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Delivering Identities: A Symbolic Interactionist Study of Doulas and the Decline of Medical Professional Dominance

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Delivering Identities: A Symbolic Interactionist Study of Doulas and the Decline of Medical
Professional Dominance

Senior Project Submitted to
The Division of Social Studies
of Bard College

by
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Abstract

Doulas are non-medically affiliated people who provide emotional, physical, and informational support to people before, during, and after childbirth. The purpose of this study is to understand the role of the doula beyond its typically-assumed value as a superficial or consumerist entity and in relation to the broader maternal health care system available within the United States. Through six in-depth interviews with doulas about their conceptions of their personal identities, as well as their relationships with their medical counterparts and their clients, this project contributes to extant literature on symbolic interactionist linkages between identities and occupations. I examine how doula work requires one to be adaptive in political, performative, and emotional contexts. These factors contribute to the conception of doulas as rooted in an alternative knowledge system. My findings show how the doula occupation contributes to a decline of medical professional dominance.

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Preface

I am walking through the historic, yet steadily-evolving Lower East Side of Manhattan when it occurs to me, I've already passed three different CBD¹ cafes. "Wait," I think to myself as I check my phone, "Where am I meeting her?" I am meeting a doula to interview her for my senior thesis. I'm a bit nervous as this is the first time I've done an in-person interview. I'm also excited as I have never been to a CBD cafe before. After verifying the location, I navigate to the correct space and feel as though I have entered a cave. Ambient, indie music fills my ears, herbal scents fill my nose; stones, crystals, and plants litter the walls of the boutique cafe along with a myriad product offering "homeopathic", "organic", and "plant-based" remedies. As I wonder if all of those terms aren't just synonyms for "natural", I find a table to sit at and start to listen to the folks around me as my interviewee has yet to arrive. Some of my fellow cafe-goers are asking sales people about migraine relief, for which they are offered "tinctures". The pair at the table next to me discuss their dogs' and their children's anxiety issues which they are hoping to solve "naturally". At another table, someone is receiving a casual shoulder massage.

This scene seems kind of bizarre to me at first. It all comes together, however, when I ask for the Wi-Fi password to which the reply is "health is wealth". My inner sociologist, hyper aware of socioeconomic stratification which renders access to certain healthcare inaccessible to some people based on their identities or position within society, wonders if it shouldn't rather be "wealth is health". But then, this original password begins to make sense of the strangeness of this new space in which I am waiting to talk to Quinn², a young hypnotist and doula. I am studying a group folks that comprise an "alternative" field, in that they are not the typically and

¹ Cannabidiol: "A nonintoxicating cannabinoid found in cannabis and hemp" (Merriam Webster).

² All participants in this study are referred to with pseudonyms.

generally, accepted norm. As will become clear over the next four chapters, this project is about alternatives and identity. Amorphous, and therefore challenging terms to define, an alternative is generally something created in response to the limitations of an existing option. Doulas, non-medically affiliated people who provide emotional, physical, and informational reproductive health support are an example of this sort of “alternative” when placed in contrast to medical doctors, usually considered in charge of his field. Identity, on the other hand can be interpreted in many ways. In the case of this study, identity refers to the conception one has for their overarching presentation within certain contexts. This project is mainly concerned with the questions: How do doulas perceive of their identities as they navigate the delicate and under-established territory in which they practice? How do doulas manage this lack of occupational stability when they interact with clients and doctors? Do they have an effect on professional dominance of the traditional medical field?

As elaborated in the forthcoming pages of this section, I discuss the nature and social weight of knowledge systems. I will place doulas within the long and complex history of childbirth and how it’s been managed in the US. Following this overview, which captures the dominating effects of the medical profession, I consider the rise of occupations such as midwifery as a response to this overarching presence and relate this to the rise of doulas. I posit that doulas are the next force in this tradition in that doulas represent a decline in medical professional dominance.

Chapter One: Literature and Framing

Authoritative and Alternative Knowledge Systems

Various types of experts can contribute to the comprehension of a field, or to a “knowledge system” (Collins and Evans 2002; Eyal and Buchholz 2010; Gieryn 1999; Reay 2007). Furthermore, some of these “knowledge systems” lay claim to more cultural value than others (Jordan, 1992). Scholars have divided knowledge bases based on their social value by referring to those with a greater value as “authoritative” and the oppositional knowledge base – that with less social weight– is referred to as “alternative” (Jordan and Davis-Floyd 1993; Henley 2015). Possessed by people in power, “authoritative knowledge” and the social clout attributed to it, allows this system to be considered legitimate and “normal” by a majority of the public. Therefore, “alternative” knowledge, because of its oppositional nature to what is accepted as the norm, is along with its supporters, subsequently considered “backward, ignorant, or naïve trouble makers” who are focused undermining the authoritative knowledge (Jordan and Davis-Floyd 1993). As will become clear throughout the following sections, mainstream medical actors, such as obstetricians, are in possession of authoritative knowledge and have continuous authoritative knowledge because of the social weight which their medical training required to practice holds within societal perspective (Davis-Floyd and Sargent 1997). Therefore, doulas represent a lens through which to explore how alternative knowledge may gain legitimacy in a field in which biomedicine is considered authoritative (Davis-Floyd and Sargent 1997).

Medical Professionalism

In order to accurately conceive of the doulas’ role within the professional dominance of the medical profession, as is the focus of this study, a review of the medical profession with an emphasis on its control over childbirth is necessary. Childbirth in the US has undergone a

colorful history. Currently, most mothers in the US –98.5% in 2015– give birth in hospitals with an obstetrician attending (CDC, 2016; Declerq et al 2013). This stands in high contrast to the schema which was relied upon until the nineteenth century; almost all births were attended by midwives and occurred within the birthing woman’s home (Starr 1982; Sullivan and Weitz 1988; Henley 2015). Only when physicians start to gain social acceptance through the professionalization of their roles and enjoy the subsequent dominating effects of medicalization of US society, did this occupational group become the authoritative knowledge source of childbirth (Abbott 1988; Starr 1982).

The medical world has been studied and classified as the ideal notion of a “profession” because of its technical and specialized nature (Begun, 1979; Evetts 2003; Timmermans and Oh 2010 and more). While there have been many different and, at times, contradictory interpretations of professionalism –that is, what constitutes something as a “profession” as opposed to simply an “occupation”– for the purposes of this research, I will be reviewing a few of these approaches, historical and contemporary alike. These perspectives collectively demonstrate the supposed “rise” and potential “fall” in dominance of traditional medicine. Furthermore, I will explain this theoretical history of the medical world via its impact on childbirth, thus setting the stage for the doula role.

Most scholarly work generally classifies professions as primarily upper middle-class, knowledge-based occupations. They often require processes of training or certification in order to provide a specialized service, which typically deal with risk or uncertainty (Evetts, 2003; Goldthorpe, 1982). More specifically, professions have been classified with a structural-functional lens, which focuses on “professional” actors as positively contributing to and maintaining normative social order through their assumed altruistic intentions, guided by

external moral ideals (Evetts, 2003, Begun 1979). For example, Talcott Parsons (1951) proposed that professional physicians are comparable to businessmen in that both employ scientific knowledge to inform the services they provide to society. However, the two compared parties' approaches differ based on the business person's focus of self-interest in the form of profit, whereas the professionals (in this case physicians) are institutionally and culturally expected to place their clients' (in this case patients') welfare as a priority. This dedication to public good is asserted to be a result of certain "attributes" –which also may serve to differentiate "professions" from "occupations"– including commitment, organization, educational attainment, service orientation, and autonomy (Moore, 1970). Scholars have cited this as the reason professionals have been granted essentially inherent trust from those they serve (Evetts, 2003).

This aforementioned approach has been challenged by more contemporary arguments which present the profession as an ideology for social control (Evetts, 2003). This classification of professions rejects the notion of characteristics inherently embodied by professionals and asserts that professions differ from other occupations in a hierarchical manner, with professions in power. "Power" in this context has been defined by Ritzer (1977) as "the ability of an occupation ...to obtain... a set of rights and privileges...from societal groups that otherwise might not grant them." This is claimed to be done through the manipulation of professionals' cultural authority into political influence, economic power, and social privilege, and allows professionals to dictate the accepted definition of the nature and value of their work in order to preserve this hierarchical power (Quadagno 2004; Starr 1982).

This may be exemplified by professions' distinguishing "social contract" with the state, which entails an exchange of the provision of professionals' specialized, knowledge-based services to the general public for economic and legal privileges, including protection from

competitors and price regulation (Timmermans and Oh, 2010). Largely supplemented by the notion of “professional dominance,” this perception of professions asserts that the holders of the power, which provides them “professional” status, use their power to dominate all aspects of the profession, in order to maintain this power (Freidson 1970; Light and Levine 1988). This has been applied to the regulatory pattern of actions exhibited by the medical profession in the 19th and 20th centuries, during which reforms were made to medical education, the drug industry, contract medicine, and public health clinics, all in an effort to further insulate the medical profession as its own powerful entity (Timmermans and Oh, 2010). Essentially, this approach classifies professions not as honorable protectors of public good –or in the case of medical professionals, public health– but instead as an entity that uses institutional protection from competitive forces to not only maintain, but advance their own interests, largely regarding profit (Freidson 1970, Larson 1977).

For example, the height of “professional dominance” has been referred to as the “Golden Age of doctoring.” Throughout the decade of the 1950s, physicians maintained complete autonomy and control over their profession in terms of its organization and nature (McKinlay and Marceau 2002). Physicians wielded strong political efficacy to structure the healthcare system, were mainly self-employed, (and therefore set their own fees) and had almost entirely unregulated control over clinical decision making, all of which allowed for healthcare costs to rise astronomically (Light 1993, 2004). Within this model of a profession, the role of the client (or patient) is seriously belittled; The professional’s conception of their relation to a receiver of healthcare as one in which they are the determinant of all interactions or occurrences places the layperson in a position which does not require being informed of, nor included in the processes and outcomes of their treatment (Reeder, 1972).

As this dynamic is highly inequitable, it has proved equally unsustainable. Scholarly research within these professionalism traditions report a decline in professional dominance in terms of “proletarianization (the notion that people move from self-employment to wage labor), deprofessionalization (the loss of professional characteristics such as autonomous decision-making), and corporatization (turning health care into a profit-maximizing corporation) within medicine (Timmermans and Oh 2010; Light and Levine 1988; Huag 1973). While this line of research points to a shift of the medical profession from an autonomous system to a regulated one, it neglects the dynamic interactions of the profession with other entities in the healthcare providing field.

This shift of the medical system’s structure (and therefore its dominance) may be further clarified in relation to the focus of this study through the application of a different perspective. This perspective deals with the roles which entities outside of the medical profession (such as clients and non-medical healthcare providers) played within this shift. While professionalism certainly embodies some aspects of the medical profession, scholars have also used another approach to address the medical profession’s ever-present and important interaction with other entities in the healthcare field and society in general in order to document the impact this has on the profession’s general function and society’s perception of it (Light and Levine 1988). This type of classification, known as “countervailing powers”, highlights a profession’s complex interplay with the state, corporate interests, and consumers. Further, it asserts that one of these parties may accrue dominance through the subordination of others, who over time may counteract against this dominance (Hartley, 2002). This is an important way of viewing professions, specifically that of medical services, in that it draws attention to how it manipulates its position in regard to those of other interrelated groups, such as “private insurance agencies,

government agencies, hospital organizations, pharmaceutical companies, medical device manufacturers, and groups of patients” in order to gain more in terms of profit, power, and authority (Timmermans and Oh, 2010).

Through this lens, the aforementioned “Golden Age” may be viewed as a time of dominance of the medical profession. Also, this framework renders the subsequently adopted system of managed care a counter-action against the aforementioned, motivated by the desires of other entities, as opposed to simply because of a decline in physician power. Specifically, through the use of this theoretical framework, it becomes clear that this shift involves a turn towards a system referred to as “managed care” which included a restructuring of the management of healthcare provision starting in the 1960s and 1970s, mostly consisting of a series of controls such as “fixed payment systems, restrictions on patient care pathways, and increased oversight of physician clinical decisions” (Hartley, 2002; Zuger 2004; Fuchs 2012). Basically, “managed care” represents the decrease of clients paying out of pocket for medical services and the increase of third-party (such as Medicaid and private insurance) payment, as well as these organizations subsequently gaining influence –or “management”– over the care for which they are paying (Timmermans and Oh 2010; Weitz [2000] 2012). As a result, organizations dictate guidelines for standard care and rely on physicians to carry out those standards (Light 2010). Even though physicians are still gatekeepers for medical treatment, their role has become less influential than the healthcare market in which they work (Conrad 2005). This was also a time of change thanks to the conception of “health social movements” which advocated for issues such as women's health, community clinics, environmental health, and consumer health information (Brown and Zavestoski, 2004; Huber and Gillaspay, 2011).

Scholars have located examples of this shift from medical dominance as largely in response to a general loss in patient trust of medical professionals, because of their orientation towards profit and power as opposed to the provision of care. One result of this sentiment was the rise of “complementary and alternative medicines” (CAM)³, that is, health practices and products that are considered distinct from allopathic medicine used, in addition to and in place of conventional, biomedical treatment respectively (Timmermans and Oh 2010; Winnick 2006). The medical profession has long attempted –with brief success during the “Golden Age”– to eliminate these competing occupations by drawing attention to their potentially dangerous inadequacy (Winnick 2005; Hartley 2002). As the “managed care” model limited the omnipotent entitlement of physicians –like the exclusive right to perform certain procedures– it similarly impacted the profession’s ability to completely eradicate these alternative bodies of care (Hafferty and Light 1995). Therefore, CAM services were subject to extreme restrictions on practice, but were able to maintain a presence which has increased overtime (Barnes et al. 2008).

Countervailing powers complicates, and therefore more accurately explains, medical professional dominance as a series of intentional interactions between other, related entities to assure their dominance. Furthermore, this this theoretical framework makes clear the conception of a decline in medical dominance as a result of the will of alternative entities.

