing mothers value the doulas’ reassurance that, in their circumstance, technology was useful or necessary.

What women remember and what happens can sometimes be different. Because when you’re in labour you are not perceiving things that are going on around you in the same sense. And your memory kind of fades, so there are chunks of women’s labours that they don’t really remember – so when the doula is able to fill in the blanks for them – especially because, as humans we don’t have memory for pain – so women don’t remember what they were feeling before they asked for the epidural. So when I am able to tell them – no, you were in horrific amounts of pain and I was really afraid that you were going to have post traumatic stress disorder from that amount of pain – they feel really validated.

I suggest that doulas’ emphasis on the telling of birth stories is part of a broader history of storytelling as personal and political healing within the feminist movement. Crossley reflects on this in an article in which she recounts the story of the birth of her first child: “the telling of personal stories such as this and the ones told by writers such as Naomi Wolf can become the first step in a process of consciousness raising, the first step by which women perhaps become aware of the need to change existing birthing

practices” (Crossley, 2007, p. 559). Thus the experience of childbirth (and the recounting of that experience) can reinforce the particularity of the experience, but also make visible collective experiences.

Several doulas described their role as that of “nurturing and protecting” the memory of the birthing woman. Charlotte said,

The goal of the doula is to nurture and protect the memory of the birthing women – so it really is for her to have a positive experience, it doesn’t necessarily mean that it is the outcome that she wanted, but that she had a positive memory of that experience....That woman can’t go back and do her birth again. That’s the thing. You walk with these women. You cannot turn back and you cannot re-do something. It’s sacred – you have to be very respectful and careful. It’s not going to be your memory. It’s going to be the woman’s memory that is going to be shattered.

I would suggest that the doula’s role here is threefold; it involves supporting the woman during birth in a way that she emerges with a memory of birth that is not traumatic, it involves helping the woman sort out and understand what happened during childbirth, and it involves creating space for the woman to tell the story of her birth.

According to Pollock (1999), the birth story is cultural, personal, and metamorphic. The telling is simultaneously a performance of birth, body, and macro-micro politics in which the center shifts and moves. Birth stories are the origins of our beliefs about birth and the counter-rituals that re/ritualize. They are told in and against other narratives. They are told through the presence and absence of voice and word. They are continually constituting and reconstituting public and private, yet they are always both” (Turner, 2002, p. 652).

Through their roles in emphasising or de-emphasising discourses of “the natural” as well as emphasizing the idea of particularity and experience in childbirth; doulas are actively constructing and negotiating metaphors for childbirth. Childbirth itself is constructed discursively. Our understanding of birth is mediated by key metaphors: Childbirth is, “dangerous...in need of management,” the childbearing body is like “a machine and doctor as mechanic” (Martin, 2001, p. 56); the childbearing woman is, “self-

determined, self-assured, and self-sufficient” (Martin, 2001, p. 157); childbirth is, “a continuation of creative energy that began with conception and will grow through years of nurturing”; (ibid) “an intimate husband/ wife love encounter”(ibid, p. 159); or, “a simpler, animal-like, unselfconscious state”(Martin, 2001, p. 164). The feminist health movement, of which I would consider doulas a part, in large part attempted to wrestle the metaphor of childbirth away from medical science. “Re-writing” the story of childbirth has been a way that “women are self-consciously trying to create meaning in the event...(to) reintegrate the whole person from the jigsaw of parts created by modern scientific medicine” (Martin, 2001, p. 159).

In some ways the new metaphors for childbirth (as “natural” for example) can be considered “empowering” to birthing women, in other ways they can be experienced as similarly oppressive (Beckett, 2005). If we consider that the dominant discourses of childbirth are either a) that women need to be rescued from their bodies in childbirth by (male dominated) technology, *or* b) women have an innate capability to give birth and childbirth should be celebrated as an expression of authentic femininity; it can be said that childbirth helps to constitute women as mothers within a hierarchical gender order.

The doulas that I spoke with seemed to understand themselves as playing a role in “re-writing” the metaphor of childbirth. This role might include either emphasizing or de-emphasizing certain dominant discourses of childbirth, constituting labouring women through discourses that emphasize personal agency, and protecting and preserving a woman’s own story of her birth by acting as a keeper (and re-teller) of the memory of the birth story. As such, doulas become agents in reshaping and redefining the moment of childbirth so as to co-construct the birthing mother.

The thread that ties the above together is the idea that childbirth is a uniquely important key life experience. While the doulas' assertion that childbirth is universally important makes space for women to experience childbirth in their own unique way and to source a sense of fulfillment and personal empowerment from that experience; it does not explain the impact of childbirth for all women. I suggest that not all women will experience childbirth as a transformative event. By privileging the voices of women who describe childbirth as meaningful and connected to identity, the discourse makes invisible the experiences of women who do not find a link between the childbirth event and their lives as women and mothers. While the doula discourse has moved away from using language such as "perfect" births, the continued use of discourses of "good and bad births" has regulatory effects. In particular, the link between "good" birthing experiences and "good" mothering places much importance on birthing experiences happening in particular ways.

Chapter 3 – Doula Care and Discourses of Reproductive Choice

Choice, Agency, and Empowerment

How do discourses of choice, agency, and empowerment constitute doula care? How do doulas negotiate tensions between their own ideas of empowerment and those of their clients? How do they negotiate tensions between the needs of the mother and the needs of the foetus?

Themes of choice, autonomy, and personal empowerment are central to discourses of doula care. These themes are consistent with a history of emphasis on choice and control in the feminist health movement. As was previously discussed, doula care emerged in the context of the second wave feminist opposition to (what were understood as) patriarchal medical systems and practices. Pillars of the feminist health movement were the democratization of health information, resistance to oppressive or authoritarian health regimes, and the “re-claiming” of women’s bodies and health care (Feldberg, 2003; Kuhlmann, 2009). The rhetoric of “choice” in health care became symbolically representative of women’s control over their bodies and their lives, most obviously with respect to the abortion rights movement, but also significant in terms of choices in childbirth.

Doulas were centrally positioned in the movement, both philosophically and physically. They advocated for women’s choices in birth, and were present at key moments to provide support and advocacy to women in exercising their choices. Doulas argue that their support helped women feel more in control of what was happening during

childbirth and to emerge from birth with a greater sense of personal empowerment.

Nonetheless, as will be seen in this chapter, doula discourses of choice and empowerment are fraught with tension and contradiction. In the words of Beckett; while, “..the rhetoric of choice is one of the most powerful weapons deployed by birth activists in their campaign to increase access to alternative childbirth choices... this emphasis on choice does sit somewhat uneasily with the movement’s pervasive and quite damning critique of the medical management of childbirth. (*What if women actively choose medical intervention?*)” (Beckett, p.257, emphasis mine).

Many of the doulas that I spoke with articulated their relationship with the concept of choice as uncomplicated, arguing that their role was always to support women’s choices. Charlotte asserted, “My job in the birthing room is not to have any opinions, just to support that woman’s choices, whatever they are, unconditionally.” Most doulas that I spoke with were explicit in asserting that their role was not to advocate on behalf of a client, to make decisions on behalf of a client, to speak for a client, or to try and influence a client’s decisions.¹⁵ Indeed, belief in a woman’s capacity to make her own decisions was a key part of the doula discourse around choice. Hazel explained, “People need to be respected that they are intelligent enough to make decisions.” Similarly Charlotte said, “I have enough respect for women that I feel like they can make their own decisions. I might give them some information, but I’m not going to give them advice.” Charlotte, Hazel, and Ellen’s understanding of their role in supporting women’s decision making was fairly consistent among the doulas that I spoke with. They expressed a strong belief in women as rational, capable, decision-makers.

¹⁵ This position is also consistent with the vision of doula roles and responsibilities articulated by DONA (DONA, 1998, p.1).

I propose that these doulas' trust in women's ability to make choices during pregnancy and childbirth represents a distinct shift from a medical model in which a doctor has the expertise and authority to make health decisions. Nonetheless, their emphasis on "intelligence" and "respect" as markers of the right to make decisions, may represent an overly simplistic view of choice making which neglects the degree to which context may influence decisions.

