

AN ABSTRACT OF THE DISSERTATION OF

Courtney L. Everson for the degree of Doctor of Philosophy in Applied Anthropology
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Title: “I’m a Mom too!” – Stigma, Support & Contested Identities among Adolescent Mothers in the United States.

Abstract approved:

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This dissertation aims to provide a comprehensive portrayal of doula care in the lives of pregnant and parenting adolescent mothers. The purpose of this research was to examine the relationships between psychosocial stress, social support, institutionalized constraints, and their impacts on health and well-being among adolescent mothers in the Northwestern United States. Guided by a biocultural approach and mixed methods design, this study involved five primary research activities and sources of data: 1) long-term, extensive participant-observation in teen parent and doula communities; 2) semi-structured, open-ended interviews with two comparative cohorts—doula-supported adolescent mothers (n=24) and non-doula supported adolescent mothers (n=18); 3) semi-structured, open-ended interviews with doulas that provide care to young mothers (n=15); 4) descriptive analyses of maternal-infant health outcomes from a national sample of doula-supported adolescent women (n=1892); and 5) content analysis of published literature on doula professional standards, core competencies, scopes of practice, and care philosophies.

Through a series of manuscripts, I examine doulas from four perspectives, that of: young mothers, doulas, outcomes-based health data, and textual representations of doula models of care. In using a multiple vantage point approach, I am able to situate understandings of doula care within the larger social contexts and structural forces that frame the experiences of young mothers and the integration of doulas into maternity reform strategies. In doing so, I explore how psychosocial stress, social support, and institutionalized constraints pattern the negotiations, aspirations, and outcomes of young women during their emergence into motherhood. By focusing on the synergy between micro- and macro-level elements, I demonstrate the potential for doula care, as a targeted form of social support, to advance health equity and long-term social well-being for young mothers and their families.

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"I'm a Mom too!" – Stigma, Support & Contested Identities among Adolescent Mothers in the United States

by
Courtney L. Everson

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APPROVED:

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I understand that my dissertation will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my dissertation to any reader upon request.

Courtney L. Everson, Author

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CONTRIBUTION OF AUTHORS

Dr. Cheyney serves as my co-author in Chapter 5, contributing original content to the conceptualization and final writing of the manuscript. DONA International manages the data collection project discussed in Chapter 4, and Stacey Klamman at the University of North Carolina at Chapel Hill—jointly with DONA International—provisioned the adolescent dataset for use in Chapter 4 analyses.

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Chapter 1: General Introduction

I just think that we need to get our voice out there more. The stigma of teen moms needs to change. You can still go to high school and college, and you can get your own place, your own job and car, and succeed in life. I think that everybody paints a negative picture when they see a young parent, but the positive stories are possible. We just need more support. Doulas are that support and so much more.”

~Reneeⁱ, Age 17, Doula-supported mother

This dissertation aims to provide a comprehensive portrayal of doula care in the lives of pregnant and parenting adolescent mothers. Through a series of manuscripts, I examine doulas from four perspectives, that of: young mothers, doulas, outcomes-based health data, and textual representations of doula models of care. In using a multiple vantage point approach, I am able to situate understandings of doula care within the larger social contexts and structural forces that frame the experiences of young mothers and the integration of doulas in maternity reform strategies. In doing so, I examine how psychosocial stress, social support, and institutionalized constraints pattern the negotiations, aspirations, and outcomes of young women during their emergence into motherhood. By focusing on the synergy between micro- and macro-level elements, I demonstrate the potential for doula care, as a targeted form of social support, to advance health equity and long-term social well-being for young mothers and their families.

PROJECT CONTEXT

In 2013, 273,105 women between the ages of 15 and 19 gave birth in the United States, for a birth rate of 26.5 live births per 1000 population (Martin et al. 2015). Further, the United States (US) holds the highest teen birth rate of all industrialized countries: an adolescent in the US is ten times as likely to give birth than a teen in Switzerland, four times as likely as her counterparts in Norway and Germany, and two-

and-a-half times as likely as an adolescent in Canada (Kearney and Levine 2012; Sedgh et al. 2015). In the US, deep disparities exist within adolescent childbearing populations, where geographic, racial/ethnic and socioeconomic variability is high. Geographically, teens in the southern and southwestern states continue to see higher birth rates than their counterparts in the northern and eastern states, and teens in rural areas have higher rates than those in urban and suburban areas. When trends are examined by race and ethnicity, teens identifying as non-Hispanic black and Hispanic are greater than two times as likely as their non-Hispanic white counterparts to give birth during their teenage years, and American Indian/Alaska Native teens have nearly twice the rate of adolescent pregnancy as non-Hispanic whites. Additionally, teens from families of origin with low socioeconomic status, as well as those in foster care, are at greater risk for teenage childbearing (Ventura, Hamilton, and Matthews 2014). The causes and underlying factors contributing to these US patterns and variations continue to be debated, and are majorly linked to social inequities in families of origin combined with policies and programs that differentially influence access to family planning services and sexual health education (see: Gold et al. 2001; Holness 2014; McCracken and Loveless 2014; Santelli and Melnikas 2010; Sedgh et al. 2015; Singh and Darroch 2000; Upadhyia and Ellen 2011; Viner et al. 2012; Young et al. 2004).

The social identities and locations delineated above often interweave to act upon a teen's life in ways that contribute not only to higher birth rates, but also to alarmingly negative maternal-child health (MCH) outcomes and subsequent lifelong social inequities. For example, women between the ages of 15 and 19 hold some of the highest preterm delivery rates (12.98%), low birth weight rates (9.31%), and fetal demise rates

(7.19/1000) relative to other age groups (Martin et al. 2015; MacDorman, Kirmeyer, and Wilson 2012; McCracken and Loveless 2014). The negative impacts of adolescent motherhood extend far beyond these immediate birth outcomes, and deep socioeconomic inequities are seen both within and across generations (East, Reyes, and Horn 2007; Jutte et al. 2010; Smithbattle 2007). Adolescent mothers and their infants experience lower educational attainment, higher rates of poverty, lower rates of stable housing and food security, as well as increased difficulties with mother-infant bonding and delayed child developmental trajectories (East, Reyes, and Horn 2007; Jutte et al. 2010; Nicolson et al. 2013; Savio Beers and Hollo 2009; Ventura, Hamilton, and Matthews 2014).

The disparities faced by teens cannot be understood, however, as merely a result of age. Rather, these disparities reflect larger social inequities in their families of origin combined with structural limitations that inhibit young mothers from obtaining many of the markers of a healthy and sustainable life (Porter and Holness 2011; Quesada, Hart, and Bourgois 2011; Spangler 2011; Smithbattle 2007). Because of these additive barriers and the limited opportunities available during early parenting years, adolescent mothers utilize social services at consistently high rates: in 2012, 81% of teen mothers secured assistance from the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and in 2010, 76% of teen mothers utilized Medicaid as their primary payment source for delivery (Curtin et al. 2013; Ventura, Hamilton, and Matthews 2014). Collectively, it is claimed that teen childbearing poses an “economic drain on society” and a “financial burden on taxpaying citizens” (Bute and Russell 2012:712), wherein \$9.4 to \$28 billion per year is spent on adolescent births in the US through a combination of

social service programs, lost tax revenue, and the high expenses of public health, foster care, and legal systems (US Department of Health & Human Services 2015).

These statistics continue to be the primary focus of policy makers, medical professionals and researchers alike, and such numbers are used in support of dominant meta-narratives of adolescent motherhood in the US that construct teen mothers as "social problems" (Linders and Bogard 2014) afflicted with a "moral disease" (Inhorn 2006), and parenting adolescents as the "undeserving poor" (Silver 2008). Following, the emphasis in scholarly, social, educational, and medical realms remains on the prevention of teenage pregnancy, or as blatantly stated in one clinical journal: "A concerted effort is needed on the part of the doctors, family and society as a whole to counsel them and to bring down the incidence of this social menace" (Grover and Sandhu 2009:41).