Whether through professionalism or the “countervailing power” perspective, it’s clear that the medical field is a potent entity. Both conceptions propose that there has been a decline in “physician-driven” dominance and an increase in “consumer-driven”, managed care. This

³ With people living longer, developing difficult-to-treat chronic conditions (Lee-Treweek 2001), and with a new cultural emphasis on the connection between the mind and body (Winnick 2006), CAM has become an important aspect healthcare treatment, with 38 percent of adults and 12 percent of children using CAM in 2007 (Barnes et al. 2008). Examples are herbal medicines, yoga, or mind-body medicine.

trajectory is evident within the process of the “medicalization” of childbirth as well as the subsequent response of alternative forms of care. A review of this history will follow.

Medicalization of childbirth and the rise of alternatives

“Medicalization” is the process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders (Conrad, 1992). A specific aspect of this process of medicalization is that which maintains that medical profession has a level of social control on micro, mezzo-, and macro-level scale, that is, over those it serves individually, the organizations and institutions with and through which it interacts, and society as a whole (Zola, 1976). It has been posited as manifest through reliance medical technologies which restrict the autonomy of both experts and nonexperts as they confront pain, suffering, and death (Casper, 2010). The medicalization of childbirth is demonstrative of physician professional dominance in a particular aspect of healthcare.

Medicalization as a form of professional dominance can be evidenced within the field of childbirth taking place in a hospital setting in many ways, largely revolving around a theme of medicinal practices being used as an attempt to control the behavior or health care options of pregnant women. This is done through professionals’ manipulation of their social or cultural authority to normalize certain procedures, which are costly and dependent on a doctor’s administration, without regard to the preferences or needs of those they serve. This may be inferred as an attempt to construct and maintain the social definition of birth as a procedure which only medical entities may provide (Stephenson and Wagner, 1993; Rothman 1978). For example, this process may take form through the heavy, and perceivably unnecessary,

reliance on labor augmentation⁴ which, while used to allow for an efficient birthing experience (in regard to time period and pain experienced) can also result in health complications. The increased use of augmentation has been connected with increased complications, such as maternal death, a significant proportion of which are connected specifically to unnecessary Cesarean sections⁵ (Danel et al. 2003; Armstrong and Declerq, 2011).

As these medicalized practices reference a physician-oriented system –in that the benefits are weighted in terms of the medical profession’s profit and dominance, not the client’s experience nor health– questioning the safety of those who give birth or are being born in the United States is justified. However, as addressed in previous sections, the professional-dominance of the medical system has not gone unmatched (Timmermans and Oh, 2010). Along with the shift to managed-care and rise of “competing” health care providers, such as CAM, came the resurgence of midwifery, a traditional style of birth-support.

While essentially illegal in the United States until the 1970s, as legal policies were beholden to the nature of professional dominance, midwifery is now legal thanks to the changes brought by the shift to the managed-care system (Rooks 1997). However, in line with the with the reminiscent dominating aspects of the medical profession, this type of care is still highly restricted in terms of autonomy and is still under siege. In the 1990s, though allowed to practice in a hospital setting, midwives had to do so under the supervision of physicians (Hartley 2002). In fact, as recent as 2008, the American Medical Association vowed to make home births –the method predominantly under the jurisdiction of midwives– illegal (Craven, 2010). This allowance of midwifery practice has set the stage for another alternative occupation dedicated to

⁴ “The process of stimulating the uterus to increase the frequency, duration and intensity of contractions after the onset of spontaneous labor.” (World Health Organization, 2014).

⁵ A Cesarean section (C-section) is surgery to deliver a baby through which the baby is taken out through the mother’s abdomen. In 2016, 31.9% of U.S. births in 2016 were through cesarean section) (CDC, 2016).

reproductive healthcare, that of the doula. A review of the history and contemporary status of doulas, the focus of this research, follows.

What is a Doula?

Historical Overview

The history of childbirth in the US has undergone many evolutions. While childbirth itself is not the primary focus of this study, a brief review of how this process has been managed is imperative, as this trajectory is the context from which doulas have arisen. Nancy Schrom Dye, in her essay, "History of Childbirth in America" (1980), addresses this aspect of US history. In order to do so she breaks down the history of childbirth and its management into three distinct time periods.

Until the late eighteenth century, birth was an exclusively female affair, a social rather than a medical event, managed by midwives and attended by friends and relatives. The second period, extending from the late eighteenth century through the first decades of the twentieth, was a long transition between 'social childbirth' and medically managed birth. Gradually, male physicians replaced midwives and transformed birth into a medical event. By the 1920s, the beginning of the third period, this major transformation had been completed. The medical model of childbirth emerged unchallenged as the medical profession consolidated its control of birth management (98).

The first half of this conception of childbirth, one based in community supported birth, has been referred to by scholars as "the symbol of traditional womanhood" (Walzer Leavitt, 1988:7).

Modeled after this dichotomy of managed birth, doulas emerged from a grassroots movement in the US centered around women who wanted natural births and include friends and childbirth educators within their support systems during birth (Norman and Rothman 2007). "Doula" comes from an ancient Greek word that means "a woman who serves" (DONA International 2014). It is translated as female slave, servant, woman-helper, or handmaiden or, in some cases "doula" is translated simply as "with woman" (Ross, 2013). The term "doula" in its

contemporary usage denotes a variety of meanings centered around, the provision of support within the spectrum of reproductive healthcare (Ross, 2013).

While there are many occupations which use the moniker, “doula”, there are particular aspects of reproductive health which these roles are respectively concerned with and for which are learned in effective models of support; there are doulas for abortion, adoption, pregnancy loss, death, and of course, birth (Basile, 2012). While all of these occupations are worth attention and scholarly exploration because of their unique structure and the alternative nature of their services offered, for the purposes of this study, I will be focusing on “birth doulas”⁶.

The largest organization of certified doulas, which is itself a training and certifying entity, Doula Organization of North America (DONA), defines a birth doula as “person trained and experienced in childbirth who provides continuous physical, emotional and informational support to the mother before, during and just after birth.” Other credible sources have defined a doula as an experienced labor companion who provides both the birthing person and her partner non-medical, culturally appropriate emotional support throughout labor and delivery to help cope in their own way (Scott et al. 1999; Katz 2015). Even more scholars have referenced the doulas’ prenatal care as “informative” due to the conversational and educational nature through which they provide support to their clients. Furthermore, some examples of support offered during labor are massage or hand holding and “verbal or non-verbal encouragement” (Morton and Clift 2014; Benson, 2016).

⁶ While the focus of my study is on “birth doulas”, in reference to them, I will use the colloquially-relied upon term, “doula” and “birth doula” interchangeably.

The Cost of Doula care

While this is ever-changing, many hospitals do not have doula programs whereby any laboring woman is offered a doula upon arrival to the institution (Henley, 2015). Furthermore, many insurance companies do not cover the cost of a doula (Morton and Clift, 2014). This means, not only do people have to pay out of pocket for doula support, but furthermore, folks that are unable to pay for these services as well as those who are primarily familiar with standard medical care have limited access to doula services. Essentially, due to these economic and structural barriers, the client-base with which doulas can most easily work is a specific population of people who both have knowledge of and the means to compensate for doula support.

Training and Certification

While it is not required in order to practice, many doulas go through a training and certification process as this may allow them better ability to help their clients as well as find work (Norman and Rothman 2007). This process usually consists of attending a workshop about labor support techniques, reading books about childbirth, assisting within a set number of births (usually between three to ten) and attaining evaluative information from both the birthing person, their partners, and their primary health care provider, participation in a childbirth education class, and a research or writing project (Basile, 2012). In 1992, the aforementioned group, DONA, was founded and thus became the first of many international organizations to train and certify doulas (Basile, 2012).

While important to include within a study about doulas and their impact, the overall amount of people certified or practicing within this occupation is not concretely known. As of 2009, DONA international, claimed to have nearly 7,000 members globally (Morton and Clift

2014). Childbirth International, founded in 1998, has more than 4,500 members, about half of which are certified as a doula, or tangentially related birth worker (Henley, 2015). Childbirth and Postpartum Professional Association (CAPPA) and Doula Training International (DTI) are other widely known certifying entities. There are about 10 to 15 more international organizations as well as numerous locally-based organizations that train and certify doulas online or in person. Since some of these organizations do not have public records and also, since formal training and/or certification is not required in order to practice as a doula in the US, it is not possible to quantify the number of doulas who serve.

Doulas Are Not Midwives

Doulas' services are distinguishable by their adherence to the "midwifery" model of birth as a baseline of care. This notion of birthing "considers pregnancy a normal condition and the birthing woman as an active agent, the giver of birth" which stands in contrast to the "medical model" of birth which deems pregnancy an "illness" of sorts and the birthing woman as a patient in need of care which only a doctor can provide (Foley, 2005). Now, while similar in their shared dedication to assisting birth, doulas are not to be mistaken for midwives or the practice of midwifery. Doulas, unlike midwives and especially unlike the mainstream systems available to people who give birth in the US, are not medically trained. Even though they are likely to be versed in medical or surgical methods of inducing or aiding the delivery of a child, they are not certified to administer these techniques themselves. Regardless of this technical division, doulas absolutely function within the medical world, as this is where most people give birth in the US (Declerq et al, 2013).

The attention and support of doula care has been on an incline since the 1980s when scholarly researchers first documented the benefits of support during labor. For example,

pediatricians Marshall Klaus and John Kennell, began to publish research on woman-to-woman assistance and found that a doula's presence throughout labor and birth improved many factors, including mother-infant bonding as well as reducing need for obstetric intervention, therefore shortening labor time (Klaus and Kennell 1983; Klaus et al 1986; Sosa et al 1980; Hodnett et al. 2011, Kennell et al. 1991). This sort of finding is commonplace within the extant research on doulas on which I will elaborate more.

Extant Literature

The extant literature about birth doula support, while addressing a wide spectrum of this occupation's aspects, remains focused on the effectiveness of this service. Specifically, scholars have studied doulas as beneficial within labor and delivery in terms of their economic impact; Kozhimannil et al. (2013), in their study suggesting that state Medicaid programs should offer coverage for birth doulas, discovered that a doula's presence was associated with reduced rates of cesarean sections and therefore the economic cost of childbirth in a hospital setting as well. This emphasis on a reduction in medical intervention during labor as well as the improvement of maternal and infant health outcomes frequents scientific journals (Gentry et al., 2010; Campero et al., 1998; Deitrick & Draves, 2008; Schroeder & Bell, 2005). However, there has also been a significant amount of scholarly research dedicated to the social implications of this sort of support.

Frequently within the socially-minded tradition of doula studies, is the notion that their effectiveness is because of their continuous presence throughout the childbirth process. Specifically, studies show that doulas have positive medical effects on both mother and newborn, in that their un-interrupted presence coincides with reports of fewer cesareans and other forms of

assisted birth (such as forceps and vacuum extraction, oxytocin augmentation, and analgesia)⁷, shorter labors, lower admission rates of infants to neonatal intensive care, as well as reductions to anxiety, and rates of postpartum depression within birthing people. Other positive outcomes associated with the work of doulas and their continuous support model, is the rating of childbirth as less difficult and painful, positive feelings about the birth experience, and increased rates of breastfeeding initiation. Additionally, studies have highlighted that this type of support offered by doulas is more effective than that which may be provided by familial members, such as fathers (Berkowitz, Scott, Klaus 1999; Cogan and Spinnato, 1988; Hemminiki et al., 1990; Hodnett and Osborn, 1989).

With these studies in mind, it's logical to assume that existing institutions concerned with childbirth —hospitals and their actors— would be a proponent of the birth doula role. However, this is not the case; Doula services are often unwelcomed in the hospital environment. For example, Torres (2013), in her comparative study on doulas and lactation consultants, found that the former had to metaphorically “enter through the back door” because the hospital staff perceived them as anti-medicine. This notion of doulas as a challenge to medical entities has been supported in other scholarly research (Hunter 2012). Furthermore, the doula occupation has been analyzed through a social movement lens; because of their structure as ordinary people making collective claims for social reform, the mission of the activities of doulas —to provide support for healthy successful birth outcomes— may be considered a social movement (Tilly 2004; Basile, 2012).

Although social reform is not a direct characteristic of doulas, generally, many practicing in this role do adopt an identity, “radical doula” which is oriented towards this ideology in that

⁷ Each of these are medical terminology for processes employed to increase the rate of the childbirth process.

they provide “non-judgmental and unconditional support to pregnant and parenting people, ultimately in service of social justice” (Perez 2013). More specifically, radical doulas’ work is focused on fighting social inequities of medicalized pregnancy and birth which especially impact non-white, gender non-conforming, and less educated women. This subgroup of doulas does this through helping pregnant people resist potentially oppressive processes possible in a hospital setting (Henley, 2015). Scholarly literature points to this mission of social justice as being more evident within theory as opposed to practice. For example, Lantz et al. (2005) found that those with the least amount of resources and therefore are in greater need of a doula’s services, such as poor women of color, are the least likely to receive them because of economic barriers. This potential barrier of underserved populations receiving doula care is not the only scholarly criticism towards the implied social justice work of doulas.

Much critical literature of this occupation is directed at the willingness of doulas to work with medical actors in medical settings. Christine Morton states that “doulas’ ability to redefine the reality of childbirth in the U.S. is...strengthened but also potentially weakened by their ongoing, continuous presence within the hospital setting” (2002:300). More specifically, Bari Meltzer Norman (2007) asserts that doulas’ tendency to work within a hospital setting renders them “apolitical” or “passive” as opposed to an activist force. In a similar vein, in her investigative piece on the over-reliance of medical technology within childbirth in the US, Jennifer Block states, “By supplementing the handholding and informed consent conversations that nurses and doctors should be doing, and by buffering the level of intervention, [doulas] are perpetuating the very system they are in the business of changing” (2007:160).

While valuable, this literature largely ignores the role of professionalism, which, as explained in the previous sections regarding medical professional dominance, impacts the nature

of healthcare —particularly that oriented towards childbirth— in the US. Through this study, I argue, that while doulas’ presences within medical settings may cause a conflation between themselves and the medical system, this is still an act of a decline in medical professional hegemony, as their presence is taking away from the doctors’ jurisdiction over an aspect of healthcare provision —childbirth. The way the doulas perceive of themselves, how they performatively collaborate with medical actors, and create alliances between themselves and their clients are all methods through which the doulas are co-opting childbirth out from under the jurisdiction of the medical profession, and therefore decreasing its overarching dominance. As a significant part of this argument is structured with the assumption that occupations impact identities, a review of literature conflating these follows.