Other doulas were much more explicit in their understanding of how and why certain decisions are made. For example, Ellen stated:

People make decisions based on so many things, their personalities, their partners, their families, their histories, there are so many things that help you decide. You can give information and then you step back and let them make those decisions. .. for me personally – and this comes from maturity and life experience and evolving as a doula is that – I can tell you 100% that I – I support women for what they decide in the end. I respect where women come from.

Ellen's description of her support of her clients is consistent with Doyal's description of choice making in which a woman's "reproductive deliberations take place within a particular set of beliefs and values about the nature of men and women, the purposes of sexuality and the meaning of parenthood and family life," (Doyal, 1995, p. 95) and is intertwined with social and economic factors. Thus it is not just intelligence, rationality, or reasonability that influence which choices are made, but also the complex interplay between a woman's wishes, desires, past experiences, personal context, spirituality, fears, beliefs etc.

Several doulas articulated that, even if they did not understand why a certain decision was being made, they were sure that there was a reason that was particular to the woman and the situation she found herself in. Hazel explained, "There is a very fine line

between pain and suffering and coping and suffering...and sometimes we might not recognize it at the time. It is never our place as doulas or medical professionals or anyone to make that decision for that person.” Ellen expanded on this idea, “...They can have all the information in the world, and they may still want to formula feed. And it doesn’t mean that they are stupid people. It means that there is something else going on. Or that’s what they need to do – so there comes a time where you have to just respect people’s decisions.”

Ellen and other doulas juxtaposed their understanding of choice with the model of “informed consent” adhered to by biomedical ethicists. They argued that the consent paradigm implies that a patient has the right to consent *to* a procedure, but not necessarily to decline or choose a different option. Unlike in the doula discourse articulated by Ellen, the prominent model of informed consent assumes that decision-making individuals are “self-present, autonomous, disembodied” (Disprose cited in Thachuk, 2007, p. 43), and neglects that “power relationships between biomedical practitioners and patients lead to unequal encounters wherein personal autonomy cannot be realized in the way it is imagined by the dominant bioethical idea” (Felt, Bister, Strassnig, & Wagner, 2009, p. 89). Finally, it discounts how broader social factors may impact freedom of choice. I argue that, in many contexts, doulas conceptualised ‘choice’ in a way that reflected an understanding of the myriad of factors which affect decision making.

While many of the doulas that I spoke with emphasised an unconditional or non-judgemental support for women’s decisions, at times they prioritised the idea of “informed choice.” Rosa felt that her key responsibility as a doula was to provide her

clients with information so that they could make choices based on specific knowledge. She saw herself as providing a service which was not generally provided by the medical system, therefore giving women access to a type of autonomy that wouldn't necessarily have been available to them otherwise.

Well, I'm a really passionate believer in informed choice. I don't believe women do have a lot of choice around birth. I think our system – as soon as you're pregnant you go see a doctor – that doctor refers you to another doctor and that doctor says take these tests, do these things, show up here when you're in labour. Never is there an “ok, congratulations” or – here are your options – midwifery, family practice, obstetrics,. Here are the pros and cons of each. Here is some contact information – inform yourselves, if you would like more information, you let me know, make a decision and at that point we'll move forward. ... Women don't believe that they have a choice. They believe that they have to do things because they are told to. And it really upsets me that they find out afterwards when something has gone really badly that they did have choice.

Here Rose articulates doula care as part of a strategy of resistance against a medical system which she believes does not provide women with information about alternative choices. Indeed, there is evidence to show that women are often forced to make decisions in childbirth based on partial or biased information provided by the medical system, which may overstate or understate potential risks to herself or to her foetus/baby (Beckett, 2005; Annandale, 2009).

While Rose emphasizes her support of “choice” for women, she goes on to explain her caveats to supporting clients' choices, “When there is a choice made with no information, then I have a problem – that I cannot tolerate, even if it means that that person hates me or that I will get fired.” I suggest that, while Rose expresses opposition to a style of health care in which women are not offered choices, her alternate vision of health care is not as open as she seems to imply. Rose presents “informed choice” as a neutral *good*, closing space for acknowledging the different ways that women make

health care decisions. In doing so, the possibility for choice-making based on feelings, emotions, intuition or spiritual beliefs rather than information is rendered *less* appropriate. Her discourse also obscures the existence of women who may choose *not to choose* when it comes to their own health care decisions. For example, Crossley, who initially expressed a strong desire for an “empowered” unmedicated childbirth, experiences a sense of “relief” when a childbirth that is not going well is eventually placed in the hands of doctors (Crossley, 2007).

I would also suggest that Rose’s understanding of informed choice, along with the several other doulas who emphasized its importance, harbours an unspoken assumption. That assumption is that, given the “right information” most women will make the “right choices.”¹⁶ For example, when doulas suggest that they don’t care whether their client breastfeeds or not so long as their decision based on information – I would argue that their underlying assumption is that, with information about the health benefits of breastfeeding, most reasonable women would choose to breastfeed. In some ways then, the doula discourse around informed choice may mask a set of beliefs which prioritises some information and some choices above others.

Indeed, Rose’s discourse rests on the idea that the information that doulas provide is neutral (and neutrally true). Some doulas that I spoke with acknowledged the impossibility of ever achieving total informed choice, because no one can ever have all of the relevant information on a particular topic. Some doulas that I spoke with

¹⁶ This assumption was also articulated in Emily Minor’s study of Crisis Pregnancy Centres and their use of the concept of “informed choice” (Minor, 2007).

acknowledged that, much like the medical profession, doulas' provision of information involves necessary selections and omissions.

While many doulas argued that they would unconditionally support women's choices, other doulas reflected on the impossibility of neutrality in the doula-client relationship. Ruth said,

While I always would respect that women would make different choices than I would make, or might have different priorities than I would have, the fact that I can't actually remove myself from the equation became ok with me and so then I didn't try not to be authentically me. I didn't try to be neutral with my clients in the same way as I became more comfortable. They chose me. And they should choose me based on me presenting myself not as neutral.

Ruth conveys a sense that there is something false about doulas presenting themselves to clients as neutral and un-invested in birth processes and outcomes. She asserts the importance of "matching" values and priorities between doulas and their clients. In doing so though, I would argue that Ruth articulates a 'static-ness' to values and principles. I am unsure how would she accommodate a client like Crossley who, before childbirth felt strongly about a certain set of values and decisions, and during childbirth experienced a shift in desires and priorities. It is this mismatch between doulas' openly expressed support of choice and subordinated set of values around birthing that Meltzer Norman and Katz Rothman address in the following citation.

...(P)art of the problem is that doulas try to deflect attention from the activist nature of their work. They sell themselves to their clients as being there, being present at birth, only to support the woman in her choices. However their work is inherently political, activist work simply because they are working in the birth field. They believe that birth matters, and they do believe that there are "good births" and "bad births". (Meltzer Norman & Katz Rothman, 2007, p. 279)

I would argue that the disconnect between stated and unstated values could negatively impact the relationship with doula and client and the clients' own experience

of birth. While discussing the role of doulas in supporting and promoting positive birth experiences Ellen said, “We always have to ask - is it the doula’s ideal birth or is it the mother’s ideal birth? ...sometimes the doula brings her ideas of what a good birth is into the birth. And whether she says it or not, she can get the message across verbally or non-verbally.” Ellen argues that doulas may judge a woman’s choices or birth experiences as “good or bad” based on a predetermined set of values which she may or may not have shared with her client. Given the emphasis that doulas place on non-judgement, choice, and autonomy, I would argue that the kind of messaging that Ellen refers to could be quite damaging to the sense of trust within the doula client relationship. Similarly, it draws attention to the fact that relationship-based support can both enhance or undermine autonomy (Thachuk, 2007).