In this dissertation, I attempt to move beyond a one-sided focus on the "costs" of young motherhood that perpetuates a "blame the victim" rhetoric to examine the micro- and macro-level factors that coalesce to shape young mothering experiences and the inequitable outcomes observed. The relationship between early pregnancy and poor health and social outcomes has often been interpreted by researchers and clinicians alike as the result of biological risk and immaturity, yet this isolated focus has produced inconsistent findings across studies (Kramer and Lancaster 2010). A growing body of research provides evidence that negative outcomes associated with adolescent pregnancy are less the result of biological immaturity (except for the youngest population of adolescents giving birth at ages 14 and under) and more a consequence of psychosocial risk combined with structural barriers and a lack of supportive networks (Cherry, Dillon,

and Rugh 2001; Erdmans and Black 2015; Kramer and Lancaster 2010; Magill and Wilcox 2007; Mantovani and Thomas 2014; SmithBattle 2013; Yardley 2008).

Cross-culturally, adolescent mothers experience increased psychosocial stress compared to their adult counterparts, and commonly come from disenfranchised families of origin (Cherry, Dillon, and Rugh 2001; Kramer and Lancaster 2010; Smithbattle 2007). However, in sociocultural milieus where pregnant adolescents are adequately supported, psychosocial risks appear to be mitigated and outcomes improved (Cherry, Dillon, and Rugh 2001; Cox et al. 2008; Delle Fave and Massimini 2000; Kim, Connolly, and Tamim 2014; Kramer and Lancaster 2010; Logsdon et al. 2005; McDonell, Limber, and Connor-Godbey 2007; Pires, Araújo-Pedrosa, and Canavarro 2014; Porter and Holness 2011; Smith et al. 2012; Wahn and Nissen 2008; Zachariah 2009; Smithbattle, Lorenz, and Leander 2013). For example, Kramer and Lancaster (2010) reviewed the young pregnancy and birth literature in light of two ongoing debates: the role of age in producing negative biological and social outcomes, and the confounding effects of socioeconomic factors. They argue that in “traditional” societies, young pregnancy is the dominant childbearing pattern, whereas in “developed” countries, teen motherhood is hotly debated as a public health issue and societal problem. They ask, then, what role age, versus sociocultural environments, has in producing documented poor outcomes in the developed (or industrialized) world. Their review leads them to conclude that it is only for the youngest cohort of mothers—those giving birth at 14 years of age and under—that biological risk and immaturity plays a strong (negative) role. For mothers between the ages of 15 and 19, adverse outcomes were associated not with chronological age, but

more with negative attitudes, a lack of supportive networks, subsequent isolation, and deficient early parenting resources.

Furthermore, the US is unique in its predominant construction(s) of young maternal age; cross-cultural discourses of teen childbearing, while often not encouraging of young pregnancies, also do not involve such a deeply held notion of disgust and contention as has been identified in the United States (Cherry, Dillon, and Rugh 2001; James and Rashid 2013; Jordan 1992; Kirk and Okazawa-Rey 2009; Kramer and Lancaster 2010; Silver 2008; SmithBattle 2013; Wiemann et al. 2005a; Wilson and Huntington 2006; Yardley 2008). Moreover, young childbearing in the US has moved from public indifference and invisibility in the 1950s and 1960s, to public concern in the 1970s and 1980s, to a “moral crisis” (Furstenberg 2010:2) by the 1990s through present times. (See Furstenberg 2003, 2010 for an in-depth review of the historicity of young childbearing as constituting a public issue and social problem). These additive stressors of stigma, judgment and low support may help to explain the increasingly poor outcomes observed in high-resource nations like the US. Their marginalized status positions young mothers as highly psychosocially vulnerable and this, ironically, may also make them more susceptible to the positive buffering effects of social support (Mantovani and Thomas 2014; Pires, Araújo-Pedrosa, and Canavarro 2014; Porter and Holness 2011; Smithbattle, Lorenz, and Leander 2013). Thus, adolescent mothers in the US are an ideal population for investigating the complex relationships between psychosocial stress, social support, and well-being.

The scholarship on both general social support and targeted social support (for example, doulas) in health susceptibility and social well-being has blossomed in the last

decade (Boath, Henshaw, and Bradley 2013; Cox et al. 2008b; Feldman et al. 2000; Kim, Connolly, and Tamim 2014; Logsdon and Gennaro 2005; McDonell, Limber, and Connor-Godbey 2007; Pires, Araújo-Pedrosa, and Canavarro 2014; Reblin and Uchino 2008; Shah, Gee, and Theall 2014; Wahn and Nissen 2008; Warner 2007; Zachariah 2009). Doulas are non-medical, childbirth support professional that provides emotional, physical, educational, and advocacy support to a woman and her family during the prenatal, birth and immediate postpartum period. Quantitative and qualitative studies have consistently demonstrated the positive effects of continuous labor support (i.e., doulas) for improving maternal-infant health outcomes and parenting experiences, specifically in the areas of: 1) improved clinical outcomes for both the woman and newborn; 2) cost savings through decreased interventions; and 3) improved mother-infant bonding and parenting experiences (Breedlove 2005a; Campbell et al. 2006; Campbell et al. 2007; Chapple et al. 2013; Edwards et al. 2013; Gentry et al. 2010; Gruber, Cupito, and Dobson 2013; HealthConnect One 2014; Hodnett et al. 2013; Kane Low, Moffat, and Brennan 2006; Kang 2014a; Katy Backes Kozhimannil et al. 2013; Kozhimannil et al. 2014; McComish and Visger 2009; McGrath and Kennell 2008; Mottl-Santiago et al. 2008; Nommsen-Rivers et al. 2009a; Phillips and Kelly 2014; Pilliod et al. 2013; Rohwer 2010; Sauls 2002; Steel et al. 2015; Strauss, Giessler, and McAllister 2014; Vonderheid et al. 2011).

However, current research is limited in demonstrating the pathways and processes by which social support improves both outcomes and experiences (Reblin and Uchino 2008; Sauls 2002). In this dissertation, I employ and expand upon the “buffering” hypothesis in understanding the relationships between social support and stress—a

hypothesis based on the claim that support can protect individuals from the harmful impacts of stressful situations and experiences (Cohen and Wills 1985; Farmer and Sundberg 2010). During childbearing, specifically, the interceding effects of social support on psychosocial stress is argued to decrease susceptibility to poor maternal-child outcomes, while also improving internalized notions of self-worth, maternal capability and confidence (Boath, Henshaw, and Bradley 2013; Brubaker and Wright 2006; Cherry, Dillon, and Rugh 2001; Campbell et al. 2007; Delle Fave and Massimini 2000; Dominguez et al. 2008; Giesbrecht et al. 2013; Kramer and Lancaster 2010; Logsdon and Gennaro 2005; Magill and Wilcox 2007; Hruschka 2005; Pike and Williams 2006; Reblin and Uchino 2008; Rodriguez 2008; Silver 2008; SmithBattle 2013b; Smithbattle, Lorenz, and Leander 2013; Warner 2007; Thoits 2010; Zachariah 2009). In centering attention on the culturally-embedded dimensions of psychosocial stress and support, I aim to elucidate the roles these play in producing variations in outcomes and experiences among adolescent mothers. In particular, I focus on the mediating element of doula care as a targeted social support intervention for improving the well-being of young mothers and their children.

The role of psychosocial factors in health and social inequities research has received increasing emphasis in the anthropological and broader social science literature (Bloom 2011; Bonell et al. 2003; Chisholm and Coall 2008; Coley et al. 2015; Dominguez et al. 2008; Dressler and Bindon 2000; Dressler, Oths, and Gravlee 2005; Gravlee 2009; HealthConnect One 2014; Hruschka 2005; Jiménez, Martín, and García 2000; Luttrell 2011; Matthews, Gallo, and Taylor 2010; McDade 2002; Spangler 2011; Thoits 2010). Collectively, this work has shown that health and well-being is not just

about vulnerability and risk, but rather, investigations must also account for pathways of protection, including the role of social support in mitigating psychosocial stressors (Boath, Henshaw, and Bradley 2013; McDermott and Graham 2005a; Campbell et al. 2007; Pike and Williams 2006; Reblin and Uchino 2008; Silver 2008; Worthman and Kohrt 2005). To advance research in human health and well-being, complex models are needed that can account for the interactions between micro- and macro-level factors, and include biological, political-economic and sociocultural determinants of health (Einstein and Shildrick 2009; Fuentes and McDade 2007; Hruschka 2005; Luttrell 2011; Mantovani and Thomas 2014; Quesada, Hart, and Bourgois 2011; Spangler 2011; Worthman and Kohrt 2005).