Occupations and identities

While there is a wide range of scholarly work which demonstrates the sociological link between occupations and identities, for the purposes of this study, only a portion of this literature will be reviewed. To start, it is imperative to define what is meant by the term “identity”.

As Stryker and Burke (2000) reference in their piece, “The Past, Present, and Future of an Identity Theory”,

Three relatively distinct usages exist. Some use identity to refer essentially to the culture of a people; indeed they draw no distinction between identity and, for example, ethnicity...Others use identity to refer to common identification with a collectivity or social category, as in social identity theory...or in contemporary work on social movements, thus creating a common culture among participants...some use the term...with reference to parts of a self composed of the meanings that persons attach to the multiple roles they typically play in highly differentiated contemporary societies.

For the purposes of this study, I will be employing the term “identity” as representative of a hybrid of the second and third definitions provided above; “Identity” within this study, refers to the collective, social category of people who are doulas as well as to the ever-evolving parts of

selves dependent on the varying roles people who are doulas tend to play. In line with this operationalization of identity, this study is focused on doulas' role within the decline of medical professional dominance via their identities felt because of the varying situations which their occupation may place them in. Furthermore, a large part of this argument is structured with the assumption that occupations impact identities.

The collective aspect of the iteration of identity as used within this study has been addressed through organizational work cultures, in which common values were found through shared perceptions of work practices (McInnis 1998). Similarly, Doherty (2009) in his piece on this very notion of a connection between work and identity, argues that while work is an important source of identity, meaning-making, as well as group affiliation, he found that, rather than defining themselves by their occupations, workers presented their identity in reference to their work because of their commitment to this work. Essentially, the length people are willing to stay at their jobs (and may therefore be considered committed to it) is positively associated with their likelihood to align their identities with it.

This emphasis on commitment as playing an important role within the dynamic of occupations and identities is supported by other scholarly endeavors which place "commitment" as a measure of "the ways in which individuals infuse roles and social structure with self-motivated behaviors, thereby linking the self to social structure...commitment...link(s) a person...to a stable set of self-meanings" (Burke and Reitzes, 1991). Essentially, this shows how when one is committed to their occupation, one locates their self within their social world, therefore contributing to a conception of their identity.

The notion of occupational involvement as a lens through which people craft identities is relevant to a symbolic interactionist framework (which will be elaborated on in the methodology

section of this study) in that it relates the meanings people create about aspects of their work to their conceptions of themselves. In other words, this tradition of scholarly work focused on occupations and identities includes the concept that identities are derived from the meanings which people attribute to the varying roles within which they act (Dietz and Ritchey, 1996). Scholars have also asserted this sort of occupationally-influenced positioning and self-defining, as linked to a “situated learning” process whereby individuals construct themselves through participation within their occupational networks (Lave and Wenger 1991).

Based on this extant research, it becomes clear that occupational involvement has an impact on one’s identity, especially when approached via a symbolic interactionist perspective. Therefore, with this framework in mind, when the doulas of this study communicate their conceptions of how they act within this particular occupation, they are also expressing conceptions of themselves. These dual personal and professional accounts provide integral information towards their impact on the dominance of the medical profession.

Methodology

To explore the felt identities of doulas and how their roles may impact the decline in medical professional dominance, I gathered data using interviews. I conducted interviews with six women who currently practice as doulas. Four of these interviews were conducted through phone call and the other two were in-person.

There are two methods through which I recruited interview participants, the first of which is through email and social-networking sites. The second form of recruitment on which I relied to recruit participants within this study was “snowball sampling” by asking my initial interviewees for suggestions of other participants who I then contacted through email or text messaging. Since working as a doula may involve training of some sort and members of this occupation are usually

involved in virtual or in-person doula communities, most participants will be in contact with others in similar lines of work. This made snowball sampling a successful and reliable method for this population.

Before the interviews took place, the doulas and I would correspond via email or text to provide an overview of my research as well as the interview process. Once they agreed to participate, we would continue correspondence in order to determine a time that worked for both of us. If we were meeting in-person, I would suggest having the interviews in places most comfortable for the women, which were usually coffee shops. Since a majority of my interviewees worked in other occupations in addition to being a doula and had children, many of the phone call interviews were conducted while they were driving or walking in between activities. I shared with the participants that the interview was completely voluntary and if at any point they did not feel comfortable, the interview could end. Every worker read my Institutional Review Board consent form and signed it and were given a copy to keep for themselves.

Epistemology

Being a doula is not a stagnant job; As will be elaborated on throughout this study, it changes depending on whatever the client needs, whether that is entirely unmedicated or totally dependent on induction technologies. The doula identity, of course, responds to their clients' needs and wishes, but also —almost equally as much— to the 'radical' and alternative political notions associated with this role, to the training, certification, and medical standards which one inevitably interacts with on this job, as well as to their own accounts of their experiences with childbirth on a personal level. In other words, the doulas of this study, defined their roles, and therefore, their identities as a doula, as contingent on the situations in which they were acting.

Therefore, I am using a symbolic interactionist perspective to analyze what these conceptions of their work mean.

A symbolic interactionist perspective as used with this study, is a theoretical framework with roots in both social psychology as well as sociology and is based on the notion that identities are not set, they are socially constructed and shaped by life's social and cultural conditions; “identities are preformed, constructed, negotiated and they vary over time” (Deeb-Sosa 2007, Blumer 1969, Mead 1934). More specifically, my research has been conducted based on Goffman’s (1963) notion of “felt identity”. This concept represents a person’s subjective sense of their own identity as a result of their various social experiences (Boydell et al., 2000).

Additionally, I employ a reproductive justice framework within the language of this study by not referencing the gender of those who give birth as consistently female or women. I do this to reflect the range of gender identities and lived experiences of folks in contemporary society as well as to not erase the experiences specifically leveraged towards and felt by those of the female sex. For the explication as well as application of this framework, I draw on activist Loretta Ross’ and sociologist Ricki Solinger’s text, *Reproductive Justice: An Introduction*, as the inclusive structure and content of their political ideology is highly relevant to the purposes of my study. Specifically, the rhetoric of this book, “recognizes the limits of traditional, biologically based binary definitions of gender at the same time as it chronicles and analyzes histories that these definitions have produced “(6). This stipulation, as applied within my study is embodied through terms such as “birthing person”, “the doula’s client”, “birther” etc. as well as “women”. In a similar vein of the importance of this non-exclusively gendered language, it is important to note that, contrary to popular belief, there is no requirement that a doula must be a woman. While far from perfect, the inclusive language of this study is, as Ross and Solinger describe it, “[a] ragged

beginning to the project of defying the gender binary and recognizing the need to develop acute attentiveness to the politics of language in this domain” (6-8).

Limitations

I acknowledge that there were several limitations to the research that I was able to perform. Throughout this research process, I underestimated the difficulty that I would experience recruiting doulas. As this occupation is as stable as the number of clients in need of services and are interested in not only hiring an alternative birth worker but specifically that of the doula tradition, it is not necessarily reliable as one’s sole, full-time source of an income. Therefore, the people involved in this work, were also involved in other positions such as that of a baby sitter, a hypnotist, a childbirth educator, an administrator at a relevant organization, or (most frequently) as a mother. This made it quite difficult to recruit participants as well as find a time and place most convenient for them to participate in the interviews.

Additionally, the doula profession is an ever-growing and diverse field; people of all races, socioeconomic status, languages, as well as place of origin, work within this occupation and are therefore relevant within the subject of this project. Due to my own language, location, as well as networking restrictions, I was unable to recruit a sample representative of this diversity. Most of the doulas in this study are white, cis-gendered, middle- to upper-middle class, women from the US. As doula work is oriented towards the betterment of childbirth experiences, it is especially useful for folks most likely to have an increased chance of complications during birth, such as people of color, people whose first language is not English, or people of lower economic statuses. To develop a more comprehensive study of doulas and their experiences, I recommend interviewing a more diverse population

Chapter Overview

The significance of this research is to explore the various felt identities of those who comprise the doula occupation while they maintain their client as their focus in the face of much resistance and simultaneously while they serve as a force within the decline of medical professional dominance. In order to explicate this, the project is divided into sections addressing the doulas' identities in relation to themselves, their medical counterparts, and their clients.

Chapter two of this project, "Becoming a Doula", illustrates doulas' conceptions of their individual identities through emphasis on storytelling and experience, thus supporting doulas' existence as rooted in alternative knowledge systems. Chapter three, "Performative Teamwork", is concerned with how the doulas of this study navigate their relationships with medical actors who dominate childbirth healthcare, thus demonstrating a doula's performative public identities.

Chapter four, "The Doula-Client Collective", addresses the doulas' relationship with their clients and presents this as a rooted in a process-based sense of a collective identity between the two parties. This bond is dedicated towards the combination of the doulas' knowledge and the clients' preferences in order to reclaim control of the physician-dominated field of childbirth. These chapters represent a brief insight into the adaptive and dynamic identities of doulas through a symbolic interactionist perspective. Doulas are slowly, but surely, adding to the steady decline of medical professional dominance, in a political and personal endeavor to deliver the experience of childbirth back to those who deserve it— the birthers.

Chapter Two: Becoming a Doula Alternative Knowledge Systems and Individual Identity

While one may become a doula through a standardized training and certification process, this is not required in order to practice (Norman and Rothman 2007). The content of these trainings is different based on the organization through which one chooses to go. For example, DONA International, one of the first founded doula training organizations has their training process described on their website as,

In your birth doula training you can expect to learn not only the *how* to doula, but also the *why* we doula. Workshops cover evidence-based information about the benefits of doula support, the history of birth, the significance of doula support to families, practical hands-on techniques, as well as the steps to begin a career as a birth doula.

Ancient Song, another doula training organization based in New York City focuses on providing doula assistance to women of color or other folks underserved within the healthcare system. The description of their training services available on their website is,

Our training is focused on the "whole" and not just its parts and seeing birth as a human right incorporating an intersectional lens that encompasses reproductive and birth justice framework into our trainings centered on communities of color and pregnant and parenting individuals. Radical in thinking on how we shape our thoughts around birth tackling the hard issues like sexual trauma, domestic violence, discrimination, advocacy, cultural competence and more...Our focus is women of color, low income areas, undocumented persons, and those families who want the best quality care by advocating and making informed decisions about their care.

From just these two examples, it's clear that training and certification processes available to doulas is highly differentiated. While certification is often described as essential in order to successfully work within this role, it is not viewed in this light by the participants of this study. Natasha, a self-described "reproductive health activist" and a doula since 2010, puts this sentiment clearly when she states, "the process of certification...doesn't make better doulas it makes more sellable doulas." Through this expository comment, Natasha is highlighting a major

difference within the ideology of the doulas and the professionalism in which the concept of a certification process is rooted. Natasha is far from alone in this stance on certification. Suzanna, a doula, mother, meditation expert, and writer who has been “obsessed with birth” since childhood, expressed concerns for the content and purpose of the certification process which she is still in the process of completing, specifically highlighting her dissatisfaction with the cost.

I find some of the material that I'm asked to read and be tested on so remedial. It's like it repeats the same stuff and a parent could read it themselves and have just the same mastery as breastfeeding, or whatever, that I do, and the videos feel like sort of self-congratulatory and limiting, so I resent it almost...I keep having to pay for random booklets that aren't that useful. I feel that there's so much information out there that I would gladly be forced to spend my time to consume. I feel sometimes some of the books that they're using are a little outdated or whatever, so I feel like there's a way that I'm sort of begrudgingly, like it's why I haven't finished my certification. If I had 10 fascinating books and all the videos felt worth my while, and broadening my mind, I would want to dive in more, but when I have the time to even do it, I have to kind of get over myself to do it.

So, if not certification, how does one become a doula? Or how, at least do the doulas of this study view their processes of becoming this role? The answers to these questions came up in many ways, some entirely unique, others related to each other, some political, some personal. The general nature of the participant's conception of their identities within becoming doulas references alternative knowledge production, to which this chapter is dedicated.

This chapter explores how the participants of this study conceive of their respective journeys into this particular role. Theories of narrative identity as well as of alternative knowledge production are employed in order to analyze the micro-level changes which seem to occur within the doulas when they become this role. Reviews of research on storytelling as well as on politicization support these concepts. Essentially, this chapter shows how, when describing their processes of becoming a doula, the participants of this study place emphasis on experiential and political knowledge, thus demonstrating that these alternative measures of expertise are integral to holding this role. This speaks to my larger argument positing doulas as a declining

force against the dominance of the medical profession, in that they are an alternative knowledge-based occupation and therefore oppositional to the authoritative nature of the medical profession.

Telling Identities

Alternative versus Authoritative Knowledge

“Authoritative knowledge” is a method of knowing that has more societal value than other knowledge systems (Jordan and Davis- Floyd 1993). Because of its social weight, those with this knowledge are considered “normal” and legitimate and those without, that is, the subscribers of “alternative knowledge”, are perceived as “backward, ignorant, or naïve trouble makers” (Jordan and Davis-Floyd 1993:152). Within maternal health care, medical actors have authority over knowledge because of the legitimacy attributed to the training needed to participate in this role (Rothman 1997). In this context, doulas are a good example of an occupation rooted in alternative knowledge as they consider experiential knowledge, as opposed to that rooted in their training or certification, to be an integral aspect of their individual identities within the process of becoming this role. This emphasis on experience is communicated through the use of narratives, and therefore a review of this theoretical identity creation is integral.

As this project is focused on felt identity from the perspective of doulas, there was ample opportunity for my participants to discuss themselves in an unstructured format. However, as has been discovered as common within qualitative research gathering, my participants seemed to adapt a particular style for answering questions (Speer, 2002). Specifically, when discussing their respective processes of becoming a doula, some of my participants took this as an opportunity to dissect how their own personhood interacts with having this job. This information was frequently manifest in the form of story-like conception of past experiences which were now

classified as not only relevant to the topic at hand –being a doula– but also distinct motivational components within their process of becoming one.

In this study, considering its focus on birth doulas, the participants’ vocalization of childbirth was, unsurprisingly, a topic frequently visited throughout the interview process. Participants talked about birth either from a philosophical standpoint or when discussing a hands-on experience within the doula role. A majority of this “birth rhetoric” relevant to individualized identities of being a doula were mainly expressed in the form of participants’ personal accounts of their own labors, if they had experienced this.