While Ellen and Ruth explicitly interrogated and rejected the ideal of doula neutrality and unconditional support, most doulas that I spoke with understood these ideas as pillars of the doula role. Nonetheless, I wondered about what they would do if a client made a decision that went against their core values. Several doulas could describe to me situations where a client made a decision that they felt was not the “right” decision. Often this was the case when the doula felt that the client had the inner resources to “push through” a difficult moment in childbirth, but instead chose to accept medication or, in one case, a caesarean birth. Shania shared a story of one such case, (when somebody who coped well all the way along decided to get an epidural at transition):

In my head I was thinking “why? Why are you doing this – you are so close – you are in transition which is the most challenging time, but it is so short. It’s such a short period of time. And part of me – I thought about sharing that with them – but again, it’s about being respectful of the decisions they have made. And having that information – is it going to make a change in the decision – am I

going to be seen as pushing her to make a choice that she is not comfortable with? And there are often times when I wrestle with myself about – do I keep my mouth shut or do I say this? How much can you, do you push them – or stall them – all of these things. But in the end it is not my decision to make.

I suggest that Shania's statement indicates a strong sense of personal struggle with the idea of "unconditional support." In fact, I would argue that, for all doulas to varying degrees, the expression of "support" will occur on a continuum in which the doula is balancing numerous possibilities of intervention or non-intervention. Doulas must choose when, where, and how to challenge a client's decision, ask questions of the client, offer alternate ways of viewing the situation, make inferences based on experiences, or unquestioningly support a client's decision. The constant weighing of these options is a significant piece of doula work.

What I believe the above discourse on doula care and choice indicates, is a sense of tension between doulas as facilitators of "informed choice" (and within this an idea that doulas are presenting an alternative to the medical model) and on the other side, an expressed desire to support women's decisions unconditionally, for whatever reason that they make them. I would argue that doula care is woman-centered care given that, on one hand, doulas are reacting to a well documented history of disinformation/ partial information when it comes to making decisions during childbirth, and on the other hand doulas are supporting a vision of women's relationship with health care that offers more opportunities for autonomy.

Links between choice-making, control and empowerment

Overall, the doulas that I spoke with were able to describe "empowerment" as the ability to exert control throughout the process of labour (often this was juxtaposed with

women who felt that birth was “done to them”), whose feelings and beliefs were validated, and who were provided with access to information and choices. The feelings of the doulas that I spoke with were echoed in the literature. As mentioned earlier, Penny Simkin has published a number of studies that interrogate the impact women’s memories of their births on their long term well-being. Simkin’s studies have shown that medical interventions and procedures, and even the experience of pain did *not* impact women’s perceptions of their birth experience. Rather, positive and negative memories were correlated with the degree to which “...they felt they were in control of what happened to them” (Simkin, 1991, cited in Gilliland, 2002, p. 763).

The doulas that I spoke with often contrasted the kind of autonomy or empowerment that women are able to feel in a doula-supported childbirth with the lack of control characterised by a more conventional medical birth. Rosa asserted that doula care was a way to promote a more holistic experience of childbirth, in which a woman is more than just a body, and where childbirth is more than just pushing a baby out, “When I see people who manage labour by managing a vagina and a foetus inside – that bothers me. That person should be treated as a whole. That family unit should be treated as a whole.” I suggest that this holistic model of health care provision described by Rosa is characteristic of relational approaches to health care, in which physical, cultural, spiritual, and mental/emotional aspects of health experiences are acknowledged and addressed, and where the “social situatedness” of the individual is considered centrally important (Thachuk, 2007, p. 39).

While all of the doulas that I spoke with highlighted the centrality of “empowerment” in doula discourses, several of the doulas argued that discourses which

focus on outcomes at times conflict with discourses of empowerment. This tension can sometimes be experienced as a struggle to individual doulas. Patricia said,

When I was first starting out, I really felt responsible for outcomes. If someone had a caesarean I was a bad doula. If someone was treated badly by a staff member I was a bad doula. I should be able to prevent these things, isn't that why I'm here....With experience I realized.... I'm not here to necessarily take someone's pain away. I'm not an epidural. My comfort measures are to help her be able to cope with it. To find her own inner resources to cope with it. That is what makes it empowering.

I suspect that Patricia's initial internalisation of the idea that doulas are responsible for specific health outcomes is related to a parallel discourse within the alternative birth movement which conflates "natural"/unmedicated childbirth with the idea of empowerment. Metzger Norman and Katz Rothman describe this definition of empowerment as it relates to childbirth: "Birth, to midwives, is not about informed choice with a shopping list of advantages and disadvantages for each possible procedure drug, position for pushing and so on. It is about reaching into the power within the woman to birth...That is what midwives mean by empowerment: not the right to exercise choice, but the power to touch the elemental" (Metzger Norman & Katz Rothman, 2007, p. 205). While I disagree with Metzger Norman and Katz Rothman that there is a singular, static definition of empowerment among midwives, I agree that the way that they describe "empowerment" is representative of a dominant narrative within the "alternative" birthing community. While the crux of their definition – that empowerment is about connecting with some kind of "natural female power" rather than accessing choice and control – directly contradicts much of the doula discourse around empowerment, the idea still resonates with some doula discourses. For example, the "inner resources" referred to by Charlotte and Patricia are articulated in the context of women being able to find the ability to deal with the pain of childbirth, not of women finding the ability to ask for an epidural.

Jennifer described the link between coping with pain and empowerment,

If I take away her pain it is not empowering – it is disempowering. And that is a big line in the doula care philosophy. That everything has to be empowering the woman. And when we do something, like speak to a staff member on her behalf – to say something like - you are not treating her well or something, we are disempowering her because she is not getting to say it for herself – so we are taking that power away from her just as much as a care provider making a decision for a woman and not asking her permission. If I were to – and I’m not allowed to as a doula, but if I were to refuse a procedure on her behalf and say no, she told me ahead of time she does not want pitocin to augment her labour – I’m disempowering her as well.

Charlotte placed a similar emphasis in her description of empowerment; “You can’t go and save women in birth, because otherwise you are not fostering maximum self determination. I need to believe that they can find their own coping mechanisms – otherwise it’ll just be doing it all for them – and they will have no power, we will strip their power away from them.” While neither Charlotte nor Patricia make an explicit link between natural childbirth and empowerment, they nonetheless understand a relationship between empowerment and drawing on inner resources to cope with pain and other challenges in childbirth. We can see a potential relationship with the idea of unmedicated childbirth and empowerment when we replace the *doula* in the above statements with *the epidural*. Suddenly, women who use ‘external’ methods of pain relief are disempowered because they do not draw on inner resources to cope.

While a marriage between the ideas of unmedicated childbirth and empowerment was drawn upon by some doulas, a much more dominant discourse conflated the ideas of choice, control, and empowerment. For example, Hazel said, “I think that (aspect of control) is what makes the difference as she looks back – she either feels like the birth was totally out of her hands and she feels violated or what have you, or she feels like –

ok, it didn't go according to plan, but everything is fine, and I felt like along the way I understood what was happening to me, the baby and my body." Shania said something similar, " (For a birth to be empowering) it doesn't matter if it is with medication or not...It's that they can say: 'along the way I was able to make my own choices and I was supported regardless of what I decided.... And hopefully they are able to look back and say – yeah, I may have had a c section or I may have been induced when I didn't expect to be, but I knew what was happening and I felt that I was in control." For Hazel and Shania, the actual decisions that are made are inconsequential to a woman's sense of empowerment, as are the 'outcomes' (unmedicated vs. medicated, vaginal vs. caesarean) of childbirth. Rather, the fact that a woman was able to make decisions and exert autonomy within the context of childbirth is what will lead to her experiencing a sense of empowerment.

I asked Ellen to describe what "empowerment" in the context of the doula-client relationship meant to her,

I think you empower people by giving them the power. You don't walk in like – I'm going to be there, so don't worry. I'm going to be la la la. That's not empowering. I think you empower people by giving them the power. So when a mother trusts you and says: "I'm really terrified and I don't know if I can do this," well..."tell me why you don't think you can do this" "Why do you think your body is different from other women's? Where does that come from?"