In this dissertation, I employ such a holistic model through the use of a biocultural framework (Goodman and Leatherman 1998). Biocultural approaches initially emerged from critiques within biological anthropology that health and biology are profoundly shaped by sociocultural factors (Armelagos et al. 1992; Dufour 2006; Goodman and Leatherman 1998; Hanna and Baker 1979; Stearns, Nesse, and Haig 2008; Wiley and Allen 2012). In 1998, Goodman and Leatherman proposed the new biocultural synthesis (NBS) as a theoretical perspective that examines the intricate connections between biology, culture and political-economy (Armelagos et al. 1992; Dufour 2006; Goodman and Leatherman 1998; Leatherman and Goodman 2011; McElroy 1990; Wiley and Allen 2012). Following Levins' and Lewontin's (1987) assertion that human biology is a social biology, Goodman and Leatherman's (1998) landmark edited volume—*Building a New Biocultural Synthesis: Political-Economic Perspectives on Human Biology*—attempted to sensitize human biology to the effects of political-economy, arguing that political-

economy should not be subsumed within the “cultural” of a “biocultural” approach. Rather, political-economy (or, unequal relations of power) should be separated out as a distinct component of a biocultural approach, alongside the conventional sociocultural and biological elements. The NBS attempts to operationalize power dynamics, poverty and the role of structural violence in producing health inequities.

To this end, one of the most notable chapters in Goodman and Leatherman’s collection is by R. Brooke Thomas (1998) on the “biology of poverty”, a concept Thomas uses to describe biological responses (i.e. – adaptation) to conditions of poverty, or the constraints placed on humans through social relations and structures that create differential resource distributions and options. The concept of the “biology of poverty” was profound for the time, but as Dufour (2006) notes, it is increasingly recognized as an inaccurate term insofar as it implies a single biological response to the same conditions of poverty everywhere. Dufour calls for replacing this term with “biologies of poverty,” where the multiplicity of poverty contexts and varying responses to unequal conditions are problematized. Thomas’ chapter is one of many attempts in the 1998 collection to illustrate the importance of expanding biocultural approaches to include explicit integration of political-economy. This commitment to models that are sensitized to the effects of power relations in health and welfare research marked the new biocultural synthesis as distinctly different from historical approaches to biosocial research that subsumed political-economy under the gloss of culture.

The comprehensiveness of the NBS makes it well-suited as a theoretical framework for exploring the role of psychosocial elements in experiences of well-being. However, Goodman and Leatherman (1998) did not originally operationalize

psychosocial factors when they argued for the NBS, and as a result, the NBS has been critiqued (Hruschka 2005; Pike and Williams 2006) for excluding an explicit integration of psychosocial variables. Advocates of the psychosocial perspective argue that proximal, psychological processes mediate the effects of macro-level sociocultural and political-economic factors on micro-level (individual) biologies and biographies (Adler and Newman 2002; Delle Fave and Massimini 2000; Goodman et al. 2005; McDade 2002; Hruschka 2005; Pike and Williams 2006; Rosland et al. 2014; Thomas et al. 2014; Warner 2007). As such, psychosocial experiences can have profound and lasting effects on health and internalized notions of worth and agency. Psychosocial health and well-being inquiries, however, remain an underdeveloped area in biocultural research (Dressler, Oths, and Gravlee 2005; Gravlee 2009; Hruschka 2005; Leatherman and Goodman 2011; McDade 2002; Pike and Williams 2006; Warner 2007). This dissertation situates psychosocial elements—notably, embodied experiences of stress, stigma, and social support—at the center of a biocultural framework. Here, I elucidate the synergistic effects of political-economic constraints and sociocultural practices on the health outcomes and subjective experiences of young mothers, and the role doula care plays as a mediating variable in these synergies.

Finally, in this work I draw on the scholarship of the anthropology of reproduction, contributing to theoretical debates on childbearing and body politics by highlighting the contentious cultural constructions on teen pregnancy and unequal power relations that interweave to shape young motherhood. Thus, critical medical anthropology (CMA) is of central guiding importance to this work, where intersecting systems of oppression (ageism, racism, classism) have reified age-based health inequities and

maintained systemic barriers to young mothers' well-being (Baer 1990; Luttrell 2011; Mantovani and Thomas 2014; Pfeiffer and Nichter 2008; Rodriguez 2008; Scheper-Hughes 1994; Silver 2008; Singer 1990; Singer 1995; Spangler 2011; Quesada, Hart, and Bourgois 2011). In combining CMA with a biocultural approach, I elucidate how the pathologizing frameworks employed in the care of young moms—where there remains an almost exclusive bias on the (assumed) physiological complications and public “costs” of young pregnancy—has diminished attention to both the lived, sociopolitical experiences of this marginalized population, and obscured more effective pathways forward (Barcelos 2014; Mantovani and Thomas 2014; Ellison 2003; McDermott and Graham 2005a; Silver 2010; Smithbattle, Lorenz, and Leander 2013; Wenham 2011; Yardley 2008).

RESEARCH OBJECTIVES AND DESIGN

The purpose of this research was to examine the relationships between psychosocial stress, social support, institutionalized constraints, and their impacts on health and well-being among adolescent mothers in the Northwestern United States. Four research objectives guided this work:

- O¹: to produce an ethnographic account of the lived experiences of US adolescent motherhood with a focus on experiences of psychosocial stress and support during the childbearing year;
- O²: to elicit the guiding philosophies and models of care doulas employ with young mothers;
- O³: to examine the impact of doula care, as a targeted form of social support, on the maternal-infant health outcomes and subjective experiences of young mothers;
- and

O⁴: to critically evaluate the position of doula care in the US maternity care landscape.

Guided by a biocultural approach and mixed methods design (Andrew and Halcomb 2006; Johnson and Onwuegbuzie 2004; Johnson, Onwuegbuzie, and Turner 2007; Mendlinger and Cwikel 2008; Stewart et al. 2008), this study involved five primary research activities and sources of data: 1) long-term, extensive participant-observation as a volunteer birth doula, perinatal health educator, and activist-anthropologist in teen parent and doula communities (fieldwork years, 2010 to 2015); 2) semi-structured, open-ended interviews with two comparative cohorts—doula-supported adolescent mothers (n=24, DSAM) and non-doula supported adolescent mothers (n=18, NDSAM); 3) semi-structured, open-ended interviews with doulas that provide care to young mothers (n=15); 4) descriptive analyses of maternal-infant health outcomes from a national sample of doula-supported adolescent women (n=1892); and 5) content analysis of published literature on doula professional standards, core competencies, scopes of practice, and care philosophies.

The participant-observation and qualitative interviewing (Bernard 2011; DeVault 2003; Green and Thorogood 2013) portions of this project took place in three research locales of the Pacific Northwest. Due to the sensitive and highly personal nature of material disclosed in interviews, specific locations are not given so as to maintain the confidentiality of participants, their families, and wider communities. During the fieldwork years of 2010 to 2015, I engaged in participant-observation in the research locales via three activities: 1) as a volunteer birth doula with a community-based organization providing pro bono doula services to young mothers; 2) as a perinatal health

educator with six high schools that provided school-based teen parent programs; and 3) as an activist-anthropologist, participating in numerous perinatal health task forces and allied community childbirth and parenting organizations. In total, I provided direct doula care to over 75 young mothers and worked with countless additional teens as an educator and advocate.