Everyone interviewed within this study who has a child had experienced birthing that child first hand. These participants brought up their personal stories about this aspect of their lives consistently. While I did inquire if my participants had children, I never explicitly asked them to explain what it was like giving birth, if they had. However, this information was continually shared as it tended to be the response to the question “What made you get into this work?”. Essentially, this section of my participants claimed that they, as well as most of their peers within this line of work, became doulas as a result of their own decidedly positive or negative experiences with childbirth. Whether they had a good experience or not, it was bound to be acknowledged as the defining moment of their lives in that encouraged them to get into birth work. Jordin, a self-described “birth evangelist”, mother, and doula practicing in the Midwest articulated this pattern quite precisely when she stated,

So many doulas and so many birth workers are called into birth work because they’ve had bad experiences and go “no it shouldn’t be like this”. But what’s neat is some birth workers that I know now have gone into birth work because they’ve had such amazing births and they’re like “I want to help women have *this*.”

Fascinating in its own rite, yet somewhat expected given my surface-level assumptions of the emotional aspects involved in being a doula, I wondered why my participants felt so compelled

not only to discuss in detail their births, but also their (usually new-found) analysis about what went right and wrong within these apparently monumental experiences. Was it a part of their training that caused them to focus on their own personhood? Research would point to no, considering anyone can become a doula if they so desire, personal experience with childbirth or not (Katz, 2015). So, what is it that motivated some of the participants of this study to situate their role as a doula within their own accounts of birth? The doulas' repeated process of self-identification, as presented via a story-like conception of a personal experience, is supported by a concept of individual identification, thus requiring a detailed description of this theoretical approach.

Individual Identity and Narrative Theory

In her study of midwives and how they interact with society as a collective group, Laura Foley (2005) analyzed and labeled the biographies of themselves which those she studied constructed through social interactions as “individual identities”. Basically, Foley found that through “telling stories” about themselves and their work –such as sharing anecdotes about working with particular clients or under certain conditions– the midwives upon which her study was based were explicating how they conceived of their own self in relation to their role as a midwife more generally. These “individual identities”, commonly explained through a story-like structure, are quite fruitful when analyzing a person’s conception of their felt identity are thus the basis of this section of the doulas’ conception of their identity. The story-like structure to which Foley (2005) referenced, is an approach to self-identification in itself. It is commonly referred to as “emplotment”, the process of assembling parts of what could be a story into a recognizable format (Kent, 2015). Emplotment has been postulated to have more than one pragmatic purpose: both to make sense of and to interpret the experience being described (McVee, 2005). This

method is a particular sect of identity presentation within the larger process known as “narrative identity” on which I will elaborate further through a review of relevant literature.

Identity has been studied from a wide-range of perspectives (Hogg, 2003; Burke, 1991; Callero, 2003). Relevant to this aspect of this study is scholarship that pertains to the notion of self-identity, which scholars have discovered as manifest in the form of people’s conceptions of their “place in the world” (Bauman, 1998). Essentially, the concept of identifying oneself is typically done by locating oneself within a larger sect of peers and/or surroundings. In other words, based on other scholarly endeavors into conceptualizing what self-identity is, the perspective of identity which I will be using in a part of this chapter, is rooted in people’s repeated biographical descriptions of themselves which are maintained through the telling and retelling of the same narratives (Giddens, 1991). Therefore, with this framework in mind, people’s conceptions of past experiences and particular formatting of this information to the external world will be analyzed and understood as a valuable insight into their personal definitions of their identities.

According to narrative theorizing, a process used to make sense of lived experience is one through which central life events are structured in a “storied” pattern –that is, one with a plot, a setting, and scenes (Fisher 1987). While not typically considered a lens through which sociological analysis may be formulated, there has been much research promoting the importance of narrative presentation as a legitimate aspect of studies within the social sciences (Foster, 2012; Boydell, 2000; Gergen 1998). A particularly impressive example of this would be Patricia Hill Collins’ “Black Feminist Epistemology”. In this critique of Eurocentric knowledge validation processes and of US power relations, although contrary to overarching academic thought, Collins argues that lived experience is a credible source of knowledge (Collins, 1990).

More particularly, scholars have noted that “social life is itself storied and that narrative is... [a] condition of social life” (Somers, 1994). This means that “stories” in this sense –meaning the ones that people “tell” about themselves– have sociologically relevant material in that the emphasis placed on certain actions or experiences serve as insight into analyzable aspects of the narrator’s personhood.

These emphases (meaning notions included within the narrative) demonstrate to the receiver many things about how the narrator views their positioning within their world: what kind of actions they deem important, how they have dealt with certain experiences, how they relate or distance their personal conceptions of self from “available social, public, or cultural narratives” (Somers, 1994). Ezzy (1998) argues for the integration of narrative theory and a sociological conception of the self. In his study, Ezzy asserts that the typical sociologist take on Mead's analysis of the self has mostly focused on the social psychological connotations of the work whereas the concepts of time have been largely considered as a philosophical aspect of the work. However, by stating, "A narrative conception of identity provides a framework for the integration and extension of Mead’s conception of time and his social psychology of the self", Ezzy is claiming that sociological analyses of self could benefit from this inclusion of the importance of temporality.

Somers (1994) references this type of self-identification as more than a method of representation, but rather as an internal, ongoing, “ontological condition of social life” (Somers 1994; Foster, 2012). Essentially, “narrative identity” is a particular mechanism through which people can conceive of themselves, their social worlds, and in particular relevance within this study, their occupational worlds. Through this, researchers have postulated that the “narrator” (the person creating the reflexive description) by engaging in this form of analysis, therefore

showcases the interrelations of all of these parts, thus producing a full image of how they see themselves within their roles. Basically, narrative identity refers to the presentation of one's life events in order to create a particular conceptualization of themselves which can serve as their felt identity. Furthermore, scholarly research has focused on sources of identity and asserted they are impacted by one's occupation (Doherty, 2009). Thus, particularly structured conceptions of one's identity in relation to their work is sociologically relevant as it can shed light on their positionality within the larger scope of their field. In the case of this study, the ways through which this kind of identity conception is used by the doulas can serve as insight into the structure of their own occupation in relation to the maternal health care system of the US in which they practice.

Childbirth Experience as Integral within Becoming a Doula

As mentioned previously, the doulas' answers to why they became a doula included storied accounts of their lives to create what I classify as their narrative identities. As these experiences are predominantly related to childbirth, to (at least a part of) the participants' livelihood and have been deemed important enough to incorporate into their "story" of themselves, they are highly personal components. Therefore, in line with the symbolic interactionist perspective, which is the methodological backbone of this study, I interpret the doulas' conceptions of their narrative identities as examples of their identity when interacting with themselves. For those to which this experience applied, the making of their narrative identities included a story of their experiences giving birth, complete with characters, emotions, and plots. As I will elaborate on later within this chapter, this pattern of incorporating their childbirth experience into their narrative of becoming a doula shows that doulas characterize

their experiences within the maternal health care system in the US as a significant aspect of their identity as a doula.

Lori, who enjoyed a career as a producer until last year when she transitioned to become a full-time doula, is originally from the UK. She describes her trajectory of becoming a doula as one that is related to her perception of the medical system in the US and her worries about giving birth under its jurisdiction.

The reason why I trained and became a doula was from my own births and the research that I had made during...my first pregnancy. I think a part of growing up in Europe and then having children here and knowing that you're kind of in a worse off situation in the medical system here. And having this kind of fighting attitude where it's like I'm not going to let them get me, I'm not going to let this American system get me...there's also like guilt thing when you come over from Europe that you're not ... you're like, well, damn, I'm missing on the health care, and the maternity leave, and all of this other stuff. Or you feel like this poor kid. I'm just jetting this kid to this country while...we could've had a very different experience. So, for those reasons was why I was trying to sort of grab the process by the balls a lot, by like 'I need to take control of this so that I can make this as good as it can be, and avoid these things that I don't want to let happen.' So I got heavy into research, and decided that I wanted to have home births, because that was my way of eliminating the system a little bit, was to say ... and knowing that many people in the UK have home births, so it wasn't this kind of crazy weird hippie thing to do, it was just like 'This is my choice, and my beliefs' and...it was ultimately a really great birth. As time went on...I had a second baby, and then after my last appointment with my midwife at six weeks, I said to her 'What do I do with this brain full of knowledge that I have? Where does this go now?' I was kind of sad, it was like, 'This is it. My interaction in the birth world is over, because that's my last [child].' Up until that it was appointments, and I got to nerd out about my birth stuff. And then she was like "You'll find something, you'll find a way to make it. You'll find some way to let it out."

This detailed account of Lori's navigation into the doula profession as through her experience with childbirth is full of "emplotted" characteristics; the plot: having a child in the US system; characters, the child, Lori herself, her midwife; the setting; the US and its problematic system. It is because of these qualities that this account can be considered a "narrative identity". This shows that Lori's notion of being learned in the birth world, and therefore her notion of being involved in this work on a more official level, is rooted in her negative connotation of the US

medical system, therefore communicating the ideology with which she practices. It also shows that she feels as though this knowledge is integral to her positive experiences with birth. Lori offered how being enlightened to the medical system's practices and her own fears allowed her to overcome these potential interruptions to the kind of birth she wanted to have. Essentially, by emphasizing her fear of the medical system as the impetus for her in-depth research on birth processes, Lori demonstrates her belief of the medical system in the US as deeply flawed. As this ideology was described as knowledge which she wished to continue to be able to apply, it may be asserted that Lori has become a doula to "save" others from the system like she was through her own experiences and because of her own research. This iteration of becoming a doula demonstrates how knowledge of the medical system as well as experience with other models of birth are valuable when becoming a doula. However, this sort of story with a positive ending is not the only type of narrative which the doulas presented.

For example, Elianna, a mother of four, and a "radical doula", narrated her pathway into being a doula when she describes her negative experience with the birth of her first child which took place while she was living in a homeless shelter for pregnant women.

I went into labor, I thought I wet my pants, I didn't even know. They took me to a catholic hospital and my wrists were tied down and they told me I was too loud, and they wanted to give me medication and I said "No, I wanna do this natural, I don't want my baby to get any medication." They gave me Demerol against my will, he was born blue. They wouldn't put a last name down because I wasn't married, just horrible shit, horrible shit. Yeah so like all of this informed my life and my desire to make sure that it doesn't happen to anybody else.

Considering the narrative structure of this conception of her birth, like in Lori's account of her process with childbirth, the "plot" is Eliana's birth and the omnipresent, controlling US medical system. The setting being the catholic hospital, the characters include the hospital staff and herself. Further supporting the narrative nature of this insight into Eliana's life, is the included

“dialogue” between herself and the medical personnel with which she was interacting. The outcome as a display of personal commitment to be sure that what she experienced is not transferred to others is presented as central to her individual identity as a doula. Basically, from this account it is clear that Elianna’s first encounter with childbirth, which was decidedly negative and traumatizing, caused her to become impassioned to protect others from enduring the same, which eventually lead her to choose to become a doula. Again, it is expressed that experience with childbirth has a role within becoming a doula.

Childbirth as a motivational factor in becoming a doula was not only offered by the participants of this study when it was in reference to their own birth. For example, Suzanna decided to learn more about birth work following a profound experience while attending her friend’s birth in a significant role.

I got into doing birth work more formerly because about 12 years ago, a really good friend of mine was getting pregnant by herself. She didn't have a partner, and she asked me to be her birth partner all the way. So, we did childbirth classes together and I was her doula and labor partner, and sort of emotional support in the bigger sense of things beyond just the course of labor... that was the first time I had done it, I did all the learning as if I was going to be having a baby of my own, and then I got to help her give birth. Being at that birth shook me in the most essential way and that really inspired me to be like, wait I just did this and that was incredible, and people get to do that? Let me look into that further.

While this comment is different from those of her fellow participants thus far in that it did not consist of her own birth as the “plot”, Suzanna’s statement nevertheless told the “story” of how she became a doula. Specifically, this comment highlights that experiential knowledge as valued within the process of becoming a doula exists on a spectrum; there is not a stable definition for valid experiential knowledge when becoming a doula.

Similarly, although in a quite different context, Elianna claims to have been at least partially called to doula work based on her time spent in a shelter for pregnant women. She

describes the support system which she represented to her fellow residents in this facility during their births.

I lived in this place run by nuns for young women who were pregnant. I helped with about 65 pregnancies there, I mean labors, because usually you go when you're showing and you live there for about two and a half, three months, but I lived there for like seven months. Every single one was different and prepared me for this job.

Elianna is telling the “story” of how certain events in her life aided in her ability to become a doula. The plot, consistent with her previously addressed conception of her own birth, describes the time which she constitutes as relevant to her becoming a doula, which is during the time of her own pregnancy. The characters in this iteration of her narrative are other pregnant women, herself, and the nuns in charge of their care. This, again, demonstrates experience with childbirth as a guiding force in the process of becoming a doula. It becomes clear, from Elianna’s account of her time spent assisting fellow women who were homeless when giving birth, that she values this experience not only as preparatory (as she directly states) but motivational in becoming a doula. Essentially, if not relevant to her pathway into this position, this experience would not be of enough value to include within her narrative of this process. It is therefore evident, that experience is essential within the process of becoming a doula.

This sort of inclusion of events which retrospectively hold relevance in one’s narrative, and therefore maintain significance within their individual identity, is related to a particular aspect of narrative theorizing. Within this method of self-analysis is the tendency to define and redefine certain aspects of one’s life, thus placing emphasis on experiences deemed –on a reflexive level– particularly impactful. In other words, as I mentioned earlier in this chapter, emplotment has more than one use within its application; developing a narrative about oneself is a method for acknowledging life events that are important, but also as a way to interpret and categorize these events as well. In other words, narrative identity may be commonly employed as

a sort of coping mechanism, particularly when processing and explicating complex or tough experience. Through story-construction and storytelling processes, individuals create and re-create their identities, relationships, and worldview (Koenig Kellas, 2014; Somers, 1994). Furthermore, this aspect of narrative theorizing makes it a logical tool when presenting information regarding an experience as impactful as childbirth (Koenig Kellas, 2014; Horstman et al. 2017). As Arthur Murphy (1959) puts it in his original introduction to Mead's *Philosophy of the Present*,

Before the emergent has occurred, and at the moment of its occurrence, it does not follow from the past. That past relative to which it was novel cannot be made to contain it. But after it has occurred we endeavor to reconstruct experience in terms of it, we alter our interpretation and try to conceive a past from which the recalcitrant element does follow and thus to eliminate the discontinuous aspects of its present status.