In some ways Ellen's articulation of empowerment speaks to a relationship of trust between a doula and her client. Yet the idea that a doula is so powerful as to have excess power to *give* to her client can be understood as a problematic reworking of the charity relationship. Ellen's understanding of empowerment is one in which the doula is able to maintain a sense of being powerful in the giving relationship and a hierarchy between

doula (power giver) and client (power receiver) is established. I share Heather Holland's sense of caution around this understanding of empowerment. Holland states an agreement with authors such as "(...Lundy, 2004; Margolin, 1997) who caution that conceiving of empowerment as something that can be given from one person to another is neither accurate nor ethical as it can exacerbate power dynamics in a helping relationship and deny the agency of the individual receiving support." (Holland, 2009, p. 30)

For many doulas, it was the context of the relationship between doula and client that allowed for the client to experience the relationship between choice making, control, and a sense of empowerment. The relationship between doula care and women's autonomy in health care contexts is highlighted by Holland. Holland describes the relationship between the doula and pregnant woman as one that is open to the creation of "relational space." That is, the doula does not "empower" the woman, but the relationship between the doula and the woman makes a space for empowerment available.

I conceptualize the social support that doulas provide as creating relational space In my view, it is not the case that doulas provide social support that empowers birthing women and gives them control (not that A causes B), but rather that a birthing woman's relationship with her doula can create a relational space where she can experience a greater sense of empowerment and control (that A can create a space where B is more possible)." (Holland, 2009, pp.30-31)

Many of the doulas that I spoke with articulated a sense that that empowerment was something that occurred within the context of the *relationship* between the doula and her client. Several doulas that I spoke with drew on this understanding to explain why the research shows that hospital-based doula programs (in which a doula is assigned to a labouring woman at the time of birth) are less successful than relationship-based models.

I concur with the understanding of empowerment suggested by Holland, in which it is the trusting relationship which creates space for empowerment to occur. This understanding is congruent with the “wellness model of care” described by Crossley. She advocates for a type of relational approach “... in which the woman feels in control of the pregnancy and labour and in a position to exercise choice and options.” (Crossley, 2007, p. 545)

Choices and Rights: the mother-baby dyad

I was particularly interested in probing doulas feelings about the mother-baby dyad, and whether doulas ever feel a tension between supporting the “needs” of the labouring woman versus the “needs” of the foetus. I thought this line of questioning would be appropriate because I had heard doulas distinguish between themselves by using the categories of “mother advocate” versus “baby advocate.” I was particularly interested in the ways that discourses of “choice” and discourses of “rights” might at times intersect and at other times contradict in the context of the mother-baby dyad.

The “mother-baby discourse” may emphasise the rights of the mother over the foetus (as with feminist activists who are interested in promoting women’s full access to reproductive control and choice), or the rights of the foetus over the mother (as with the anti-abortion activists who promote the rights of the ‘unborn child’ as separate from and at least equal to those of the mother). Martin argues that the medical model constructs the mother-baby dyad as perpetually in conflict. “Mother and foetus are seen in the medical model as a conflicting dyad rather than as an integral unit...(and the doctor’s role is constructed as)...an ally with the baby against the potential destruction wreaked on it

by the mother's body." (Martin, 2001, p. 64) Through the language that they use, the information they provide, and how they frame certain processes, procedures or technologies, doulas implicitly or explicitly align with discourses that champion the rights of women over their bodies, or the rights of fetuses as "unborn children."

Almost all of the doulas that I spoke with argued that their responsibility was to the mother as opposed to the fetus/baby. In keeping with the literature cited above, several doulas felt that their role was to support the mother, and that the medical system was there primarily for the baby. Ellen stated,

I've always felt that my job was primarily to look after the mother, and then a close second is her partner – whether that is the father, or a family member, or her life partner, or whatever. My job is to care for the mother and then after all that, the baby. But really that is the job of the midwife or the doctor or the nurse looks after the baby, then they look after the mother or the family members, but their main priority is the baby. My main priority is the mother.

Similarly, Jennifer stated: "My responsibility is to the mom. And hers is to the baby. There is obviously an interest there – in the apgar and all those kinds of things. I've certainly been holding the baby while the team is busy with the mom. But in terms of decisions it is always to the mom. That is my focus - the mother. The medical team does the baby." While Ellen and Jennifer's conceptualisation of the mother-baby dyad preserves doula care as 'woman-centered,' that they both articulate a split in interests between mother and baby is interesting.

Despite assertions of woman-centeredness, many of the doulas agreed that they experienced a sense of tension in their wish to support the mother but still feeling the desire to advocate for the needs of the fetus/ baby. Ruth stated, "I don't feel like I am just a mother advocate. I guess because the process is instrumental in the outcome. Um,

I don't think I can disconnect it. Like, maybe I'm a mother advocate until we come to pushing and then I'm a baby advocate. ...Like, I know it is going to be better for the mom in the long run if she breastfeeds, but right now, it is important for the baby." Rosa had a similarly nuanced relationship with the idea of tension between mother's needs and baby's needs.

I'm a mother advocate when I feel that mother is being poorly treated. I'm a baby advocate when I feel that decisions are being made without informed choice or that are really selfish. That's my own thing and my own judgement call. And of course I don't voice it, but I feel it. I have to say that I would probably lean toward being the baby advocate and it might be because I am a mother and I know I would walk over red hot coals for my children that I feel very strongly about that. But frequently I've been in a position where I am a mother advocate.

Both Ruth's and Rosa's assertions suggest a clear idea that when faced with a decision between her own needs and the needs of her child, a good mother would choose her child. Similarly, despite earlier assertions of the importance of preserving maternal choice within the birthing context, when rights discourses (particularly rights of the child/foetus) emerge, they at times conflict with discourses of female autonomy and control in childbirth. Both Ruth and Rosa display an allegiance to the types of choices which they believe will be "best" for the baby.

What was particularly striking in my conversations with doulas, were the silent discourses around pregnancy terminations and "bad outcomes" such as stillbirth, serious complications or newborn death. For the most part, I didn't explicitly bring up the theme of abortion in my interviews. I was concerned that the word abortion would elicit a politicisation, or even a dichotomisation of our conversations, rather than encouraging an understanding of our philosophical and political positions as ever-changing grey spots on a continuum. I wondered whether this theme, or other themes that touch on "bad

outcomes” would emerge organically throughout our conversations. Interestingly, these themes were rarely brought up. I suggest that these silences are reflective of a general thrust within doula care toward having a healthy baby at the end of the process.

Jennifer was one exception to this rule. She acknowledged that these conversations around decision making in the case of a “bad outcome” was part of her role as a doula.

I try to ask the women beforehand: in the case of a severe disability, would you want to use any means necessary to sustain life? Mostly I find that they say, oh I would want it saved at any cost. And, at least I know because I’ve asked the question – I mean it’s not my answer, but I’d never insert my own opinion. Fortunately I’ve never been in a situation where that decision had to be made. So my concern has to be with the mother, but overall – I also have to support her by asking those kinds of questions.

In exploring the meaning of Jennifer’s perception of her role as a doula in helping clients navigate unexpected outcomes, I was struck by the juxtaposition between Jennifer’s voice and the silence of most other doulas. Doulas generally place great emphasis on the idea of ‘choice,’ and often draw on the same kind of rhetoric that has been employed by various waves of feminist movements to explain their position on choice. “The notion of choice is a crucial subject in feminist moral discourse (from the right to choose if and when to conceive, the right to choose whether to carry a pregnancy to term, the right to choose where to give birth” (Thachuk, 2007, p. 42). That doulas’ relationship to the idea of choice is limited to a certain context (childbirth/postpartum/baby care) with a certain outcome (healthy mother and healthy baby) suggests a limited set of possibilities for doula care. When the only outcome is a live birth, there is no role for a doula to support a woman who chooses to terminate a pregnancy after certain test results, or to provide information to guide decisions about

prenatal testing or terminations, or to support a family's decisions around providing life support to a very ill newborn. At the best these silent discourses indicate a discrete and narrow field of work for doula care. At worst they constitute doulas as potential underminers of women's reproductive choices that take place outside of the trajectory toward parenting.