My positionality as both a medical anthropologist and doula, as well as my identity as a trusted presence among young women, teachers, doulas, community organizations, and clinicians, facilitated unprecedented access to and rapport with adolescent mothers, allowing me the opportunity to observe many of the relationships, interactions, and formative moments of mothering I describe in this dissertation. Additionally, my positionality as a white woman who appears younger in age and, at times (depending on attire that day) had visible tattoos, should be explicitly considered in light of the co-constructed nature of ethnographic research. For example, my more youthful and casual appearance was often noted by young mothers as “non-threatening”, and my familiarity with (and non-judgmental attitude toward) their experiences, ways of beings, and communication styles led many participants to disclose feelings like “you are easy to talk to” and “I feel comfortable telling you the whole truth because you get it.” My identification by participants in this way conferred me a certain level of “insider” status that arguably promoted additional access and depth in data collection that may not have been conferred to someone viewed only as an outsider with no prior involvement with young mothers (Bernard 2011; DeVault 2003; Naples 2004; Weinreb 2006).

However, I also possessed certain markers of privilege and “outsider” status during this research (e.g., white privilege, high educational level, moderate economic

status, adult, non-mother, non-teen mother) that created obvious power dynamics, which I strove to be consciously aware of during data collection and analysis procedures (Errante 2004; Hesse-Biber and Yaiser 2004; Marshall and Batten 2004). To this end, I capitalized on feminist approaches to interviewing (see: DeVault 2003; Harding 2004; Wilkinson 2004) and employed reciprocal ethnography (Charmaz 2011; Lawless 1992) as processes to help obtain inclusion of a multiplicity of voices and the sharing of power with young mothers. Through the research process and subsequent write-up, I strove to strike a balance between ethnographic authority as the researcher with multivocal manifestations of participants' narratives (Hesse-Biber and Yaiser 2003; Marshall and Batten 2004). In doing so, I call on the work of feminist scholar Nancy Naples (2004), who has argued for the falsity of the insider/outsider dichotomy, contending that this boundary is fluid and constructed, and through recognition of this fluidity, the false divide of insider/outsider can be challenged, power differentials between researcher and participants unmasked, and self-reflection on positionality and the co-constructed nature of knowledge production made explicit.

Following approval by the Institutional Review Board (IRB) at OSU, semi-structured, open-ended interviews were elicited from two voluntary cohorts of adolescent childbearing women—doula-supported adolescent mothers (DSAM, n=24) and non-doula supported adolescent mothers (NDSAM, n=18) between April 2014 and March 2015. I then engaged in thematic analysis of their narratives, and organized emerging, emic codes using the descriptive framework of shared critical moments (Thomson et al. 2002; Wenham 2011) and the theoretical model of vital conjunctures (Johnson-Hanks 2002; Johnson-Hanks 2006). I also employed reciprocal ethnography (Lawless 1992) or

“member checking” (Charmaz 2011) as a reliability and validity measure among the adolescent mother cohorts. Following preliminary analysis, I held a series of focus groups wherein I returned a summary of initial findings to a voluntary sample (n=13 total; n=8 DSAM, n=5 NDSAM) of interview participants, inviting them to comment on results and provide critique. Their feedback was incorporated into final analyses, and allowed for greater elaboration of emerging constructs.

To be eligible for this study, adolescent participants had to have given birth in the Pacific Northwest within the last seven years, the pregnancy and/or birth must have occurred between the ages of 15 and 19, and the baby needed to be at least eight weeks old at the time of the interview in order to answer questions about early parenting experiences. Because pregnancy is a lengthy process, women are likely to have an age change between the time of conception and the time of delivery. For the purposes of this study, either pregnancy and/or birth must have occurred between the ages of 15 and 19, meaning that mothers who conceived at 14, but gave birth at 15 are included, as well as mothers who conceived at 19, but gave birth at 20. Because previous studies have shown that women who give birth at ages 14 and under are at greater risk for negative outcomes as a result of both psychosocial *and* biological risks (Cherry, Dillon, and Rugh 2001; Kramer and Lancaster 2010; Jiménez, Martín, and García 2000; Magill and Wilcox 2007), I only included women ages 15 – 19 in order to focus on psychosocial risk and social support as cultural modifiers in health and social outcome variation.

Semi-structured, open-ended interviews were also elicited from a voluntary sample of doulas serving young families (n=15) in the Pacific Northwest, following obtainment of Institutional Review Board approval. To be eligible, participants had to

self-identify as a birth doula having served at least two young mothers (ages 15 to 19) in the seven years prior to the study period. A modified grounded theory approach (Charmaz 2006; Charmaz 2011) guided both data collection and analysis. Grounded theory was originally proposed by Glaser and Strauss (1967) as a systematic method for analyzing qualitative data. As originally proposed, Glaser and Strauss argued that all analytical codes and theoretical categories should emerge directly from the data, not from any preconceived notions of the researcher, and even called for doing literature reviews after data were analyzed. They believed that by using this method, themes could be “uncovered” by researchers in a way that was unbiased. Several grounded theorists following, however, critiqued this presumption and in 2006, Kathy Charmaz proposed a modified grounded theory approach dependent on what she called a “constructivist lens,” wherein the co-constructed nature of knowledge between researcher and participant is recognized. While researchers still attempt to allow emic codes to emerge from participants’ experiences, there is no pretense of starting the project from an “objective” standpoint. Modified grounded theory thus allows for a co-constructed, iterative, and flexible, yet systematic process of data collection, analysis and theory production, and is often applied in studies like mine where I began the interview process already well versed in the topic and, thus, having a sense of what I might find. Modified grounded theory allowed me to hear and incorporate themes I had not anticipated as I spoke with doulas.

The outcomes-based perinatal health data reported for a national sample (n=1892) of doula-supported adolescent childbearing women come from the Doulas of North America (DONA) International data project. Analyses include all women in the dataset who gave birth in the United States between the ages of 15 and 19. All analyses were

conducted using IBM SPSS Version 22.0 (IBM Corporation, Armonk, NY). The content analysis (Creswell 2012; Hays and Singh 2011) of published literature on doula professional standards, core competencies, scopes of practice, and care philosophies come from three national childbirth/doula professional organizations—Childbirth and Postpartum Professional Association (CAPPa), Doulas of North America (DONA International), International Childbirth Education Association (ICEA)—and two maternity care advocacy organizations—Lamaze International (Lamaze) and Childbirth Connection (CC). Additional information on methodology used for each research activity is detailed in the manuscripts that follow.

PROJECT SIGNIFICANCE

Intellectual Merit

This research expands current scholarship on the relationships between psychosocial stress, social support, health and well-being for marginalized communities. Specifically, findings from this study will contribute to the development of models that describe the pathways and processes via which social support may act as a cultural modifier of psychosocial stress, thus influencing variations in experiences and outcomes among at-risk populations. This project makes an important contribution by distinguishing doula care as a targeted social support intervention, and elucidating the ways in which doula care mediates micro- and macro-level factors, and subsequently influences individual biographies and biologies. This study also contributes to the anthropological body of literature on adolescent pregnancy and parenting, advancing efforts to move beyond an excessively narrow focus on the risks associated with

biological immaturity to explore the synergies between psychosocial, sociocultural and political-economic determinants of well-being.

Applied Significance

In highlighting the culturally-embedded dimensions of health and well-being, results from this study may be used to develop best practice models for improving the experiences and outcomes of young mothers and other marginalized communities. In particular, this research indicates the need for further investigation and implementation of doulas as a cost-effective, innovative maternity care strategy. Findings from the study have the potential to position doula care as a strategy for achieving the “triple aim” (Berwick, Nolan, and Whittington 2008) of the Affordable Care Act as health care delivery is re-conceived nationally with attention to: 1) improving health outcomes; 2) improving patients’ experiences of care; and 3) lowering the costs of health care. This research may also help further the efforts of community-based doula programs that are working to increase access to doula care as a pathway toward health and social equity in their communities.