This concept of experience being remodeled in a method to communicate one's conception of their location within the social world is represented by the doulas' accounts of labors— their own or those of others in which they were acting “characters”. As the folks being studied in this research are accustomed to the culture of birth work —considering they participate within it and therefore, it is a part of their daily lives— their narrative constructions of their birth experiences were based around the aspects which they, now as doulas, focus on in their respective practices.

This was particularly evident within Jordin's description of her emotionally and medically complicated birth of her first child.

I grew up just believing in natural birth, my mom birthed 4 of us naturally and was very pro-breastfeeding, as was my grandma...so I had this confidence, almost like this belief...this trust in the whole birthing process. I had over twelve hours of labor. My husband didn't really know how to support me, and I really remember just feeling alone in my pain...I finally read more [after giving birth] and realized that all the stuff that had happened to me was so inappropriate and so not okay. And realizing if I had just known. If someone had been there to say 'this is normal. It's hard but it's normal. Keep going...let's try this. Maybe you should eat something.' If someone had been there supporting me, encouraging me, normalizing it. And also giving me more advice about what I could do to work with my body instead of just 'suffer through it', what a

difference that would have been. It still would have been a hard freaking labor, but it would have been so much better. In retrospect as a birth worker and doula now, I hadn't been prepared for my history of sexual trauma to be triggered with all of these things...I didn't know that, but my body just shut down.

Jordin's narrative of her first encounter with childbirth is centered on how difficult it was for her. She particularly articulates that her birth experience could have been better if someone with more experience was present and able to provide more accurate insight into how to navigate the process under which she was going. As this guiding role was clearly unfulfilled and maybe unable to be filled by medical personnel or familial people present at her birth, Jordin's comment sheds light on where she views gaps within the system of care. The retrospective aspects of this comment demonstrate what Jordin categorizes as under a doula's jurisdiction: aspects of giving birth related to intimate and individual history. While Jordin doesn't specifically articulate that this encounter with childbirth is what motivated her journey to become a doula within this comment, she is analyzing her experience through the lens of her current status as a birth worker. Through this typified aspect of narrative identity work as a re-interpretive framework for coping with experiences, it becomes clear that having support to validate the childbirth process as articulated within this comment, could have made Jordin's birth more positive. This shows that experience is not only motivational, but also seen as genuinely effective within the action of aiding a birthing person and therefore further adds to the continually emphasized notion of experience as important within the process of becoming a doula.

Suzanna's narrative eventually included herself as a mother. While she did not make the claim as directly as her fellow participants did, that experiencing childbirth is what led her to become a doula, she did however, acknowledge a degree of importance within this positionality in regard to her role as a doula.

I was very grateful as a doula and as a mom that I had both experiences of vaginal birth and a cesarean birth, and in that order and an emergency birth, and a home birth and a hospital birth, because you don't need to have that direct experience of it, but I feel like it really opened me up where I have touch points into all of those things happening, and what that might feel like.

Essentially, although Suzanna became interested in birth work because of a peripheral experience with childbirth, she still incorporated the significance of her own birth within her narrative identification of herself as a birth worker. It's almost as though this aspect of her positionality within doula work—as one who had already encountered the maternal health care system—solidifies her ability to perform the role to its fullest extent. This further supports the notion that being knowledgeable in the form of experience is an important facet of the individual process of obtaining the “doula” identity.

The Politics of Storytelling and of Doula-ing as Alternative Knowledge

This storying of events, while demonstrative of how doulas of this study view experience as knowledge, is also a part of a legacy of alternative knowledge production. In their groundbreaking book *Reproductive Justice: An Introduction* (2017) Loretta Ross and Ricki Solinger explain the political roots of the importance of stories,

...storytelling is an act of subversion and resistance. Stories help us understand how others think and make decisions. They help us understand how our human rights—and the human rights of others—are protected or violated. Storytelling is a core aspect of reproductive justice practice because attending to someone else's story invites us to shift the lens—that is, to imagine the life of another person and to reexamine our own realities and reimagine our own possibilities.

Essentially, relying on personal experience to tell one's “story” of their identity is a method of finding a unique standpoint to delineate one's own positionality within the social world. This format of transmitting knowledge has been relied upon by many oppressed groups within the US; enslaved people used stories to express the truths of their conditions in a safe manor, in the 1970s

members of the women's movement relied on storytelling to fight their oppressive silencing (Ross and Solinger, 2017). In addition to this political legacy, the doulas' usage of the storied format of identity expression with an emphasis on experience contributes to an alternative knowledge production in that it does not fall under the usual determinant of what is defined as legitimate, authoritative knowledge (Jordan and Davis-Floyd). In the case of the study, authoritative knowledge would be that which is rooted in medical and/or certification and so the doula's notion of experience as knowledge can therefore be considered an act of resistance.

Conclusion

This chapter is centered on what it means to be a doula from the perspective of the participants' individual identity. The conceptions of this process of "becoming a doula" extended beyond the relevant notion of certification given its non-standardized nor required nature. Essentially, by employing narrative theoretical frameworks (which imply that what is included within a biographical vignette is important to the narrator) when analyzing doulas' storied accounts of their births, I gleaned from the commentary shared with me that doulas perceive experience with childbirth as highly meaningful within becoming a doula.

Furthermore, because of the political nature of this mechanism of expression being one of stories, and the similar importance of experience, it is evident that the doula's process of becoming this role, and therefore their individual identities are rooted within an alternative knowledge base. Within the overarching purpose of this study, this discovery of doulas as an alternative is a base-line reinforcer of their declining effects on medical professional dominance in that it ensures that the former are in opposition to the latter. In other words, the notion of politicization of the doula's individual identities allows this aspect of the occupation to be further

associated with a tradition of alternative knowledge, therefore strengthening the argument of this study, that doulas represent a continuation of the decline of medical professional dominance.

This radical, alternative nature of their individual identity is not, however directly translated within their praxis when working within the mainstream medical world. Therefore, a deeper exploration of the doulas' relationship with medical counterparts through the participants' conceptions of their "public identities" the center of the following chapter in order to continue the examination of their impact on the dominance of the medical profession.

Chapter Three: Performative Teamwork Impression Management and the Creation of a Public Identity within the Medical World

There are many factors that influence the outcome of a birth; the physical space, the health of the mother, but also –perhaps most important from the perspective of this study– the people present. Each participant in this study referenced the importance of the dynamic between themselves and people who they work with when aiding a delivery. In this vein, they discussed midwives, nurses, clients, their family members, and of course, doctors. From the articulations of these interactions, it became clear that doulas had a certain conception of their identity in relation to their medically affiliated, non-doula counterparts.

Midwives versus Medical Actors: Productive Collaboration

The participants in this study acknowledged a significant difference between how they approach dynamics with midwives, versus the relationship among themselves and mainstream medical actors. Specifically, the doulas tended to have overwhelmingly positive experiences when working with midwives during births. Natasha articulates this quite clearly when she states, “When I work with midwives it’s very collegiate...I’m their assistant as well as the client’s. They understand that my support keeps the client in a place where they can do what they need to do, and everything goes really well.” This cooperative dynamic between doulas and midwives is logical in that midwifery can, like the doula occupation, be considered an alternative occupation, despite their medically guided certification processes and practice. This is because this group of birth workers is structured on the “midwifery” model of birth as opposed to the “medical model” upon which most mainstream medical actors rely. The former is the ideal that posits birth as a normal process throughout which the birthing person is the main figure, whereas the medical model frames birth as pathological and thus the birthing person becomes a “patient”

in need of the doctors' "treatment" (Foley, 2005; Rothman 1982, Davis-Floyd 1992). Quinn, a 27 year-old, certified hypnotist and childbirth educator, enforces the prevalence of this dynamic when she describes her positive relationship with midwives, however, in a style different from Natasha's comment, Quinn does this in relation to the nature of her relationships with hospital-based staff.

[Before the birth] the midwife, myself, and the clients all have a meeting together which is really great. 'Cause we really do function as a team. I mean there's a hierarchy like I'm, I definitely feel like I'm, below the midwife, but we do work as a team. Whereas the hospital is just, they want me to be in the periphery. Even the nurses, I mean, get agitated, just because I'm another body taking up space and they can't like access wires as easily. So sometimes I sense that frustration. I'm insisting that I be close to my client and they're insisting that they have access to my client's like stomach to do X, Y, and Z, like something not medically urgent.

Even though she can sense a difference in role importance between herself as the doula and the midwives with which she may work, Quinn's comment makes it clear that she feels a mutual degree of respect when working within this dynamic. This is countered with her interpretation of her working relationship with medical personnel including doctors and nurses. Quinn's account of tension between the doula and the hospital staff is definitely widely shared with her fellow participants within this study. However, other participants, when referencing this perspective the doctors may have of the doulas, also include how they deal with this relationship. While doulas work with a variety of labor-oriented healthcare providers, this section of this study will center on how the doulas conceive of their identity within the mainstream medical world and its actors as this dynamic represents an aspect of their role within the decline on medical professional dominance.

Most of the doulas were in unison when discussing the importance of a sense of collaboration with the medical personnel present at a birth. For example, Suzanna made the following statement in regard to how she prepares for what she views as a cooperative

engagement with whoever else may be present during a birth. “I really try to go in [to a birth] with a spirit of collaboration. We're all trying to support this baby's healthy birth and the healthy mother.” Whether accomplished through a genuine sharing of responsibilities, split based on each other's respective specialties, or through a doula’s embellished presentation of reliance on the medical personnel, almost everyone in this study claimed that –at least the performance of– teamwork is an integral part of how they carry out their work and will therefore be the focus of this chapter. This promulgation of behavior when working with mainstream medical actors is patterned with speech, demeanor, as well as performative action, as will be supported with expository quotes from interviews. Furthermore, since these behaviors are categorized by the doulas as in response to medical actors’ perceptions of doulas, they are considered, for the purpose of this study, as evidence towards the construction of the participants’ public identity, a concept which will be elaborated on later within this chapter (Foley 2005). There are several “publics” with which the doulas interact and therefore to who’s general conceptions they can respond: medical personnel, clients, and their networks. This chapter will deal with the doulas’ conceptions of their felt public identities in relation to the doctors and nurses, and hospital systems with which they are interacting as this contributed to the overall argument of this project.

I will show that doulas’ conceptions of their public identity demonstrate Goffman’s theory of “impression management” through the use of “negotiation”. I assert that this process of aligning themselves with the ideals of the medical actors they work with is a form of reputation control. Furthermore, this represents the participating doulas’ attempts to annul negative perceptions of themselves as held by their mainstream medical counterparts. I highlight patterns of what I refer to as “performative teamwork” within my participants’ accounts of their relevant

experience in order to support these claims. This adds to my argument of doulas as a declining force in medical professional dominance as it highlights how they infiltrate aspects of maternal health care usually under the jurisdiction of their medical counterparts in order to preserve a place for their alternative work.

This notion of managing the potentially tense dynamics between medical staff and doulas and the complex relationships between doulas and their clients is navigated through what has been studied and labelled “impression management” and “negotiation”. These processes are employed towards the creation of the doulas’ conceptions of their “public identity”. In order to properly situate the doulas’ behavior within this study of their felt identities, a brief review of the literature relevant to the creation of public identity as well as the processes of which it may be comprised is imperative.

Public Identity, Impression Management, and Negotiation

Public Identity

Laura Foley (2005) describes the concept of a “public identity” as the portions of collective and individual identities which are influenced by the general public’s conception of the non-mainstream community at hand (in this case the doulas). Foley concluded that public identity work may be conducted as a method towards enhancing positive conceptions about identity and negating those which are undesirable or inaccurate. According to the participants of this study, working with medical actors is a process whereby they must confront the doctors’ negative, stereotyped images of the doulas as anti-medicine, given their aforementioned preference for alternatives to the “medical model” of birth. As this aspect of their work is in direct response to the perceptions of themselves by the medical system in which they work, this can be considered a function of their public identity creation. Within public identity work are

many different mechanisms through which one may control the way they are perceived by particular “publics”. This includes impression management (Goffman 1959), which may be considered the umbrella under which falls the method which I also found implied by the participants in this study, “negotiation” (Foley, 2005).

Impression Management

In scholarship on organizational groups, it has been found that these entities maintain themselves through the approval of “target audiences” (Meyer and Rowan, 1977; Oliver, 1991, 1997). In order to obtain this endorsement, groups rely on “impression management”. As was referenced in the first chapter of this study, in *The Presentation of Self in Everyday Life* (1959), Goffman uses the dramaturgical approach to study the organization of social life and social interaction. Essentially, this method of thought assumes that individuals are interested in controlling the impressions which others have of them. It is from this approach that the notion of performance as a significant aspect of daily life came about and is now known as “impression management”. This notion of inauthentic presentation within interactions between stratified parties is relevant to Erikson’s argument in his piece “The Importance of Authenticity for Self and Society” (1995). Erikson asserted that this process is embodied by marginalized sectors of particular social contexts in that they are forced to “choose between acting in accordance with their self-values or in accordance with the expectations of powerful others” (McDonnell and King 2013). In other words, folks within an excluded population act in particular and intentional ways to appease and/or somehow negate potentially tense situations with powerful others. In the case of this study, this means that the doulas working within the medical world carry out certain behaviors as part of seeking the approval –or at the very least, willingness to work together within a delivery– from the medical staff with whom they interact. This is supported in Jennifer

Torres' (2013) comparative study of lactation consultants and doulas and how they legitimate their roles in that she argues that doulas must metaphorically enter a medical institution through a "back door" entrance, in order to work. In other words, doulas must behave in a particular way, usually undermining their expertise, in order to be accepted in the mainstream medical world of maternal healthcare.

Jordin aptly summarizes the dichotomy of having to choose between acting on one's own unabridged ideals or in a way that may advance, or at least, not harm one's positionality when existing within a space in which one is subordinated. More specifically, in this statement she articulates how challenging the liminality of her position can be at times, particularly during medical processes which she views as invasive and unnecessary and therefore, which she does not support.