As this chapter has shown, the concepts of choice and empowerment are central to the doula role and identity, but often exist in state of tension with each other and with other discourses of doula care. At times doulas emphasise the woman as decision-maker in a way that is divorced from her social, cultural and economic contexts, and at other times they display a nuanced understanding of the role that those contexts play in guiding decisions. At times doulas argue that their role is simply and always to support the woman's decisions. At other times doulas construct an understanding of decision-making in which information is not only central but also morally imperative. These two ideas are sometimes in tension. What information? Given by whom? For what purpose? What about when women don't want the information, or use it in unexpected ways? The dominant doula discourse articulates a link between the ability to engage in choices and empowerment/ autonomy. This model of decision making and empowerment is understood by most doulas to occur within the context of trusting relationships. A sub-discourse of doula care, however, asserts a link between a type of internal self-reliance (often sourced in unmedicated childbirth) and a sense of empowerment. Finally, the doula discourses display a sense of tension around the idea of choices and rights when it comes to the mother-baby dyad. Silences that exist within the discourse of choice,

particularly around the idea of reproductive rights as a continuum, play a role in constructing the doula as a facilitator of pregnancy for the specific purpose of live birth.

Conclusion-

In this qualitative piece of research on doula care, I explored the constitution of doulas through competing and contradictory discourses. My conversations with doulas led me to suggest that doula care, both as a practice and as an identity, is constituted through the interwoven discourses of “the natural,” of choice and empowerment, and of caring labour. Rather than finding a concrete and describable “essence” of a doula, this study proposes that doulas are constituted primarily *through* the tensions and contradictions within the different discourses.

Tension was present as a theme throughout this exploration. A sense of tension was expressed between various “stakeholders” in the realm of pregnancy and childbirth: the needs of the labouring woman versus the needs of the doula; the doula as “professional” versus the doula as “woman,” the health care system versus the pregnant woman; and the needs of the mother versus the needs of the foetus. Similarly, a sense of tension seemed to structure the doulas’ sense of identity: between the doula as worker, doula as carer, and doula as woman; between a sense of allegiance to the idea of ‘the natural’ to an emphasis on agency; and in a tendency to describe birth and birth work in terms of “good” and “bad.” The sense of tension is highlighted further in this work with the consideration of the tension between the voice of myself as a researcher versus voice of the doulas that I spoke with.

The doula’s relationship with the discourse of the natural was an important thread that ran through this study. While the mainstream construction of the doula tends to bond

her inextricably with the narrative of the “natural childbirth,” I found the relationship to be more complex. I argue that doulas are both constructed by the discourse of the natural, and reject it. At times they draw on it to legitimise their work, and at other times they dismiss it as illogical or unrealistic. Rather than rejecting this sense of contradiction, I argue that the doulas’ “push and pull” with the discourse of the natural becomes the *thing* that constitutes the doula.

In contrast to the dominant characterisation of the doula, the findings of this study highlight that doulas do not adhere to a singular and coherent narrative of what childbirth (or pregnancy, or womanhood, or motherhood) *is* or what it *should be*. This sense of flexibility around the “naturalness” of pregnancy, childbirth, and doula care exists despite the fact that doula care is intrinsically entwined with the idea of the natural by virtue of its history and its material reality. As scholarly and non-scholarly discourses of doula care reinforce the doula’s potential in minimizing interventions in birth (and as doulas exploit this connection in order to gain clients) doula care is symbolically connected and re-connected with an un-interrogated idea of “the natural.”

I found that in some contexts doulas explicitly draw on the discourse of the natural to elaborate a type of resistance against a misogynist medical system. I would suggest that in this way, the doula movement can be considered to be continuing the legacy of the second wave feminist health activists. Similar to how doulas have been characterised in this study, the legacy of feminist health activism is not made up of a singular and united narrative. The discourse of feminist health activism is woven from disparate threads which include abortion rights activism, lactivism (promotion of breastfeeding), and the fight for access to as well as freedom from medical interventions

in childbirth (and other aspects of reproductive health). As such, it too has emphasised and de-emphasised the roles and values of the ideas of 'the natural' versus 'the technological.'

The relationship with the idea of the natural also has a material resonance with doulas. On the one hand, it serves their interests to emphasise the impact of their care on achieving a 'desired' kind of birth – on the other hand, not limiting themselves to one group of potential clients could help to expand their client base. In one sense, I suggest that it makes sense for doulas *as workers* to emphasize the impact of their services on childbirth outcomes as well as the benefits of those outcomes: (hire me and you will be more likely to have a natural childbirth; a natural childbirth will be healthier for you and your baby.) I imagine, though the doulas that I spoke with were reluctant to concur, that the correlation between the doula and tangible health outcomes would be particularly useful in a 'pitch' to a potential client. At the same time, I would argue that it also serves the interests of doulas *as workers* to *de-emphasise* the discourse of the natural so as to not alienate former, current or future clients. So long as their services are not characterized as rightfully belonging to only one group of clients, they will have a bigger pool of potential clients to choose from.

Interestingly, the discourse of the natural was mobilised by many of the doulas in their articulation of themselves as workers. Doulas described feeling "called" to their work. They felt motivated by love and caring more than by financial gain or prestige. Many of the doulas that I spoke with expressed a sense that there were "right" and "wrong" ways to be a doula. A "good" doula would be motivated more out of love than for other reasons, would have a capacity for caring and nurturing, would want to serve

her clients needs, and would be humble. They often characterised these sensations and motivations as particularly womanly, or innately female. Some doulas characterised the role of the doula as “natural” in and of itself, arguing that doulas (in some form or another) have always been involved in childbirth. In this sense, I argue that the doula discourse allies itself with the narrative of “natural-ness” as well as a discourse of good womanhood and good motherhood.

At times, the doulas that I spoke with articulated a link between the vision of an “unmedicated/ un-intervened upon childbirth” and a sense of empowerment. I argue that the conflation of the idea of the “natural” with discourses of control/ empowerment can result in a closing of space for alternative forms of empowerment. I wonder about the doula’s role in supporting women who would prefer *not* to be given information about the consequences of certain decisions, who would prefer for their doctor to make decisions for them during childbirth, or who would like to make decisions based on feelings or intuition rather than information or rationality. The doulas’ silence on these issues may help to construct a way of understanding childbirth in which there exist both legitimate and illegitimate routes to empowerment.

The concept of “power” was a central theme in this study. I argue that doulas understand their clients as positioned within a set of power relationships. For the most part, doulas describe “empowerment” as the ability of their clients to make choices within healthcare settings. They articulate a role for themselves in this power dynamic in that they help to facilitate the empowerment of their clients by providing information, by supporting self-advocacy, and by trusting their clients to make choices in their own interest. While doulas often expressed an understanding of unequal power relationships

between clients and medical professionals, they did not address the potential for hierarchy within the doula-client relationship itself.

Similarly, doulas' conceptualization of their own power "situated-ness" was rarely articulated. While the doulas recognized that the doula role involved a sense of personal sacrifice, this was seen as so entwined with the doula's responsibilities that any possibility of equalising the client-doula relationship was not seen as feasible or even desirable. The doulas in this study had remarkably little to say about their own position within power hierarchies in health care settings. There was also a notable silence around certain aspects of power in the doula-client relationship; for example, discourses around the role of race, class, or sexuality in constituting the client, the doula, or the doula-client relationship are largely absent from this study. I argue that, in some ways, the doula discourse around power is grounded in material interests. Again, emphasising the role of the doula in the empowerment of the client while minimizing the personal needs of the doula (vis a vis the client and vis a vis the health care system at large) would presumably help doulas sell their services to clients and encourage the uptake of doula care within the health care system. On the other hand, by downplaying the effects of power relationships on themselves, doulas construct themselves as without needs (other than the need to serve others), effectively writing out of the discourse the possibility of a doula who is dedicated both to clients and to her own needs. This narrow construction of the doula can be further problematised when it is considered in association with femininity. Doula equals woman; good doula equals good woman; good doula has no needs therefore good woman has no needs.