OVERVIEW OF THE MANUSCRIPT FORMAT

Collectively, the four manuscripts presented here create a polyvocal platform from which the models, practices and outcomes of doula care for young mothers can be explored. Moreover, this approach allows the complexity of adolescent pregnancy to emerge, avoiding a harmful, solitary focus on young pregnancy as social ill. In their 2015 integrative review of professional doula care, Steel and colleagues found four broad areas of concentration for doula research to-date: 1) professional workforce issues; 2) the skillset and role of doulas; 3) clinical outcomes; and 4) social outcomes. In their review,

they highlight the often disparate nature of these categories, where doulas and the experiences of mothers are fragmented and explored in isolation. In positing areas for future research, the authors argue that:

...quantitative and objectives medical measurements, such as maternal and neonatal outcomes and rates of intervention, should be collected and analysed with equal importance to qualitative data to provide a global understanding of the outcomes of professional doula care...Of primary importance is the need for future research to include a mix of both qualitative and quantitative research methods to capture all dimensions of women's health which may be affected by trained or professional doula support" (Steel et al. 2015).

In the series of manuscripts that follow, I seek to meet this call for doula care among adolescent mothering communities. In Chapter 2, I place the voices of young women front and center as I explore their negotiations of motherhood against a backdrop of teen pregnancy stigma and insufficient support, and the role of doula care in mediating social and institutionalized barriers to create positive maternal identities and an expanded array of possible futures. In Chapter 3, I explore the models and philosophies of care that doulas employ as they serve young mothers, highlighting the ways doulas intentionally construct counter-narratives of respect, empowerment and maternal worth. Over the course of care, doulas explicitly reject pathologizing frameworks they see as governing the treatment of young mothers in the US, and help young women to resist their identities as "lost cause" mothers, fostering instead positions of respected motherhood. In Chapter 4, I examine maternal and infant health outcomes for a national sample of doula-supported adolescent women, in an effort to assess the potential of doula care as a cost-effective, novel strategy for decreasing health disparities in this population. Finally, in Chapter 5, through a textual analysis of the doula profession, I situate doulas within

larger childbearing paradigms, highlighting both the tensions and opportunities for doula care within larger maternity reform debates.

I conclude this dissertation by underscoring the implications of this research, making applied recommendations grounded in the narratives of participants, and highlighting areas for future study. Through this work, I seek to contribute not only to scholarly understandings of doula care and adolescent motherhood, but also to local and national reproductive and social justice efforts aimed at improving the immediate and long-term well-being of young families.

NOTES

ⁱ All names used in this dissertation are pseudonyms to protect the identity of participants.

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**Chapter 2: “It felt like everyone’s world kept spinning, but mine had stopped” –
Negotiating Shifting Horizons at the Vital Conjunction of Adolescent Motherhood**

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INTRODUCTION

The hardest part for me was doing it alone. I mean, it felt like everyone's world kept spinning, but mine had stopped. For me, I was stuck with it no matter what. I didn't have any other choice but to be pregnant, so what makes it okay for someone to leave me? What makes it okay for someone to abandon someone? That was the most difficult part. And it was even more difficult because my parents were so angry because I was pregnant, and as much support as I had, I knew it wasn't for me. It was for the baby.

~Angelinaⁱ, Age 18

Dominant discourses in the United States frame teenage childbearing as a social, medical, public health and economic “problem” to be managed or solved (Barcelos 2014; Bute and Russell 2012; Mantovani and Thomas 2014; Yardley 2008; Wenham 2011). Mkhwanazi (2006) has argued that these discourses result in “partial truths” or incomplete messages that communicate only the negative consequences, poor health outcomes, and socioeconomic costs of young pregnancy. The problematization of adolescent childbearing has given rise to essentialist depictions of young mothers as irresponsible, selfish, and incapable of “good mothering,” doomed to live in poverty and as “welfare queens” (Breheny and Stephens 2010; James and Rashid 2013; McDermott and Graham 2005b; Wilson and Huntington 2006). These prevailing meta-narratives have led to an almost exclusive emphasis on prevention and narrowly conceived outcomes, while far less work and resources have been devoted to examining the subjective experiences of teen mothers and the effects of social and economic support on psychosocial well-being and parenting success.

The purpose of this project was to produce an ethnographic account of the lived experiences of adolescent motherhood in the Northwestern United States, and to examine the impact of doula care, as a targeted form of social support, for young mothers. I use

two theoretical constructs—vital conjunctures and critical moments—to explore the ways young women negotiate adolescent motherhood, emphasizing the complex interplay between social relationships and structural elements as they coalesce to shape their young mothering subjectivities and the futures they imagine, rework, and ultimately occupy. First proposed by Jennifer Johnson-Hanks, “vital conjunctures” are defined as “socially structured zones of possibility that emerge around specific periods of potential transformation in a life or lives” (Johnson-Hanks 2002:871). Thomson and colleagues (2002) propose “critical moments” as a narrative approach for exploring pivotal occurrences in the stories of individuals as they recount vital life events, experiences, or transitions. The negotiation of conjunctures, then, can be elucidated through exploration of critical moments.

As the opening quote illustrates, adolescent childbearing is a time of profound uncertainty when “zones of possibility” are navigated, often against a backdrop of insufficient support and intense social stigma (Barcelos 2014; Porter and Holness 2011; Yardley 2008). In order to illustrate the social-structural context of young motherhood as a vital conjuncture, I explore the shared critical moments of two cohorts of young women—doula-supported and non-doula supported adolescent mothers—as they pass through varying spheres of influence that shape and re-shape the horizons available to them. Informed by their narratives, I describe how participants’ maternal self-concept and future possibilities are both structurally bound and integrally intertwined with experiences of social support and psychosocial stress. I situate doula care as a mediating critical moment that can alter conjunctures by introducing new horizons from which transformed futures and maternal identities of confidence, capability and self-worth can

emerge. In positioning adolescent motherhood as a vital conjuncture, I examine the interplay of institutions with individual agency, demonstrating how risk constructions of teen pregnancy must be reconceived to account for larger structural constraints that have reified age-based health inequities and maintained systemic barriers to young mothers' well-being.

THEORETICAL FRAMEWORK

Johnson-Hank's (2002, 2006) conceptualization of vital conjunctures developed in response to a call for the re-envisioning of life stage and transition models, which have been critiqued as too rigid, singular, and abstract (Camfield 2011; Jeffrey 2010; Langevang 2008; Liversage 2009; Notermans 2004). Conventional models fail to recognize the multiplicity of individual life pathways, the unpredictability (and subsequent change) of life trajectories, and the possibility for interdependent agency (Jeffrey 2010; Notermans 2004). As a result, traditional life stage models are being replaced by theoretical constructs that allow for more flexible, pluralized, and empirically informed interpretations of youth experiences. As a unit of social analysis grounded in "aspiration rather than event" (Johnson-Hanks 2002:865), vital conjunctures help to account for the fact that vital life events (e.g., marriage, childbirth, death, graduation, migration) are seldom congruent with predictable routes and fixed results. Rather, life events are more often imbued with tension and ambiguity, continually negotiated, challenged, and revised as new elements come into view and old elements fall out of consideration. As such, vital conjunctures attempt to move beyond the presumed universality of life stages by framing significant life events and experiences as contingent

upon socially constructed, imagined futures, thus helping to explain variation in outcomes and experiences of demographic phenomena (Johnson-Hanks et al. 2011).

Posited as a “new anthropology of the life course” (Johnson-Hanks 2002:865), vital conjuncture models attempt to grapple with the uncertain, ambiguous and, at times, radical nature of life experiences and transitions (Langevang 2008). Central to this construct is recognition that during a conjuncture, both multiple futures *and* identities are at stake. The range of envisioned futures and (transformed) identities that can be claimed are what Johnson-Hank’s calls “the horizons of the conjuncture” (2002:872). Which horizons are imagined depends on the structural context, the individual’s position within wider social networks, and their own cultivated subjectivity. Thus, “although the conjunctures and their horizons are variable, actors’ orientations to them are often systematic; imagined futures may be idiosyncratic, but the forms of imagination belong to the social field” (Johnson-Hanks 2002:878).