...bearing witness to injustices in the birth space...it's taken me a few years to even realize how much I hold, even within my body that manifests as pain or anxiety for me, for these women, where I see not proper care for women, not proper informed consent, literal violations of women's' bodies in front of me where I'm unable to say anything because it's not my place in a way and it would damage my relationship and my reputation, it becomes really tricky to know where my place is as a birth worker, and to bear witness to certain violations that sometimes [birthing] women aren't even aware of.

The interactions, or lack thereof, which Jordin is explaining here, occur on a level which, for the purposes of this section of this study, will be considered "public" in that they are between doulas, their clients, and medical counterparts. Jordin, by commenting on her concern for her role in this public sphere, brings up an interesting dynamic commonly reported as felt by doulas when they work in medical settings. Highlighted here is the dual and sometimes contrasting nature of servicing the client, while not interrupting the medical actor's work within their own domain. It is probable that Jordin is worried about her presentation as being considered interference, because of the largely negative stereotypes which the medical world public holds about doulas being an unnecessary addition to the birthing dynamic. The other doulas within this study offer

insight into how they cope with this aspect of the creation of their public identities upon which I elaborate further in the following sections.

Negotiation

The dynamic referenced by Jordin's previously described comment may also be analyzed by the notion of "negotiation", a topic frequently addressed in occupational as well as social movement literature. Negotiation as a concept represents "the ways in which members of the collective resist negative definitions of their group and work to establish and disseminate positive ones" (Taylor and Whittier 1992; Foley 2005). In other words, negotiation is a group's action-based response to their public conception and will be therefore be implemented within this study as a part of public identity creation.

Performative Teamwork: Operationalization and Application

The aforementioned aspects of public identity creation work are applicable to how the doulas expressed their experiences when working within the mainstream medical world. The actors of this world—who have hierarchy over them, as the hospital is a site under their jurisdiction—hold certain stereotypes about the doulas to which the doulas respond in a particular way in order to counter these assumptions of their identity. More specifically, the doulas expressed a tendency embellish certain actions to elicit a collaborative ethos during the births by which they were all employed. This is embodied in a management of identity to which I will refer as "performative teamwork" (PT). PT is the invocation of impression management on which doulas rely in order to counter the largely negative assumptions about their role created and held by mainstream medical actors and systems concerned with childbirth. PT may include a range of actions such as speech or general demeanor and may also be implied via the absence of

certain actions. The doulas studied in this case present their personal encounters with situations which I will analyze through the application of PT within the sections that follow.

Elianna explicates this dynamic precisely when sharing how she feels judged upon initial interaction with the mainstream medical world and its actors. She elaborates on how she manipulates her presentation of herself as a doula within these situations which, in this particular instance, lead to a positive outcome.

I would really like doctors and nurses to value it [doula work] and see that we [doulas] actually make their lives easier, not harder. I have a lot of situations where I walk in and they're like "Ugh, she's got a doula." So often what I do is I repeat something the doctor said, in front of the doctor I'll repeat what they said in a way that says that I agree with them. So that they know that I'm on their team. That we're all here for the same reason. Then I do whatever I want anyway. I sort of try to soften the environment because it can be immediately adversarial, doctors do not always see us as help. We end up walking out being thanked and being told that we're such help, such great help.

This comment shows that, at least in the circumstances of the medical world with which Elianna interacts as a doula, the general public conception of her in this role is inherently negative.

Therefore, she relies on performative teamwork as a method through which she, the doula, attempts to nullify the medical staffs' negative assumptions about doulas and the role they play. This is impactful to a portion of the public identity of the doula, as it is clearly a significant aspect of their job when assisting a birth in a hospital or otherwise medically-affiliated setting.

Elianna is not alone in her articulation on the pragmatism of performative teamwork. Many of the doulas reference a sort of performative method through which they deal with the medical world; Doulas articulated patterns of creating dynamics of this sort which might be manifest in the form of a doula asking questions to the nurse or the doctor or repeating something the doctor said. This idea of collaboration as a necessity seemed allow the doulas to feel more comfortable socially, as these methods of inciting teamwork frequently soothed the

relationships between medical staff and doulas on a personal level. This, as well as another aspect of performative teamwork as embodied by doulas came to light when Lori referenced her personal incorporation of this method.

And sometimes the nursing staff are wonderful, and so we kind of bring them into the fold and be like "Yeah, you're part of our team!" And I help kind of use them to engage in discussion. A lot of my question asking is in this faux-naïve kind of way ... it's partly to say, to show the client look, this is how you can interact with someone and ask the questions, and also to show the nurse we are considering every single step of this birth. Every single decision that is being made is a group collaborative event.

Lori's use of presenting as more naïve than she genuinely believes herself to be appears to have a function that is two-fold. As congruent with previously mentioned goals of performative teamwork, Lori's interpretation eases medical staff-to-doula dynamics on emotional and practical levels. Additionally, this alliance-creating approach seemed to create more room – physically and metaphorically– for the doulas to provide the type of services in which they are trained: that of emotional and occasionally physical support for their clients. In other words, Lori is expressing that, not only does she rely on performative teamwork as a method to maintain a productive, civil dynamic with medical staff, but also as a model for how her clients may do so as well. It is therefore evident that the doulas' use of performative teamwork is an important process not only for their relationship with their medically-affiliated counterparts, but also for their own sake of fulfilling what they see as their responsibilities as doulas more generally. Considering that the absence of this would likely result in further limitations placed on their already finite ability to perform their role as a doula, it is clear that performative teamwork is an integral aspect of doulas' public identity when interacting with the mainstream medical world.

Even though the above described behavior oriented towards teamwork is conducted through a performative pattern, the will to work together with the medical world is not a mere facade presented by the sect of the doula community that participated in this study. In fact, when

discussing these allusions to incite teamwork, it became clear that a more naturally “negotiated” dynamic is desired. This sentiment is articulated clearly by Lori when she states,

It would be nice to have more dialogue with the obstetric community. I feel like so often, and you can probably kind of sense from my tone there's a sort of very eye-rolling "Ugh, there's doctors, ugh there's hospitals, ugh." Because, philosophically, we kind of butt heads on a lot of things. It would be nice to feel more collaborative. I just don't think they have time for that. It doesn't seem like they have time to see birth workers, and talk to pregnant families about what they want

While demonstrative of the doulas’ personal beliefs, this comment is still reflective of a part of the doulas’ conception of their public identity as it relates to how they view themselves when they work with the mainstream medical world, which occurs on a public, and shared level as well as to the medical world’s public conception of doulas. In other words, as this sentiment of desired collaboration reflects the reasoning behind certain behaviors which contribute to the doulas’ creation of their public identity, it is as well a part of this aspect of their identity.

Natasha also articulates her hope for the perceptions of her field to become negotiated without the performance of the doulas. This is clear in her overall conception of how the medical actors with which she works may present as unwilling to collaborate regardless of how she approaches the dynamic.

I’ve had medical staff who think I’m in the way, who don’t like anyone who may be questioning, because usually that’s easier or efficient for them, [the medical staff] may feel like I’m going to do something antagonistic...But, in my best case, I want to be cooperative with staff...I’m not one of those doulas that’s like ‘I’m going to save you from the terribleness of the medical establishment’...I’m very much collegiate and cooperative, but that doesn’t mean that the staff is going to be collegiate or cooperative with me...I have seen so much that the choices that the medical staff make really affect people’s outcomes and people’s experience, so if I can facilitate teamwork where everybody’s trying to do the same thing...to make sure the client’s really getting heard and really get the best decisions that are made for them and not just what’s a generally, procedurally best situation...I’m going to do that with the assumption...that the medical staff is there in good faith, they also want the best thing for people

It's clear that Natasha genuinely wants to believe that the medical actors with whom she works have a similar motivation as her for the work that they all do: to help birthing people and their babies experience healthy and safe births. This may not always be the case, especially with the births at which Natasha doulas, considering she primarily supports poor women of color on a volunteer basis and the rates of obstetrical violence⁸ are higher for this population (Ross and Solinger 2017). However, since Natasha claims to have this mindset for all births from the outset, it may be asserted that this is a significant part of what she views as her responsibility as a doula. Furthermore, since it is in at least partial response to the stereotypes which medical actors largely have about doulas, it is a part of her public identity as a doula.

While this comment directly references the dynamics in which other participants claimed to present PT, Natasha isn't claiming to use it herself. Rather, by presenting that she genuinely believes that the medical personnel have the same goals as her, she is articulating *why* the doulas would engage in PT at all in the first place. Essentially, this comment solidifies that doulas engage in PT as a mechanism by which they may be able to manage how at least one aspect of the public perceives their role. As it is in response to the medical world's assumption of the doulas as a supplementary rather than an integral component to the birthing process, this shows that engaging with performative teamwork is a significant part of how the doulas integrate negotiation work within the creation of their public identity.

This is particularly interesting, because, as mentioned previously, it is oft assumed that doulas, as an alternative and non-medical form of care, do not support any form of medical

⁸ Obstetric violence is defined as "...birth injustices such as forces Caesareans and other unnecessary medical procedures, some of which have resulted in women being imprisoned for poor birth outcomes if they resist this treatment...many women report that they have been bullied in hospitals into accepting aggressive medical interventions they did not want or necessarily need. They are often denied midwifery services and hospital staff members often ignore a woman's birthing plans" (Ross and Solinger, 2017: 188).

intervention. This notion was frequently disproven by the sample of this study. Each time the medical world came up, unsurprisingly (given the aforementioned association between doulas and the affinity for ‘naturalizing’ or ‘demedicalizing’ the entirety of reproductive processes) the participants in this study referenced a distaste for the –according to their analyses– unnecessary and abusive reliance on medical technology. This was especially the case in regard to medical endeavors used for the purpose of inducing birthing people to have quicker labors when there is no emergent need. Jordin referenced this surprising acceptance of medicinal services frequently provided to birthing people and subsequently addressed the root of doulas’ distaste with them.

If used wisely, epidurals are incredible. If used wisely the narcotics or the nitrous oxide gas have very specific roles in supporting the unique story of a woman and they’re not all bad. But they’re definitely over used and abused in our medical system right now for birth. And a lot of women make decisions for medication out of fear, not so much out of information or informed decisions.

Even though the doulas may genuinely have faith in the techniques employed by the doctors, Jordin’s comment shows that the doulas may perceive of their application as responsible based on a different set of values –that is, one rooted in the interest of the clients’ knowledge, as opposed to being rooted in making the doctors’ jobs easier. This difference of conceptual approaches is significant enough that the doulas must negotiate their alliance with the medical public with which they work through the use of techniques like performative teamwork as a way to constantly manage their public identity.

Conclusion

The notion analyzed in this chapter is one of impression management within the doulas’ public identity creation as embodied by “negotiation”. This is representative of the particular ways through which doulas, as an entity rooted in alternative knowledge, must navigate the medical system, which is oppositional rooted in authoritative, or more widely accepted

knowledge. More specifically, doulas, when working in a medical setting and therefore engaging with what is largely considered the authoritative knowledge of the maternal healthcare system in the US, rely on their own iteration of impression management –performative teamwork– in order to be accepted in their role.

As was mentioned in this chapter, this is an example of entering the medical system through a “backdoor” (Torres, 2013). While in response to their hierarchically lower position in relation to the medical world, this may still be interpreted as a form of alternative knowledge reliance in that they are navigating the system in order to provide support to their clients. The doulas’ public identity as performatively appeasing medical actors is demonstrative of the overarching nature of medical professional dominance. However, this exploration of “performative teamwork” nevertheless adds to the overall argument of this study of doulas as an actor within the decline of medical professional dominance, in that it shows how doulas manipulate the potentially unjust system in order to keep their clients safe. Essentially, they understand that the system in which they are working is complex and that they must appease the authoritative knowledge producers and enforcers in order to embody their alternative knowledge for the sake of those whose care they are in charge of, their clients.

In order to support this argument, it must be acknowledged that performative teamwork may easily be interpreted as doulas embodying a medical professional role and therefore allowing the actors within this field to maintain (at least a sense of) control. However, the doulas work towards creating a collective identity from which they may successfully empower their clients counters any gaps of this public identity they create in response to the medical world. This concept will be further elaborated in the next chapter.

Chapter Four: The Doula-Client Collective

Emotional Labor and Empowerment within Doula-to-Client Collective Identities

Each doula interviewed for this study had worked within a medical setting. However, this is not the case for doula populations at large. One of the only truly shared experiences of all doulas is the structure of working with a client. Therefore, it is important to include within a study of doulas their conception of identity in relation to the population they serve. The doulas all engage with their clients via intimate, and decidedly conditional frameworks. This is evident from the lack of a standardized “doula” practice. Of course, there are some foundational concepts, like effective methods of caring for people when delivering a baby, that are integral to the occupation. However, based on the information provided by the participants within this study, it became clear that the application of the doula practice is utterly dependent on the experiences of the doula, the client, as well as their relationships –which depend on many variables including the location of the birth, the concept of the most successful kind of birth for the birthing person, and the doulas’ knowledge, as will be elaborated on later.

This sense of un-generalizability of doulas’ relationships with their clients remained true when this aspect of the work came up within the interviews on which this study is based. However, the participants did present a common perception of how clients perceive them and how to respond to this perception by creating an alliance. This is important to acknowledge not only because of its shared quality among many different actors within this occupation but also, as it points to a trend of doulas establishing a “one-ness” between themselves and their clients, which is characteristic of an aspect of identity work, known as “collective identity” (Snow, 2001).

The Processual Nature of a Collective Identity

While a stable definition of collective identity does not exist, there is a consensus that “its essence resides in a shared sense of “one-ness” or “we-ness” anchored in real or imagined shared attributes and experiences among those who comprise the collectivity and in relation or contrast to one or more actual or imagined sets of ‘others’”(Snow, 2001). Furthermore, scholarly work has emphasized the role of shared and interactive process and action when analyzing sentiments of a collective identity (Melucci 1989). More specifically, collective identity is the outcome of an “agreed upon definition of membership, boundaries, and activities for the group” (Johnston, Larana, and Gusfield 1994). Essentially, collective identity refers not only to the process of the creation of a specific group of actors dedicated towards a shared sense of existence within a particular context, but also to the process of this group’s actions. Therefore, in this chapter I will explain the methods which the doulas use to create a sense of “we-ness” with their clients as well as the subsequent actions of this bond in relation to medical professional dominance within childbirth.