The theme of power permeated the doula discourse around decision making and choice. In many ways, the doulas spoke of choice in a way that expanded the realm that doulas are traditionally considered to work within. The doulas expressed support for a wide range of decisions and a great acknowledgement of the range of factors that would influence decision making. I would suggest that the doulas' discourse of choice helps to construct women as the primary decision makers when it comes to decisions affecting themselves, their bodies, and their health. Moreover, I argue that the way that doulas speak about health and bodies/ minds helps to paint a picture of health care which is resistant to the dominant biomedical model. In this sense I would describe the doula discourse as helpful to opening possibilities for woman centered and holistic versions of health and social services.

While there are some 'opening' aspects of the doula discourse around choice, there are also some 'closing' aspects. The doula discourse around 'informed choice' presents information as neutral, neglecting that doulas choose which information is important to give to which client. It also presents information as inherently desirable, and assumes that certain information will lead to certain choices. The emphasis on informed choice constructs doulas as holders of legitimate knowledge, and asserts that there are 'right' and 'wrong' ways to labour and give birth. This emphasis constructs choices *not* based on information (or based on the 'wrong' information) as less valid. This discourse not only delegitimizes different pathways to childbirth, but it constructs doula care as appropriate only for women who want to center their childbirth experience around the idea of informed choice. I can imagine a role for doula care in a range of situations including

women who want support, but who choose to make decisions based on intuition, or who feel less anxious when they have less detailed information.

The silences around the theme of choice also exemplify a closing of possibilities in doula care. While the doula discourse emphasizes an acceptance of any choice that was based on information, there are notable exceptions to this rule. These “silent discourses” include any discussion about “bad pregnancy outcomes,” such as the termination of a pregnancy. The neglect of possible decision-making outside of the realm of “healthy mother, healthy baby” limits the possibilities for a doula role that extends across the continuum of reproductive health such as providing information and support around the termination of pregnancy.

Overall, the findings of this paper indicate that doula care is constituted through a sense of tension between contradictory and interrelated discourses. Doula care at once opens possibilities for pregnant women within the health care system, and closes other possibilities for those women and for doula care as a movement. It constructs women as rightful agents in decision making, but narrowly defines the terrain for decision making. It draws upon certain discourses to present a woman-centered alternative to the mainstream medical model of pregnancy and childbirth management, but in doing so it sometimes defines womanhood, pregnancy, and childbirth in binaries of good/bad, legitimate/illegitimate, right and wrong.

Despite these tensions, as I reflect upon the interviews I am able to see some lines of consistency. Doulas characterise birth as a singularly unique and transformative experience; as much a “birth of a mother” as much as a birth of a child. In the doula discourse, birth holds within it the capacity to be either empowering or disempowering,

but never neutral. In some ways this reflects an effort on the part of birth activists and feminists to make visible an experience shared by many women; a rejection of a model in which birth and the metaphors for birth were not constructed by women themselves. Yet, if the discourse articulates that *all* women experience birth as transformative, what or who are the women who experience birth neutrally? Are they not women? Or not mothers?

In a broader sense, this makes me wonder how doulas have responded and will respond to shifting cultural discourses around birth and reproduction. If doula care (as we now know it) developed largely as a response to a misogynist birthing practices, what will happen to doula care as discourses and practices of the alternative birth movement are increasingly absorbed into more mainstream birth discourse and medical practices? Will this be considered threatening to doulas (as their support may be perceived as less necessary and their care less valuable)? In fact, I would argue that this trend has begun. I believe that the discourses that inform doula care (alternative/ natural childbirth and feminist health) no longer exist exclusively outside the medical system but have also reshaped the system itself. I wonder whether the more reactive position of the dominant doula discourse is already shifting as the system against which it reacts also shifts. I believe that the doula discourses reflected in this thesis represent a maturing of the discourse; a shifting from a reactive discourse to a more reflective one. It is possible that the emphasis on choice and agency (as opposed to natural childbirth) seen in this thesis is evidence of that shifting discourse.

While I argue that doula discourses are slippery and fraught with tensions, I would like to suggest a possibility for doula care to create a space in which a differently

imagined form of social support is possible. Doula discourses emphasize the importance of relationship-centered health care which places support as central and which values a balance between physical, mental, emotional, spiritual, and social needs. These discourses can help to reinforce social support as a potential bridge between outside life and the health care system and de-emphasize the health system's emphasis on time and schedules. In all this, the doula discourses have the potential to react to and reflect on health care systems and support the creation of systems and services in which the person is central and where choice and agency are valued.

Bibliography

ALACE, A. o. (2009). Retrieved November 4, 2009, from International Birth and Wellness Project:
<http://www.alace.org>

Annandale, E. (2009). *Feminist Theory and the Sociology of Health and Illness*. New York: Routledge.

Annandale, E., & Clark, J. (2008). What is gender? Feminist Theory and the Sociology of Human Reproduction. *Sociology of Health and Illness* , 18 (1), 17-44.

AOM, A. o. (n.d.). *Differences in midwifery care and regulation before and after Legislation in 1994*. Retrieved January 12, 2012, from Association of Ontario Midwives:
http://www.aom.on.ca/Health_Care_Professionals/Benefits_of_Regulation/

Armstrong, P., & Armstrong, H. (2002). Thinking it Through: Women, Work and Caring in the New Millennium. *Canadian Woman Studies/les cahiers de la femme* , 21/22 (4/1), 44-50.

Armstrong, P., Armstrong, H., & Scott-Dixon, K. (2008). *Critical to Care: The Invisible Women in Health Services*. Toronto: University of Toronto Press.

Beckett, K. (2005). Choosing Caesarean: Feminism and the Politics of Childbirth in the United State. *Feminist Theory* , 6 (3), 252-275.

Benoit, C. (1997). Professionalizing Canadian Midwifery: Sociological Perspectives. In F. M. Shroff, *The New Midwifery: Reflections on Renaissance and Regulation* (pp. 93-115). Toronto: Women's Press.

Benoit, C., Wrede, S., Bourgeault, I., Sandall, J., De Vries, R., & van Teijlingen, E. R. (2005). Understanding the social organisation of maternity care systems: midwifery as a touchstone. *Sociology of Health & Illness* , 27 (6), 722-737.

Blee, K., & Taylor, V. (2002). Semi-structured Interviewing in Social Movement Research. In B. Klandermans, & S. Staggenborg, *Methods of Social Movement Research* (pp. 92-117). Minneapolis: University of Minnesota Press.

Bourgeault, I. L. (2006). *Push: The Struggle for Midwifery in Ontario*. Montreal: McGill-Queens UP.

Bowers, B. (2002). Mothers' Experiences of Labor Support: Exploration of Qualitative Research. *Journal of Obstetric, Gynecologic, & Neonatal Nursing* , 31 (6), Journal of Obstetric, Gynecologic, & Neonatal Nursing.

Budig, M. J. (2006). Gender, Family and Occupational Class. *Social Forces* , 84 (4), 2223-2239.

- Butler, J., & Modaff, D. (2008). When Work is Home: Agency, Structure, and Contradictions. *Management Communication Quarterly*, 22 (2), 232-257.
- CAPPA, C. a. (2011). Retrieved 02 15, 2012, from Cappa Canada: <http://www.cappacanada.ca/>
- Chodorow, N. (1978). *The Reproduction of Mothering: Psychoanalysis and the Sociology of Gender*. Berkely: University of California Press.
- Cranford, C. (2005). *Self-Employed Workers Organize: Law, Policy, and Unions*. Montreal: McGill-Queen's University Press.
- Crossley, M. (2007). Childbirth, Complications, and the Illusion of 'Choice': A Case Study. *Feminism and Psychology*, 17 (4), 543-563.
- De Beauvoir, S. (1997). The Second Sex - Introduction. In L. Nicholson, *The Second Wave: A Reader in Feminist Theory*. New York: Routledge.
- DONA. (2009). Retrieved November 20, 2009, from DONA International: <http://www.dona.org/>
- DONA. (2009). *International Statement on H1N1 - Mothers being denied support in labor*. Retrieved 11 28, 2009, from Doulas of North America (DONA): <http://www.dona.org/Website/PDF/H1N1%20Communication%20V3.pdf>
- DONA. (1998). *Position Paper: The Doula's Contribution to Modern Maternity Care*. Retrieved 06 30, 2011, from <http://www.dona.org/PDF/BDPositionPaper.pdf>: <http://www.dona.org/PDF/BDPositionPaper.pdf>
- Doyal, L. (1995). *What makes women sick: gender and the political economy of health*. Rutgers Press.
- England, P., & Folbre, N. (1999). The Cost of Caring. *Annals of the American Academy of Political and Social Science*, 561, 39-51.
- Feldberg, G. (2003). Comparative Perspectives on Canadian and American Women's Health Care since 1945. In F. e. al., *Women, Health and Nation: Canada and the United States since 1945* (pp. 15-45). Montreal: McGill-Queens UP.
- Felt, U., Bister, M. D., Strassnig, M., & Wagner, U. (2009). Refusing the Information Paradigm: Informed Consent, Medical Research, and Patient Participation. *Health*, 13 (1), 87-106.
- Foucault, M. (1980). *Power/Knowledge: Selected Interviews and Other Writings 1972-1977*. (C. Gordon, Ed.) Hemel Hempstead: Harvester Wheatsheaf.
- Gannon, S., & Davies, B. (2011). Postmodern, Poststructural and Critical Theories. In S. Hesse-Biber, *Handbook of Feminist Research* (2nd ed., pp. 71-107). Thousand Oaks: Sage.