In order to demonstrate how “conjunctures are navigated in reference to their horizons—the imaginable futures that are hoped for or feared” (Johnson-Hanks 2002:878), I analyze adolescent mothers’ narratives through the lens of critical moments (Thomson et al. 2002). Critical moments, or occurrences described in interviews that the researcher and/or the interviewee see as having significant consequences, reveal the pivotal experiences of young pregnancy from which mothering identities are shaped. Critical moments thus reveal those interactions, self-reflections, and structures that are “implicated in processes of social inclusion and exclusion” (Thomson et al. 2002:335). Wenham (2011:153) has extended Thomson and colleague’s original notion to argue that “certain aspects of a young person’s identity may take prominence...and result in a

distinct set of ‘shared’ critical moments amongst different groups of young people. It is these very critical moments that are most likely to have repercussions on the ‘self-identity.’”

It must be noted that critical moments are not static, one-time events, per se, but rather, the narratives portrayed here demonstrate how “material spills over the boundaries of concepts such as the critical moment, suggesting series, or sequences of moments that may be better understood as processes” (Thomson 2002:351-352). Thus critical moments do not “belong” to one place or time, but rather, emerge, fall out, and re-emerge across the continuum of the childbearing yearⁱⁱ (Langevang 2008; Thomson et al. 2002). In the pages that follow, I trace the unfolding of young mothers’ conjunctures and their projected horizons through a narrative portrayal of the shared critical moments that surfaced (and resurfaced) in participants’ narrative tellings of their experiences.

METHODS

This research was guided by three overarching aims: 1) to elicit the predominant psychosocial stressors experienced by young mothers during childbearing; 2) to describe adolescent mothers’ experiences of social support during childbearing; and 3) to examine the subjective negotiations young mothers engage as they navigate social-structural constraints and opportunities. To address these areas, I combined qualitative interviewing with long-term participant-observation.

During the fieldwork years of 2010 to 2015, I engaged in extensive participant-observation (Bernard 2011; DeWalt and DeWalt 2010a; Green and Thorogood 2013) as a birth doula, perinatal health educator, and activist-anthropologist via three primary activities. First, I worked closely with a community-based non-profit organization that

provided *pro bono* doula services to young mothers. Through this organization, I worked as a volunteer birth doula for teen mothers, providing pregnancy, birth and postpartum care, as well as observation of prenatal visits, the birth itself, and postpartum check-ups. I also helped facilitate the program's teen-centered childbirth education classes and parenting groups. Second, I volunteered with six local high schools that provided school-based teen parent programs as a guest educator and observer. Third, I participated in numerous local perinatal health task forces and allied community childbirth/parenting organizations as an applied medical anthropologist. These organizations included teen-focused programs, maternity homes for young mothers, and local perinatal coalitions. In total, I provided direct doula care to over 75 young mothers and worked with countless additional teens as a perinatal health educator and advocate. Due to the intimacy involved in conducting research with pregnant and parenting adolescents, and their status as a "hidden" population (Heckathorn 1997; Schensul et al. 1999), participant-observation served as an essential method for building the rapport and trust necessary to collect rich and nuanced ethnographic data among this population.

Following approval by the Institutional Review Board (IRB) at Oregon State University, I elicited semi-structured, open-ended interviews (Bernard 2011; DeVault 2003) from two voluntary cohorts of adolescent women—doula-supported adolescent mothers (DSAM, n=24) and non-doula supported adolescent mothers (NDSAM, n=18,)—in three primary locales in the Northwestern United Statesⁱⁱⁱ between April 2014 and March 2015. For the purposes of this study, "doula support" was defined as women who received care from a trained doula during the prenatal, birth, and immediate postpartum period. To be included, participants had to have given birth in the Pacific

Northwest within the last seven years, the pregnancy/birth must have occurred between the ages of 15 – 19,^{iv} and the baby needed to be at least eight weeks old at the time of the interview in order to answer questions about early parenting. This study focuses on mothers who carried their pregnancies to term and became social mothers, as well as biological mothers; thus, I excluded those who intended to place their child for adoption and those who terminated the pregnancy. Because previous studies have shown that women who give birth at ages 14 and under are at greater risk for negative outcomes as a result of both psychosocial and biological risks (Cherry, Dillon, and Rugh 2001; Kramer and Lancaster 2010; Jiménez, Martín, and García 2000; Magill and Wilcox 2007), I only included women between the ages of 15 and 19 in order to focus on the culturally-embedded dimensions of psychosocial stress and social support as adolescents negotiated their conjunctures of young motherhood.

Mothers were recruited through a variety of social service (e.g., WIC), public health/medical (e.g., medical clinics), and community-based agencies (e.g., teen parent and doula programs), as well as through the use of online social media platforms (e.g., Facebook) where young mothers and the community agencies that serve them are active. Mothers willing to participate self-identified by contacting me using the information provided on the recruitment flier. The participants chose the date and location for the interview. Following completion of the interview, mothers were provided with a \$20 gift card to a local grocers/department store to compensate them for their time.

I started interviews by asking participants to tell me the story of their pregnancy. As their stories unfolded, I asked follow up questions to further elicit specific areas of information, such as: how they felt when they found out they were pregnant, reactions by

others, and treatment by social service agencies, educational/employment institutions, and medical providers. I also asked targeted questions around stressors/challenges, support systems/opportunities, and the hardest, as well as best parts (if any) of becoming a mother. Participants in the DSAM cohort were additionally asked to describe their experiences with doula care. Interviews concluded by asking participants to share their advice on what could be done to improve the welfare of young mothers. Interviews were audio-recorded with participant permission and hand-written notes taken to help document non-verbal and verbal elements of the telling (Charmaz 2006; DeVault 2003; Green and Thorogood 2013).

I performed thematic analysis (Bernard 2011; Braun and Clarke 2013; Braun and Clarke 2014) on narratives collected using QSR NVivo 10 software. I then organized the emerging, emic codes using the descriptive framework of shared critical moments (Thomson et al. 2002; Wenham 2011) and the theoretical model of vital conjunctures (Johnson-Hanks 2002; Johnson-Hanks 2006). Theoretical sampling and concept saturation were used to determine the final sample size ($n=42$) as well as the sample size for each cohort (DSAM, $n=24$; NDSAM, $n=18$) (Charmaz, 2006, 2011; Glaser 2001). Following analysis, I held a series of focus groups wherein I returned a summary of preliminary findings to a voluntary sample ($n=13$; $n=8$ DSAM, $n=5$ NDSAM) of interview participants, inviting them to comment on results and provide critique or elaboration. This process of reciprocal ethnography (Lawless 1992) or member checking (Charmaz 2006, 2011) promotes reliability and validity in qualitative research (Barbour and Kitzinger 1999), and helped me to refine emerging theoretical constructs. I integrated participant feedback, both support and criticism, throughout.

Ultimately, my positionality as both a medical anthropologist and doula, as well as my identity as a trusted presence among young women, teachers, community organization directors/staff/doulas, and clinicians, facilitated unprecedented access to and rapport with adolescent mothers, allowing me the opportunity to observe many of the relationships, interactions, and formative moments of mothering described in this article. Adolescent development and the childbearing process foster delicate implicit and explicit transformations in thoughts, attitudes, and behaviors of young mothers (Erdmans and Black 2015; Gabb 2009; Jones and Sumner 2008; SmithBattle 2005). As such extensive participant-observation—combined with qualitative interviewing—allowed a dynamic picture of adolescent motherhood conjunctures to emerge.