“...a voice in a sea of voices...”: Accepting Limits

In order to navigate the dynamic between themselves and their clients, the doulas expressed the importance of understanding their clients’ expectations of the doula role. The doulas frequently mentioned feeling as though they were hired as a preventative tool to keep the birthing person from experiencing any negative aspect of childbirth within a medical setting, or any hardship from the process as a whole. While this notion is absolutely supported by credible research, as described in the “What is a Doula” section of the first chapter, avoiding medical support in childbirth is not a sole insurer of a positive birth. More specifically, much of these

medical enhancements, while potentially over-relied upon, may be quite helpful to someone going through the birthing process. This acceptance of medical care as sometimes useful is referenced by the doulas of this study, as elaborated on within the second chapter, “Becoming a Doula”. The application of these medical procedures, is described as dependent on many other variables besides a doula’s presence, including the medical actor overseeing the delivery, the history of the birthing person, the nature of the pregnancy, and much more. Therefore, as Lori references within the following comment, it is quite inaccurate to claim that a doula should be considered a total anecdote to the presence of medical augmentation within childbirth. When discussing this, it was also common that the doulas expressed understanding that there are limits on what they can do. This becomes clear through comments by Lori as well as Suzanna.

...there’s this great responsibility like “oh, doulas are supposed to help with the C-sections, and help lower your levels of inductions”, but you [the doula] are still going to see those things, and you have to know that you can only do so much, and you're a voice in a sea of voices. And it's really up to them [the clients] to make the decisions.

Lori explains how she feels the aforementioned pressure placed on doulas by their clients because of the latter’s assumption that the presence of doulas can decrease their likelihood of receiving medical inductions or augmentations during their process of giving birth. Within this expository comment, Lori acknowledges that a significant part of her doula work is acknowledging her own limitations within the role, especially when the presence of medical augmentation is concerned, as this usually occurs beyond a doula’s control. Within this acceptance of her own impact on someone else’s birth, Lori is also acknowledging that in the end, she considers it as a part of the jurisdiction of the client to make the decisions that will affect the outcome of the process. Suzanna feels similarly to Lori, in that there is a cap on what a doula can do and that burdening herself with the entirety of the experience is not a part of her conception of being a doula.

I feel good, sure, if I provide a good experience for someone. But the flip of that is that if someone's birth goes like fucking horribly, is that because of me? Hopefully not. If it is, we've got bigger problems, but it's a fine line, and that's when meditation practices are really helpful to just to not get too attached either way. Recognize your humility in the experience. I have had moments where I see again, a sort of a decision getting made where I wish I could be like, "Hold on," but the most I can do is sort of look at a client or a client's partner and be like, "What's happening right now is..." and just let them speak for themselves.

Through this comment, it becomes clear that for Suzanna, a part of coming to terms with the inherent dynamic between doula and client is acknowledging and accepting that there are certain aspects of the birthing process that the former cannot impact. This is commentary on a doula's methods for coping with the outcomes of births. It is relevant to the overall process of creating a sense of collectivity between themselves and their clients in that it motivates the doula to understand from where the pressure on a doula in regard to the outcome and nature of births may stem, and subsequently where to direct the activity of this newfound alliance.

It's not the client's fault

While this pattern of expectations of doulas may understandably become a source of frustration for those within this role, the ones featured within this study showcased a particular way of dealing with it. This approach consisted of the doulas reminding themselves that the clients' will to assume the doulas' roles and to place responsibility of their birth outcomes on them is not due to sheer ignorance. As elaborated on through valuable commentary from some of the participants within this study, it becomes clear that a reaction to a client's perception of doulas is a part of the doulas' structuring of their work against the dominating nature of the medical profession's conception of childbirth. For example, Quinn explains that in order to remember this dichotomy, it is important for her to view the clients as the "victims" of the whole birthing system in general. She says, "I mean honestly the parents are the victims in all of this so

I don't know what parents should or shouldn't be. I mean they really are the victims of mainstream medicine honestly. So, something I've had to let go of is like getting furious that they [parents] don't know certain things.” Through this comment, it’s clear that Quinn views the inaccurate perception of doulas as the ultimate anecdote for a positive birth as a product of a larger system of maternal healthcare. Furthermore, it’s evident that she sees accepting this aspect of the field in which she works as a part of her job. In other words, this is the framework she must operate under in order to be successful within what she does. Lori echoes this sentiment when discussing how she perceives this relationship between herself as a doula and an overly-expecting client.

You don't want to apply blame to people, because they're only acting based on their comfort level of the process. I can't expect people to make this full U-turn from the way that the whole culture about birth is presented to them for the whole thirty five years of their life they've heard about labor being like this, and birth being like this...Obviously these images don't get erased by one conversation with me, it takes a long time to come around, unless you're totally willing and open and you are of that frame of mind to do that, you're ready to think differently about it. Otherwise they're going to take their sister's story, or their best friend's story, or someone at work's story with them into that delivery room. That's how I kind of absolve myself of these responsibilities, that I can't change their brain. I can't change the system and I can't change their brain. All I can do is try and steer and put my eggs and try and hatch where I can...I'm not some oracle, I don't know everything about this.

Lori’s comment makes it clear that she holds her clients’ perception of birth to a very high level in regard to the outcome of their birth experiences. Specifically, she references how clients potentially gain their fears from folks within their personal networks who are also impacted by the dominance of a medical model of birth and that this is what leads to clients’ notions of doulas as the ultimate remedy. Again, as was present within Quinn’s comment, Lori is explaining that a part of her work is accepting the status quo and working with clients regardless of their apparent naïveté. This pattern of doulas acknowledging the roots of –what they deem as– an unrealistic conception of their roles as held by their clients is a part of the larger process of creating a

collective identity. Essentially, within their methods to align themselves with their clients, the doulas' express undergoing a paradigm shift of sorts in order to direct their subsequent collective action against the dominance of the medical profession. This processual behavior will be analyzed in terms of the concept "emotional labor".

Emotional Labor

As mentioned in the beginning of this chapter, collective identity is processual. The collective identity of a group refers to both the alignment of ideals as well as the subsequent action towards the fruition of these shared ideals. The former aspect of this concept was shown through the doulas' practice of ideological processes in the form of accepting the limits of their role as well as the shortcomings of a birthing person's knowledge. This is done for the sake of alignment with their clients' perceptions of a positive birth experience. In this section, I am concerned with the activity of the collective identity being created. Emotional labor as an action component of the collective identity between doulas and clients demonstrates the role of the doula occupation in the decline of professional dominance, in that it renders the ideals of the client as the guiding force, at least within the activity of the doula and the client, of the childbirth process.

As was discovered through the use of narratives within the construction of individual identities (see chapter 2), it is often the case that the doulas of this study have a personal connection to this role. This remains true within other aspects of identity-creation as a doula, such as in relation to their clients. For example, Jordin articulates her personal take on the potentially tense or hierarchical dynamic between doulas and the general public. To do so, she invokes her own journey towards coming to terms with what a doula's role really is, which she articulates as one concerned wholly with the needs of her client, no matter their nature.

I think doulas...to some people feel like a luxury item or like, super hippy out there, like only if you're going to have a natural birth should you have a doula. So It's been very interesting to debunk my initial, utopian ideal about birth and kind of go 'no, this is so not about natural birth. This is about each woman's unique story and what she needs for birth.'

Jordin presents her tasks as a doula to be entirely responsive to the needs of the client for whom she is working. She describes that her interpretation of a doula role was originally in line with the aforementioned conception of doulas as held by their clients, that a doula is an ambassador for a natural birth. Jordin references that throughout her journey as a doula and from working with clients, she has learned the shortcomings of this mindset and that acting as a doula for someone implies aligning with their needs. This becomes a clear pattern within the doulas' accounts of creating a sense of collectivity between themselves and their clients in that the participants of this study continuously reference employing tactics to make themselves entirely available to whatever their clients' needs are, whether congruent with their own personal opinions, those previously articulated by the clients, or none of the above.

This pattern will be supported and analyzed through the application of "emotional labor". Emotional labor is usually embodied by people within a work setting, responding to their role requirements as desired by their organizational entity. Generally defined as behavior oriented towards managing feelings during service and/or interpersonal transactions, Emotional labor can be carried out in many different ways (Hochschild 1983; Niza and Shahar, 1998). This process "may involve enhancing, faking, or suppressing emotions to modify the emotional expression" (Grandey 2000). As emotions have been largely considered removed from social processes, emotional work, as a general concept, is often ignored within social science-based studies. However, with the employment of a symbolic interactionist perspective, this notion has been studied to have a profound impact on one's identity, as well as their perception of this (Franks

2003; Sandstrom and Kleinman 2005; Sandstrom et al. 2001). Essentially, symbolic interactionists insist that emotion is not able to be separated from social aspects of life as it defines much of our interactions with others and the spaces in which we exist (Clark 1997; Franks 2003). Furthermore, emotional processes have been documented as encompassing identity work in itself especially “when people possess an identity that attracts either strong moral opposition or ardent public support” (Fields et al. 2006).

Within this tradition of literature, and of particular relevance to this project considering its focus on felt identities, scholars have claimed that emotions allow us to define where we stand in the overlapping or defined spaces in which we exist; they allow us to move or to respond to cues within these settings which thus reflect our identities (Fields et al., 2006). In other words, the emotional labor as embodied by doulas is a signifier of their unwavering alignment with their clients’ needs and demonstrates a part of the process through which they create a collective identity. The behaviors expressed by the doulas as integral within their work with clients which I will be classifying as emotional labor are in the form of rhetoric as well as actions. Furthermore, this action of the doula-client collective enforces the notion of doulas impact on medical professional dominance, in that it allows the clients to feel a sense of control within their own births— something nearly impossible if the medical system is in possession of entirely unabridged authority.

“It’s not my birth”

Although the participants of this study practice independent of each other, and therefore, each iteration of their work is entirely different, some of the varying practices may be grouped within this section, “it’s not my birth” as they are all oriented towards the notion of a particular

framework. This conceptual categorizing of behavior will be referred to as “it’s not my birth”, as this is how a majority of the participants described it. “It’s not my birth” shows how the doulas maintain a sense of distance between their own personal preferences within births and those of their clients, in order to offer the appropriate support. This framework exemplifies emotional labor in that it represents a management of personal sentiments for the sake of the service exchange, which in this case, is a childbirth experience considered successful by the birthing person. Suzanna explains her interpretation of this mindset with the inclusion of a first-hand experience to support her claim.

You [the doula] have to let your client lead. A lot of it is through conversation, body language. You can become pretty adept at reading people, but also just, I would say I trust my intuition, but, you know, it's not my birth. So, at my birth, my intuition and the support I get from others is what helps me make my decisions, but my job as doula is to help people listen to their own intuition, and also to accept that they may make a radically different decision even than we discussed in a prenatal. So, my job might be to say something like, "Let's take a minute and take a breath," and letting the person articulate what they want in that moment, but maybe buying them a little more space. "Do you have any questions about what's happening, or do you want to take a minute to be just with your partner?" Something that returns them to themselves... [While practicing as a doula at a birth, a client] requested an epidural pretty much right away. ...but I remember just being like, okay, she picked that. She's a full grown adult. She doesn't need me to say, "But, you wanted a natural, remember?" She needed to be affirmed in what the decision that she first chose to make at that moment in time, based on everything that was going on within and without, and there it was and so, we did that birth. if you were too attached to your own ideology, or even what your client had said, you could kind of railroad someone's birth, and that is not really my job. It's not for you to be convincing or preaching or whatever, and so you could very easily make somebody feel bad about their own decision making and process and so, “it's not my birth” is a pretty common inner counsel that you give yourself as doula.

Through this comment and example, Suzanna is providing insight into how she may provide someone with the most effective assistance at their birth, that is, by basing her behavior on the client's' preferences within the moment. By reminding herself “it’s not my birth”, Suzanna is adhering to the needs of her client, whether or not they match her own personal ideals or not and is thus practicing emotional labor. This process of managing one’s own perceptions of the

situation at hand is also referenced in Quinn's comment regarding how she copes with assisting births with people who have values different than her own.

I've learned to not take things personally. I've learned that it's not my birth. And even though I would do differently, it's not my birth and even when someone's telling me one thing and they're doing another, it's because they're not ready to do what they say what they wanna do. My morals really aren't relevant to their birth. I mean I'm like firmly against circumcision, and one of my clients circumcised and that's really devastating for me, 'cause I truly feel that they're mutilating their children, but I can't say that.

Quinn's comment showcases that by employing the "it's not my birth" framework, she is able to not only support her clients' decisions within the moment, but also makes sure she is not forcing them to do something for which they are not fully prepared. In other words, by managing her own emotionally-based, personal ideas in response to the clients' wishes, she is catering to their needs as they become apparent. This aspect of a doula's work towards aligning their identities with those of their clients, was addressed several times throughout the research process for this study.

For example, Jordin presented her own iteration of "it's not my birth" when describing how certain experiences as a doula remind her of her own traumatic experience with childbirth when she says, "And...there are a few situations during [clients'] births where I was like "oh trigger to my birth!" But I think it almost happens that way on purpose. Because you need to face it and go 'well this isn't my story this is their story. And what do they need.'" Jordin is committed to her clients' ability to have a positive sense of their childbirth experience, even when they threaten her own sense of mental wellbeing. The intense nature of this management of emotional response, considering it is related to a highly personal experience of Jordin's, embodies emotional labor to the fullest extent. Elianna mentioned a similar conception of her maintenance of unwavering support when she worked as an abortion doula.

I have worked with people who don't like abortion, but decided they need and want one. My job wasn't to make them pro-choice, just to make them comfortable in their procedure. It was deeply frustrating for me, but I did not make it about my views, it was about the patient and their needs.

This comment portrays that clients, while utilizing the services of a doula, may not be totally aligned with the ideals of their particular doula. In other words, people may come to be in need of a doula's services not by choice, but because of necessity and doulas, such as Elianna, nevertheless manage their personal ideals for the sake of their clients' experiences. The emotional labor necessary to assist the outcome of whatever the client may deem a positive birth is integral within doulas' conceptions of collective identities in that they set the stage for another action component of this dynamic.