Gilliland, A. (2002). Beyond holding hands: The modern role of the professional doula. *JOGNN* , 31 (6), 762-769.

Haraway, D. (1991). A Cyborg Manifesto: Science, Technology, and Socialist-Feminism in the Late Twentieth Century. In *Simians, Cyborgs and Women: The Reinvention of Nature* (pp. 149-181). New York: Routledge.

Himmelweit, S. (1999). Caring Labor. *Annals of the American Academy of Political and Social Science* , 561, 27-38.

Himmelweit, S. (1999). Caring Labor. *The Annals of the American Academy of Political and Social Science* , 561, 27-38.

Hoang, A. (2000, May 8). Giving Birth the Pro-Life Way. *Western Catholic Reporter* .

Hodnett, E. (1997). Commentary: Are Nurses Effective Providers of labor Support? Should They Be? Can They Be? *Birth* , 24 (2), 78-80.

Hodnett, E. G., Hodnett, E., Gates, S., Hofmeyer, J., & Sakala, C. (2009). Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews* .

Hodnett, E., Gates, S., Hofmeyer, J., & Sakala, C. (2009). Continuous Support for Women During Childbirth. *Cochrane Database of Systematic Reviews* .

Holland, H. (2009). *Relational Spaces in Maternal Healthcare: A Qualitative Study of Young Mothers' Experiences with Community-based Doula Care*. Carleton University: MSW Thesis.

Jasen, P. (1997). Race, Culture, and the Colonization of Childbirth in Northern Canada. *Social History of Medicine* , 10 (3), 383-400.

Kennell, J., Klaus, M., McGrath, S., Robertson, S., & Hinkley, C. (1991). Continuous emotional support during labor in a US hospital. *JAMA* , 265, 2197-2201.

Klaus, M. (1993). *Mothering the Mother: How a Doula Can Help you Have a Shorter, Easier, and Healthier Birth*. Da Capo Press.

Klaus, M., Kennell, J., & Klaus, P. (2002). *The Doula Book*. Cambridge, MA: Perseus Publishing.

Klein, M. e. (2009). *The Attitudes of Canadian Maternity Care Practitioners Towards Labour and Birth: Many Differences but Important Similarities*. Retrieved 12 1, 2010, from JOGC: http://www.sogc.org/jogc/abstracts/full/200909_Obstetrics_3.pdf

Kuhlmann, E. (2009). From Women's Health to Gender Mainstreaming and Back Again: Linking Feminist Agendas and New Governance in Healthcare. *Current Sociology* , 57 (2), 135-154.

Lantz, P., Low, L., Varkey, S., & Watson, R. (2005). Doulas as Childbirth Paraprofessionals: Results from a National Survey. *Women's Health Issues* , 15, 109-116.

- Lenzi, A. (2009). *Radical Doula Profile*. Retrieved 11 20, 2010, from Radical Doula: <http://radicaldoula.com/2008/09/02/new-series-radical-doula-profiles/>
- Mahoney, M. (2008). *Radical Doula Profiles Mary Mahoney*. Retrieved 11 25, 2010, from Radical Doula: <http://radicaldoula.com/2008/10/23/radical-doula-profiles-mary-mahoney/>
- Martin, E. (2001). *The woman in the body: A cultural analysis of reproduction*. Beacon Press.
- Meaghre, G. (2006). What Can We Expect from Paid Carers? *Politics and Society*, 34 (1), 33-54.
- Meltzer Norman, B., & Katz Rothman, B. (2007). The New Arrival: Labor Doulas and the Fragmentation of Midwifery and Caregiving. In W. Simonds, B. Katz Rothman, & B. Meltzer Norman, *Laboring On: Birth in Transition in the United States* (pp. 251-283). New York: Routledge.
- Minor, E. (2007, March 11). The New War on Abortion. *The Palm Beach Post News*.
- Mitchinson, W. (2002). *Giving Birth in Canada: 1900-1950*. Toronto: University of Toronto Press.
- Morgan, K. P. (1998). Contested Bodies, Contested Knowledges: Women, Health and the Politics of Medicalization. In S. Sherwin, *The Politics of Women's Health: Exploring Agency and Autonomy* (pp. 83-121). Philadelphia: Temple University Press.
- Morris, L. (1987). Constraints on Gender: The Family Wage, Social Security and the Labour Market. *Work, Employment and Society*, 1 (1), 85-106.
- Morrow, M. (2008). 'Our Bodies Our Selves' In Context: Reflections on the Women's Health Movement in Canada. In M. H. Morrow, *Women's Health in Canada: Critical Perspectives on Theory and Policy*. Toronto: University of Toronto Press.
- Morton, C. (2002). *Doula Care: The (Re) Emergence of Women-Supported Childbirth in the United States*. Berkeley: University of California.
- Munson, Z. W. (2008). *The Making of Pro-Life Activists: How Social Movement Mobilization Works*. Chicago: University of Chicago Press.
- Nestel, S. (2006). *Obstructed Labour: Race and Gender in the Re-Emergence of Midwifery*. Vancouver: UBC Press.
- Noddings, N. (2002). *Starting at Home: Caring and Social Policy*. Berkely, California: University of California Press.
- Oakley, A. (1993). *Essays on Women, Medicine and Health*. Edinburgh: Edinburgh University Press.

- Papagni, K., & Buckner, E. (2006). Doula Support and Attitudes of Intrapartum Nurses: A Qualitative Study from the Patient's Perspective. *The Journal of Perinatal Education* , 15 (1), 11-18.
- Patton, M. (2002). *Qualitative Research and Evaluation Methods* (3rd ed.). Thousand Oaks: Sage Publications.
- Peck, P. (2005, 08 23). 'Mothering the Mother' During Birth. Retrieved 10 21, 2010, from CNN Health: http://articles.cnn.com/2005-08-23/health/profile.doula_1_doula-child-care-prenatal-care?_s=PM:HEALTH
- PHAC, P. H. (2009). *What Mothers Say: The Canadian Maternity Experiences Survey*.
- Ruddick, S. (1989). *Maternal Thinking: Toward a Politics of Peace*. Boston: Beacon Press.
- Ruzek, S., & Becker, J. (1999). The Women's Health Movement in the US: From Grass-roots Activism to Professional Agendas. *Journal of the American Medical Women's Association* , 54 (1), 4-8.
- Saggies, M. (2007). *MarySaggies*. Retrieved November 18, 2009, from Abortion Doulas: <http://marysaggies.blogspot.com/2007/10/abortion-doulas.html>
- Sbisa, M. (1996). The Feminine Subject and the Female Body in Discourse about Childbirth. *The European Journal of Women's Studies* .
- Scott, J. W. (1992). Experience. In J. Butler, & J. W. Scott, *Feminists Theorize the Political* (pp. 22-40). New York: Routledge.
- Shaver, S. (1994). Body Rights, Social Rights and the Liberal Welfare State. *Critical Social Policy* , 13 (37), 66-93.
- Shroff, F. M. (1997). *The New Midwifery: Reflections on Renaissance and Regulation*. Toronto: Women's Press.
- SOGC. (2008). Joint Statement on Normal Childbirth. *JOGC* , 30 (12), 1163-1165.
- Sosa, R., Kennel, J., Klaus, M., Robertson, S., & Urritia, J. (1980). The effect of a supportive companion on perinatal problems, length of labor, and mother-infant interaction. *New England Journal of Medicine* , 303 (11), 597-600.
- Szollos, G. (2009, November 20). Personal Communication. (J. Dwyer, Interviewer)
- Thachuk, A. (2007). Midwifery, Informed Choice, and Reproductive Autonomy: A Relational Approach. *Feminism and Psychology* , 17 (1), 39-56.
- Tuana, N. (2006). The Speculum of Ignorance: The Women's Health Movement and Epistemologies of Ignorance. *Hypatia* , 21 (3), 1-19.