RESULTS

Participant Characteristics

Select characteristics of study participants are outlined in Table 2.1. The average age of participants was 16 at pregnancy and 17 at birth. Fifty-seven percent of participants self-identified as white, 19% as Hispanic or Latina, 10% as Black or African American, 5% as Native American or American Indian, 7% as more than one race, and one participant identified as Pacific Islander. Public insurance was used to cover childbearing expenses for 86% of participants, while 14% of participants used private insurance through their parents or, less commonly, of their own. Ninety-five percent of participants received the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), 74% received the Supplemental Nutritional Assistance Program (SNAPS), and 17% received Temporary Assistance for Needy families (TANF) at some point during the childbearing year. Regarding medical care, the majority of participants

received prenatal care from an Obstetrician/Gynecologist (76%), while a smaller percentage (19%) saw a Certified Nurse-Midwife (CNM), and two participants sought prenatal care from a Certified Professional Midwife (CPM). Additionally, the vast majority (93%) of participants birthed in the hospital, while one birthed in a freestanding birth center and two delivered at home.

Narrative Analysis of Shared Critical Moments

In this section, I present the shared critical moments that emerged from participants' narratives, illuminating the socially constituted, structurally bounded, and dynamic nature of vital conjunctures and their horizons in adolescent motherhood. Beginning with the process of "finding out" and moving through to participants' discussions of how they came to understand their identities as mothers following the birth, I examine eleven critical moments and their variable, complex manifestations. The first nine moments were shared by all or most young women in the sample, while the last two are specific to doula-supported adolescent mothers, and demonstrate the mediating role targeted social support can have in re-calibrating conjunctures and creating additional horizons.

Table 2.1. Participant characteristics: Young mothers

Characteristic	% (n)
Age at Pregnancy	
14	12 (5)
15	21 (9)
16	19 (8)
17	24 (10)
18	12 (5)
19	12 (5)
Age at Birth	
15	14 (6)
16	29 (12)
17	12 (5)
18	24 (10)
19	14 (6)
20	7 (3)
Race/Ethnicity	
Black/African American	10 (4)
Hispanic/Latina	19 (8)
Native American/American Indian	5 (2)
Pacific Islander	2 (1)
Multiple	7 (3)
White	57 (24)
Primary Source of Payment	
Public insurance	86 (36)
Private insurance	14 (6)
State Services Utilized	
SNAPS	74 (31)
WIC	95 (40)
TANF	17 (7)
Prenatal Care Provider	
Certified Nurse-Midwife	19 (8)
Certified Professional Midwife	5 (2)
Physician	76 (32)
Place of Delivery	
Home or Freestanding Birth Center	7 (3)
Hospital	93 (39)

Abbreviations: SNAPS, Supplemental Nutritional Assistance Program; TANF, Temporary Assistance for Needy Families; WIC, Special Supplemental Nutrition Program for Women, Infants, and Children

Critical Moment – “Finding Out”

At the time I had stopped taking birth control, and my son’s dad had gotten taken to juvy [juvenile detention]...So I was like “No, I can’t be pregnant, I don’t even know how long he’s gonna be in jail.” I was just kind of weirded out by everything. And so me and my friend went to Planned Parenthood and I took a test, and they said I was pregnant. At that moment, I was just very shocked. Like what the heck am I going to do? I don’t have a job. I’m not even old enough for a job. (Isabella, Age 14, DSAM)

Isabella’s words illustrate some of the profound first reactions of finding out—the critical moment when they recognize their new identity as a young pregnant woman.

Common throughout these narratives is feelings of denial and shock. At first, no horizons are seen, only the gravity of the circumstances directly before them. Others expressed how their world felt “over” as illustrated by Makayla: “I started crying and I was really upset and disappointed in myself because I was in college, like just started college, and I was working, and just trying to start my life. And then found out I was pregnant, and it was just really devastating for me” (Age 18, DSAM).

In the gamut of reactions, perhaps the most common one described was that of mixed feelings. Audra expressed: “When the test came out positive, boy, so many emotions came into me. I was happy, I was excited, I was really sad, I was crying ‘cause I was only sixteen” (Age 16, NDSAM). Mixed emotions came up time and time again throughout their narratives, not only during initial reactions, but also as they re-negotiated their changing identity in light of societal rhetoric saying they were “too young” to be a mother and that they would be “fucked for life.” The critical moment of “finding out” and the ways this was experienced was thus closely tied to their fears and anticipations around how others would respond.

Critical Moment – “Telling Others”

In telling others, the most common starting place was with their family. Feelings of anger, disbelief, and ambiguity plagued reactions by their mothers and, secondarily, their fathers, if present in their lives. Maria said: “I called my mom, and I told her. I was like ‘mom, I need to tell you something. Don’t be mad’ and she’s like ‘ok’ and I told her I was pregnant and she said ‘[Maria], I don’t know if I should be happy or excited or scared or mad. So I’m going to call you back.’ Never called me back” (Age 16, NDSAM). Disappointment was nearly universal. Carrie recalled: “They [my parents] were surprised; they were disappointed because they expected a lot out of me” (Age 17, DSAM).

The sub-text to these expressed feelings of anger and disappointment was that the teen’s life was now over. Rather than being a start to a new identity, their pregnancies were treated as the end of what could have been. For some young women, this presumption was made explicit, and indicates the (presumed) economic ramifications of their “decision.” Sofia’s experience poignantly illustrates: “So when I got pregnant at fifteen my grandma felt like, ‘She’s not gonna finish school, she’s not gonna go to college, she’s gonna live off the welfare, she’s gonna be a drop out, and she’s just gonna be another statistic’” (Age 15, DSAM). These narratives illustrate the horizons many young women are first introduced to: a horizon of being “just another statistic” with no economic, employment or educational prospects. Their ability to be capable mothers is also commonly called into question not only by family, but by teachers, peers, and society-at-large. Gabriella expressed: “Society just thinks that because teenagers get

pregnant at such a young age, that they're less than everybody, they have no future, and their child, their children, aren't going to be worth much" (Age 15, NDSAM).

Negative and disapproving reactions were often internalized by the young women. Feelings of guilt, helplessness, and incapability surfaced in young mothers' stories, influencing their senses of maternal worth and confidence. As Katie explains: "If someone keeps telling you you're a bad mom, you don't know how to do anything, you're not doing it right, you're still not doing it right, you're gonna get that in your head because that's just human nature, and then you're gonna convince yourself of that" (Age 15, DSAM). Angelina described the ways in which expectations of failure became tied up with feelings of self-worth and the pressures young moms felt to make a decision—any decision—besides keeping the baby. Angelina recounted with a tone of sadness:

And when I went to church, a lot of the stuff I heard there was, you know, "give your baby up for adoption, you're not old enough, he left you." I mean I had someone walk up to me and say, "My son is looking for a baby to adopt, if you're willing to give your baby up." And I'm sitting there like, "I'm not giving my baby up, this isn't fair, no." I had someone else walk up to me and say, "I was adopted and I can't thank my parents more for what they did for me." And I'm sitting there like, "So why am I not good enough? What did I do to not be good enough?" (Age 18, DSAM)

Being pressured to place the baby for adoption or get an abortion were common reactions to the disclosure of pregnancy, and the women themselves often considered these horizons as well—horizons that would stop their experience at being only biological, not social, mothers.

The critical moment of "telling others" was most significantly marked for young mothers by the reactions of the father of the baby (FOB). Relationships with the FOBs were most often filled with turmoil, and were cited as the most constant and significant

source of stress for the majority of participants. As they told the fathers, prospects of being a single parent, of having “terrible fathers to their children,” of being stuck in a relationship they didn’t want, all surfaced and had to be navigated as real, even if undesirable, horizons. Carla’s emotions were raw as she described her experience:

He was like “oh okay let’s go to Planned Parenthood. We’ll get you a speedy abortion. We’ll take care of this.” And I basically told him to Fuck off. It was mine. And if he didn’t want anything to do with it, that was fine. But I already loved him [the baby] more than anything, and he [the dad] wasn’t going to influence my decision at all. And he broke down and started crying, told me that I ruined his life. And I said “okay well have a good life. You don’t have to take part in it. I’ll let you know how the birth goes.” And he pretty much walked away.
(Age 17, DSAM)

In Carla’s quote, we also see an underlying narrative of love for the child. Indeed, despite societal rhetoric that presumes young mothers are “too selfish” to have their child’s best interest at heart, participants emphasized repeatedly how they “just wanted to make sure the baby was okay. I’d do anything to make him be safe” (Jocelyn, Age 17, DSAM).