Empowerment

In this section, I am concerned with another action-based component of the doula-client collective identity. I will describe how doulas encourage the dissemination of their and the clients' collectively-supported preferences through the empowerment of their clients. This collective action is through the clients' vocalization their wishes as directed to the medical actors charged with their care. Empowerment as the action component of the collective identity between doulas and clients demonstrates the role of the doula occupation in the decline of professional dominance, in that it places the control of the birth in the hands of their clients as opposed to those in the medical field.

In order to justify this action work as the empowerment of clients, a review of this term is necessary. "Empowerment" is a term largely debated across a wide range of scholarship and is thus not easily defined. In fact, many scholars invoke this "fuzziness" as the source of the concept's value (Kabeer, 2001). One format through which it is fruitful to perceive of empowerment is through clinical sociological studies which highlight its effectiveness as a

behavioral corrective treatment. In this context, “empowerment” is the purposeful enhancement of one’s conception of their values and goals and the autonomous inclusion of these within daily behavior (Babad, Birnbaum, & Benne, 1983). Also within this construction of empowerment is the idea that “an empowered person makes meaningful commitments and undertakes effective goal-oriented activities” (Hall, 1990). While articulate, these notions of empowerment are highly interpretive in that their substance is based on elusive concepts of identity and behaviors. Other scholarship which has employed this term and thus attempted to define it, has framed empowerment as that which allows for increased communication, goal setting, and a willingness to perform independently and responsibly (Hardy and Leiba, 1997). More generally, one study describes that “empowerment...refers to the processes by which those who have been denied the ability to make choices acquire such an ability...empowerment entails a process of change” (Kabeer, 2001).

With this literature in mind, and for the purposes of this study, empowerment is the process of encouragement and practice of decision making and behavior that reflects one’s personal values. More specifically, the process of empowerment as embodied by doulas is representative of their conception of a collective identity with their clients in that it demonstrates collective “action” in the form of a doulas’ knowledge of the childbirth and healthcare system, while allowing for the salience of the particular needs and preferences of each client. Empowerment in this way adds to the overall purpose of this study –doulas’ roles in the decrease of medical professional dominance within childbirth– in that it shows how the doulas extend their ability intervene within the process to the clients themselves and therefore allow them a sense of control within their experiences.

It's not about birth

Similar to the previous trend in doulas' conceptions of their relationship with clients, this aspect refers to the notion that a part of being a doula and working with a client is understanding that the job is not solely focused on the delivery of a child. As elaborated on by many of the participants in this study, the creation of a collective identity between a doula and their client involves the empowerment of the latter with the knowledge of the former. Lori emphasizes this aspect of her occupation when she states,

This work is not about birth. It's about like really opening people's mind to the possibility that can happen in their lives. Like the change that can happen in their lives. It sounds really cliché, but like the birth experience is like this portal, it can be a traumatic event that they are recovering from for the rest of their life. But can also be this like powerful, challenge, this experience that they've overcome or never thought they would even get pregnant, let alone have a beautiful birth. You know, they can draw on the experience for the rest of their lives...I like sharing information. I like empowering couples. It's not just about the birthing person, but the couple sees their role as being, like I really shift the responsibility to them and make them take ownership and responsibility for their birth, it's not my responsibility. I'm not gonna save them. The doctor surely isn't gonna save them. Their midwife's not gonna save them. It's really in their power and it's their first like step of parenting is taking ownership and responsibility. So that's my role to give them all these tools so that they don't resort to the tool that has many, many side effects.

Lori's comment demonstrates how she empowers her clients; She encourages her client's participation and sense of control within their birth experiences. Instead of viewing her role as merely a support system throughout childbirth, she considers it an educational and emotional partnership between herself and her clients. Through this process of empowerment, Lori is reframing birth as a shared experience through which her clients may be able to rely on their own ideals to navigate a process usually dominated by the medical profession. Other participants provided insight into how this sort of client-inclusion and education is brought to fruition.

For example, Natasha describes her strategic relationship with clients as starting far before the birth. This is evident through the articulation of her goals when she meets with her clients before they go into labor, referred to as prenatal meetings. In this comment, she makes it clear that while she has much advice to provide her clients, she is cautious not to overstep where she sees a boundary –speaking on behalf of the clients– and risk stating something not in line with their wishes.

I hope that in the prenatal meeting, I've communicated with the client about how to ask good questions...I'm providing a framework for people to make great choices. I hope that I've given my clients the tools to ask the right questions or ask for time to talk to me about it or to make a good decision...to ask why are you recommending this, what's going on...[During birth] if the client...looks like they are wanting to ask a question or feeling nervous or feeling uncomfortable but feeling afraid to speak up...I don't become my client's voice. I advocate for people when they want the help, but I don't step in. I will sometime ask the question that's getting unasked without making the decision...*Sometimes I will speak up, this happens to me a lot because I work with clients who may be younger, clients of color, who may not feel like they have a voice in that context. to make sure that they get heard and get good information to make good decisions and helping to facilitate that, if for whatever reason that isn't happening.*

In this comment, Natasha explains an emotionally-managed interpretation of empowerment. She references that by prompting her clients with methods to express their personal ideas within a birth, she is essentially allowing them to make decisions which are aligned with their own values and are therefore good. Furthermore, she emphasizes that she will not speak for her client unless she feels it is absolutely necessary, thus highlighting her commitment to the clients' choices being respected and the most influential factor in the delivery room. Jordin expresses a similar conception of her role in relation to her clients

That's really a big part of what I do, just helping them [clients] develop questions and also develop this kind of mindset of exploring these benefits, risks, and alternatives so they can feel confident in their medical decision making. Also, we [doulas] get to know the hospital environments around here and the nurses and the doctors and the reputations so we could help our clients ask the right questions so that they could have the right picture in mind of what they were signing up for, what they were hiring, what

environment they were going to be giving birth in and how that would affect their birth experience.

Jordin's iteration of enforcing her clients' authority while they give birth is centered on confidence. Representative of empowerment, this comment demonstrates how Jordin offers her unique insight, as an experienced doula, into the environment where her clients' will be giving birth as a model to frame how the clients can best present their preferences in a space not necessarily designed for that efficacy. This combination of placing the clients' in a position of control in that they are able to act on their personal preference, as well as being able to draw on the doula's knowledge is essential within the process of the collective identity between the two. Lori furthers this idea of promoting her clients' confidence as a consumer within a medical setting when she says,

I try and kind of plant in my clients' heads that this doctor and this hospital is in service to you...They're getting paid lots of money for your birth, there might be other easier [patients] around, but be the squeaky wheel...make some noise. A lot of the prenats, for me at least, is establishing a philosophy. Trying to encourage people to feel more emboldened with their power, because many people feel powerless to the authority of the white coat.

This information explains that Lori's relationship with her clients, and therefore her conception of their collective identity, is at least partially concerned with the encouragement of her clients. Specifically, she explains that her role is to help her clients feel confident that the doctors in charge of their care, are in fact working for them. Lori's particular iteration of her collective identity with her clients is one in which she contributes her knowledge of the medical structure in order to combat the fear of doctor's authority her clients probably have. Similarly to the rest of the participants, this sense of empowerment within the collective identity dynamic is for the sake of the clients' satisfaction with their births. This outcome seems to only be possible

if the clients are given a sense of control over their birth. According to Jordin, even if the overall experience is challenging, a client can still feel this positive sense of control.

I can support women so that they don't have an awful traumatizing birth experience. Like even if it is the most complicated, challenging labor experience, that if they have the right support and they have the right information, and they feel in charge of their bodies and in charge of their birth and they can come out on the other side and can say "well, I had what I needed for that journey even though it was fucking hard."

Within this comment, Jordin is highlighting that even if a client's birth is difficult, they are still entitled to a sense of empowerment. She makes clear that this sense of control and knowledge is possible only if they are given the right support, which she, as a doula can provide.

Conclusion

This chapter shows that the doulas construct a collective identity with their clients in order to resist medical professional dominance and its effect on their clients' childbirth experiences. Due to the processual nature of collective identity in both its creation as well as its activity, this is done through a series of components all working towards a similar outcome. These processes include ideological shifts on the doulas' behalves in order to properly align themselves with the wishes of their clients including accepting the limits of their role as well as accepting that the high expectations clients have for doulas is because of the shortcomings of the medical system in general, and therefore not the clients' fault. The action-based aspects of the soul-client collective identity is two-fold which involves the provision of emotional labor as well as empowerment for their clients.

Emotional labor in this context, implies the doulas ability to set aside their personal conceptions of birth in order to fully unite with their clients' needs. This activity supports the overall argument of this study, because it shows how the doula allows for the ideals of the clients to be placed at the forefront of the experience, which is decidedly not the case if the medical

profession –unable and unwilling to cater to every need of the client– is in possession of total dominance. Empowerment, on the other hand, is the embodiment of the doula’s knowledge by their clients. Essentially, this action-based process of the doula-client collective identity demonstrates that the ability to impact the nature of their birth can be under the jurisdiction of the clients and not solely under that of the overarching medical profession.

Conclusion

Throughout this project, I show how doulas contribute to a decline in medical professional dominance. The introductory chapter, dedicated to a review of literature relevant to this study, demonstrates how professionalism as embodied by the medical system, has been studied through a variety of lenses. The most robust of these theoretical frameworks, posits that the medical profession has intentionally accrued dominance over societal knowledge but also that this dominance is on the decline. Also documented in Chapter One, is how this medical superiority and its decline are, respectively exemplified by the medicalization of childbirth as well as the rise in popularity of the alternative resource, midwifery. I postulate doulas as the continuation of these countering efforts.

The symbolic interactionist nature of this study is embodied by each chapter's unique focus on a different aspect of identity as presented by the doulas, dependent on the varying aspects of their work. By analyzing their identities, the doulas' purpose takes on a meaning far beyond an oft-assumed vision of them as a superficial or consumerist entity. This insight into how doulas view their work in relation to several different aspects of it, themselves, their medical counterparts and their clients, is valuable in that it gives the occupation new significance; the conceptions of their individual, public, and collective identities which the doulas present showcase their nuanced structure and therefore their efficacy when engaging in the decidedly radical work of an alternative.

In Chapter Two, the application of narrative theory allowed for the conception of the doulas' individual identities within the process of becoming a doula. This demonstrated that childbirth as a learning opportunity for experiential knowledge was integral within the doula's notion of transitioning into this role. Further analysis of this method and content of information

shared emphasized the political nature of the doulas' individual identities. The relationship between political motivation and alternative knowledge bases, reinforced the ability to view the doulas as this latter category, and therefore capable of infiltrating the dominance of the medical profession.

Chapter 3 portrays doulas public identity with their medical as an example of “performative teamwork”. This supports the doulas' ability to impact medical professional dominance in that they, as an alternative health care provider, can strategically integrate within doctors' area of “expertise” and continue to provide their particular iteration of care. Chapter 4 shows how the doulas construct a collective identity through a total acceptance of their clients' needs and the empowerment of their clients to use doulas' knowledge base in order to manipulate the medical dominated process of childbirth to refocus on the birthing person.

Chapter 4 demonstrated the processual construction and activity of the doula-client collective identity. This is carried out through a reliance on emotional labor to align the two parties' ideals, with an emphasis on the clients' preferences for their birth experience. The collective identity is strengthened through the doulas' empowerment of their clients through the offering of knowledge and communication skills which shift the control from under the jurisdiction of the medical profession back to the birthing person.

While each component of this study contributes to a different aspect of the identities of those in the doula occupation, the underlying theme within these findings is of doulas as extraordinarily aware of their clients' needs. Considering the maternal mortality crisis within the US maternal healthcare system, this research may point to important insight into the doula role.

More specifically, The United States spends more on health care per capita than any other country in the world but is lacking in basic health indicators. Infant and maternal mortality rates

are of particular interest within this discussion as these statistics point to a variety of telling factors about a society such as maternal health, quality and access to medical care, socioeconomic conditions, and public health practices. (MacDorman and Mathews 2008). The US is one of 13 countries in which maternal mortality rates have risen over the past 25 years; Currently about 700 women die each year in the United States because of pregnancy or delivery complications. Furthermore, this issue is even more disparate in regard to race: Black women are three to four times as likely to die from pregnancy (CDC, 2018). This is clearly a pressing issue and in order to confront it productively –meaning with an orientation towards what can be done to counter this trend– a restructuring of the medical systems is integral as this is the entity through which most births occur (CDC, 2016; Declerq et al., 2013).

In light of the research presented in this study, future policy reform could tackle this issue via the either the inclusion doula services within medical institutions and/or the coverage of doula services by insurance providers. This integration of what is clearly a dynamic and client-centered occupation could significantly impact the state of maternal healthcare in the US for generations to come.

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Appendix A: Interview Questions

- 1) Tell me about yourself
 - a) Where are you from?
 - b) How old are you?
 - c) Do you have children?
 - d) Have you ever been pregnant?

- 2) Tell me about your role working with pregnant women
 - a) What is your official title?
 - b) How did you come into this role?
 - i) How long have you been in this role?
 - c) Was there a training involved?
 - i) If so, what was the format and content of this training or certification like?
 - ii) What was the most important thing you took away from this training?

- 3) What is your definition of a “successful” pregnancy?

- 4) Tell me about your clients
 - a) Describe the interactions with your clients. What are your goals during these interactions at each of these specific time periods?
 - i) Before a birth (how do you meet?)
 - ii) Throughout pregnancy
 - iii) During a birth (if applicable)
 - iv) After a birth (if applicable)
 - b) Do your clients fall into a particular demographic category? [Racially, socioeconomically, politically]

- 5) How do you determine your clients’ needs?
 - a) Does this differ based on a client’s identity? [i.e. race/socioeconomic status]?

- 6) Describe interactions with other people/entities that work with pregnant people
 - a) Who are these people/entities?
 - b) What do these interactions look like?
 - i) How or why do they happen?
 - ii) What is the content of these interactions?
 - c) Do you find these people/entities to be an obstruction or beneficial to your role? How so?

- 7) What do you think about the current state of medical care available for pregnant women in the US?

- 8) Tell me some general reflections of your role working with pregnant people
 - a) What are/is something(s) you dislike/are uncomfortable/wish to change about being in this role?
 - b) What are/is something(s) you appreciate/respect/enjoy about being in this role?

- c) Do you have hopes and/or expectations for the future of this kind of work? If so, what are they?