Turner, P. K. (2002). Is Childbirth with Midwives Natural? The Gaze of the Feminine and the Pull of the Masculine. *Qualitative Inquiry*, 8 (5), 652-669.

Twigg, J. (2000). Carework as a Form of Bodywork. *Ageing and Society*, 20, 389-411.

van Wagner, V. (. (2004). Choice of Caesarean Birth. *Canadian Journal of Midwifery Research and Practice*, 3 (1), 1-17.

Williams, M. (2008). *Outlaw Midwives: A Manifesta*. Retrieved 06 30, 2011, from Combahee Survival: <http://combaheesurvival.wordpress.com/tag/intention/>

Witz, A. (1992). *Professions and patriarchy*. London: Routledge.

Zadoroznyj, M. (2009). Professionals, Carers or 'Strangers'? Liminality and the Typification of Postnatal Home Care Workers. *Sociology*, 43 (2), 268-285.

Zhang, J., Bernasko, J., Leybovich, E., Fahs, M., & Hatch, M. (1996). Zhang, J.; Bernasko, J.W; Leybovich, E.; Fahs, M.; Hatch, M.C. *Obstetrics & Gynecology*, 88 (4), 739-744.

Appendix A- Interview Guide

Doula as Woman, Doula as Worker, Philosophies of Doula Care

Beginnings and Motivation -

Can you tell me about what sparked your interest in doula care –

How long have you worked as a doula for?

How many women have you provided doula care to?

Do you have a “most memorable” doula experience?

How does being a doula fit in with your career plans and life in general?

Doula as Worker

How do you describe your role as a doula? What is the most important part of your role?

What skills do you use in your work? How much do you touch bodies or bodily fluids? How do you feel about this?

How are you compensated for your work? Do you feel like this is fair compensation?

How do you deal with time off/ vacations/ regular hours/ sleep schedule etc.

Are there any special protections that doulas need?

What is the most challenging part about your role as a doula? How could these kinds of challenges be mediated?

Principles and Values

What do you understand as the principles or values of doula care? Would this be different for every doula, or is there an “essence” that stays the same?

Do doulas need to be women? Why or why not? Is it significant that doulas are associated primarily with childbirth? Why or why not?

What does the idea of “informed choice” mean to you? Do you think your definition of “informed choice” is different from the “informed consent” provided by a doctor? What about informed choice provided by a midwife?

Are there specific things that you **do** that improve a woman’s ability to make her own choices, or would you describe it another way?

Have you ever had an experience when a woman made a decision that you did not agree with? What did you do? How did you feel? How would you describe a “good birth”?

How does your relationship with the woman’s partner fit in? Have you ever felt a conflict between your desire to provide support for the mother and your desire to provide support for her partner?

Tell me about how you feel about your responsibility toward the mother versus your responsibility to the baby. Is there a hierarchy of responsibility?

How do you feel about doula care being connected with the concept of reproductive rights?

Power Dynamics and the Medical System

Can you tell me a little bit about your relationship with other health care professionals? (Is it different with obstetricians, family doctors, midwives, nurses etc.)

If you could change anything about the way that the medical system provided care for pregnant and labouring women, what would it be?

Do you ever experience a sense of tension between your care for the woman and your care for the baby in your doula work? Can you describe this tension? How do you deal with this?

Closing

Is there anything you would like to add?

How was the interview for you?
Any questions for me?

Appendix B – Letter of Information

Letter of Information: Doula Care – A Qualitative Study

Purpose of the Research:

The main purpose of this research is to explore the philosophies that inform doula care. I am interested in how doulas understand the continuum of reproductive health care; how doulas balance the competing needs of the mother and the foetus in their work; and how doulas negotiate the issue of power in their relationships with their clients and with other health care professionals. The goal of this research is to add to the body of research on doula care specifically, and women's health care more generally.

Criteria for Inclusion in the Study:

This study is open to birth doulas who have received training through DONA, CAPP, ALACE, or the Birth Companion Program and who have attended at least one birth (paid or unpaid) in their role as a doula. Any Birth Companion, past or present, who attended a Birth Companion training that was co-facilitated by the researcher, Jessica Dwyer, is excluded from this study.

What You Will Be Asked to Do in the Research:

I am interested in your experiences as a doula, and how you define your work and your work-related relationships. You will be asked to take part in an individual interview that will take place in a private room and will last between 60-90 minutes. You will have the opportunity to review the information about the study, and will take part in the interview if you feel comfortable doing so. The interview will take a semi-structured format, meaning that the interview will follow a set guide, but may extend to themes that you introduce. Interview questions will focus on your experiences as a doula, the motivations for your work, the relationships you have built as a doula, and how you understand doula care, childbirth, motherhood, and the medical system. Interviews will be audio-taped, and you will have an opportunity to review your transcripts if you wish.

Risks and Discomforts:

The qualitative nature of this study means that you will be asked to share experiences about your role as a doula. At times sensitive topics may be raised and you may feel uncomfortable answering some questions. You may opt out of answering any question at any time without negative consequences. Because this research involves sharing personal stories, there is a very remote possibility that specific stories or events might be attributable to a particular doula.

Benefits of the Research and Benefits to You:

Participants may receive some indirect benefits through their participation in this study. These benefits include increased knowledge about doulas and doula care in the academic community as well as in the medical and doula communities.

Withdrawal from the Study: Your participation in this study is completely voluntary and you may choose to stop participating at any time. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researcher, Carleton University, or any other group associated with this project. Should you decide to withdraw from the study, you may choose to have the audio recording of your interview and /or the transcript of your interview destroyed and not used. You may withdraw from this study at any time prior to the data analysis phase, April 2011.

Confidentiality: The researcher will place a priority on maintaining the confidentiality of all information you supply during the course of this research. Your name will not appear in any report or publication of the research. Pseudonyms will be used and information that could identify individuals or organizations will be altered in order to protect confidentiality. Research participants will be asked to respect the confidentiality of the people or organizations that they bring up during the course of the interview by using pseudonyms and changing identifying details. Audio recordings and interview transcripts will be kept in a locked area or a password protected flash drive and will be destroyed following completion of this thesis.

Questions About the Research? If you have any questions about this research project, the researcher, or your role in this study, please contact Jessica Dwyer, principal researcher, jdwyer@connect.carleton.ca or 613-791-6657.

Appendix C – Recruitment Email

Hello Ottawa doulas!

I am writing in search of participants for a research study on doula care. I am a trained doula and worked with Ottawa's Birth Companion Program for several years. I am conducting this research study as part of the thesis component of the Master's of Social Work Program at Carleton University. It is my hope that this research will contribute to a greater understanding of doula care in the academic world, and will help foster conversations among doulas about their roles, identities, philosophies, and challenges.

I am interested in talking to doulas about their motivations in becoming doulas, their experiences as doulas, their relationships with their clients and other health care providers, and the joys and challenges of their work. Interviews may take place at Carleton University, at my home, your home, or another mutually acceptable location. Interviews will last between 60-90 minutes.

If you are interested in taking part in this study, or have any questions about this research or about myself, please contact me,

Jessica Dwyer

jdwyer@connect.carleton.ca