Critical Moment – “Everything, everyone, changed”

After the initial navigation of telling others and coming to terms with the reality of their pregnancy, participants had to negotiate their (visibly) growing pregnant adolescent body and subjective self, as well as the futures they began to plan, envision and rework. The embodied experience of being pregnant was tied to how their pregnant body impacted relationships with others. Changing relationships were cited as one of the top stressors experienced. As Roberta explained: “I just stopped hanging out with them [my friends] because they just wanted to party, and I was like how am I supposed to do that?” (Age 14, NDSAM). Losing friends and tensions with the FOB were significant experiences shared by almost all participants, as their pregnant bodies felt at odds with

adolescent behaviors that form much of the social arena (e.g., partying) teens occupy.

Often, this led to deep resentment toward the FOB for him not having to change his behaviors as a result of the pregnancy. Sofia recounted the anger and isolation she felt:

I didn't have any friends. I like cut all my social life off. I wasn't in school because it was summer. I obviously felt really self-conscious because of all the weight that I'd gained. I felt very angry. Very very angry with [FOB]. I felt like, "How dare you do this to me, and then not even be there to do it with me?" Like why would you do that? Why would you rip me from my innocence and my childhood and everything that I had going for me? 'Cause he was older, he was already done with school. He had his social life. He got to live, and be a kid, and have his fun. (Age 15, DSAM)

Further, shifting relationships with FOBs was an influential element in the mother's prenatal behaviors. For many, being a single mother was a "worst fear" and they described being willing to "do anything to stay with him." For others, being a single young mom was chosen as an alternative horizon to staying with someone who "caused more harm than good." Even for participants with supportive partners, economic needs often pulled the partners away for incredibly long shifts at multiple jobs, leaving the mom to be alone in her conjuncture.

The perceived collision of adolescence and motherhood changed other relationships as well, most notably around health care seeking behaviors and familial dynamics:

The doctor's office I think was where it [being young] seemed the most weird. Because first I went to my pediatrician and then he's like "well you can't really come here, you have to get an OB and then an adult doctor" and so... The nurses always seemed a little bit weird about it just because I was *so* young. I still had a Strawberry Shortcake purse! (Katie, Age 15, DSAM)

Changing relationships with their parents or guardians, in particular, were marked by tensions arising from the fact that they often relied on their parents to house, clothe and

feed them—arguably a source of economic support—but that support was then imbued with emotional stress and messaging of their “less than” status as mothers. Through tears, Emily described the lasting hurt that permeated her experience of becoming a mother: “My mother would stress me out. She was a blessing sometimes and also a burden because she would say things like, [crying], not nice things. Like pregnancy is physically hard and she would say ‘well you shouldn’t have kept the baby if you can’t handle it’” (Age 19, DSAM).

Participants’ narratives also reflected the ways in which pre-pregnancy familial dynamics influenced the immediate opportunities available to them. Intergenerational cycles of single, young motherhood, poverty and/or drugs were often their norm, and wanting to break that norm was a significant motivator for seeking out different relationships and new horizons. Tammy described the core importance of this goal:

I had already been on my own for a while because I moved out of my mom’s house when I was 14. I’d been with her [the child] dad since then...My mom, she was in and out of jail most of my life...She was in there for drugs and a whole bunch of other stuff, and so I didn’t want to be around it. So I left before I could even get close to all that. I just mainly wanted to focus on giving her [the daughter] a better life than my mom gave me. (Age 17, NDSAM)

As new horizons were envisioned in light of changing relationships and circumstances, young mothers began to piece together support that would ultimately shape what pathways they had available to them. Some of this support would turn out to be pivotally helpful, while much of the time, it was fraught with new or additional tensions. Over the course of their pregnancies, participants came to realize that when “you don’t do it in the right order” (school, marriage, babies), and your pregnancy occurs

against a backdrop of teen mom stigma, celebration and support in motherhood are far from a given.

Critical Moment – “Who was in my corner”

Oh my gosh, there’s actually a baby now. This is actually going to happen. I didn’t really account for this. But then there were all of the people that I did not expect that came around me and supported me. And like I’ve never bought baby clothes because I’ve gotten so many boxes and bags and just so many hand me downs...I have a network that I can reach out to and say I need this for [baby] or that. I’m struggling with this or that...I was not accounting for all these people that were in my corner and who wanted me to succeed. (Lorelei, Age 16, DSAM)

For Lorelei, as the pregnancy progressed, she came face to face with the weight of becoming a mother, but also came to find that support could and did exist. Interesting to consider against the backdrop of Lorelei’s quote is her life reality during the childbearing year. She had been on her own already for almost two years, having left her family because “the entire environment was really hostile” due to her parents disapproval of her boyfriend, turned father of the baby, turned fiancé, who she is still with today. In the 18 months leading up to conception and through the entire pregnancy, she moved from shelter to shelter to maternity home and other forms of community housing, sometimes filling in gaps living with disapproving family members or friends she met at previous homes. Her biggest fear, then, was “the fear that I wouldn’t have a safe place for her [the baby] to be.” When strangers she met through a community housing agency for homeless youth provided her their entire basement to live in for free—securing this housing mere weeks before baby came—she felt it a “true blessing” as they “gave me space to become a parent.” This space was not just physical, but also conceptual:

Basically the gift that she gave me was space, but also invitations to be part of their family, to have dinner with them, but I also had space as much as I needed it. And that was exactly what I needed to feel capable and to not feel pressured. She

gave me space to figure out how to change a diaper and how to calm down a crying baby, but she was also there if I needed it. (Lorelei, Age 16, DSAM)

As Lorelei's story illustrates, support often came in unexpected ways. While commonly referred to as a "gift" or "blessing," support received was discussed using patchwork metaphors (see also: Logsdon et al. 2005) where teens pieced together a bit here or there from varying sources to help meet their needs and open up additional horizons. Support was often inconsistent, fraught with tension, and all too often, minimal at best. Thus, "good support" was discussed by participants as support that either helped them navigate daily structural challenges and/or was meaningful for their emotional health and sense of self. One of the primary patches of "good support" for those still in high school came in the form of school-based teen parent programs. Participants discussed these programs not only in terms of their educational offerings, but also as "judgement-free zones" where they received emotional and peer support: "I enjoyed going to school and having everybody there. That's when I was really able to enjoy my pregnancy. They accepted who I was" (Gabriella, Age 15, NDSAM).

The educational and emotional support received through the programs was further heightened in the early parenting period via material support when they went back to school. These programs provided supports like a special bus to take young mothers and babies to and from school and free, state-funded daycares on campus. They also buffered young moms from social isolation. Renee said:

I think once you become a parent you feel lost in like a high school of a bunch of kids who are deciding who's having a party at their house that weekend and getting ready for prom and homecoming, this and that, you know? I'm going to school and being a mom. So it was really nice to be surrounded by people who have the same common things with you. (Age 17, DSAM)

In addition to the teen parenting programs, another pieced together form of “good support” came from community agencies and groups that worked to provide emotional connections in a stigma-free space. Organizations that were deemed “safe places” by the young mothers were passionately talked about in their narratives: “I went to this young mom’s group. There was the perfect amount of love and support, not just for the baby, but for the moms too. They would pamper us...and they’re really welcoming and it was fun sharing our stories with each other and having play dates and everything” (Carley, Age 14, NDSAM). Carley’s words highlight not only the peer support many programs provided, but the fact that some groups focused explicitly on the mother as well as the baby. Teens noticed this difference and were quick to condemn a fetal-centric focus in programming. Many felt that as soon as they got pregnant, they were treated as though they did not matter as anything more than a vessel for the baby. Angelina said: “It’s never about you anymore. It’s never about how I feel...It was always about what’s best for him [baby], and I’ve learned that and I’m okay with that, but at what point are my health or my feelings important?” (Age 18, DSAM). Programs and teachers that took time to focus on the mother for her own sake (and not just the baby) were thus championed by participants.

Some participants also found support through select friends. Alisha recalled: “What was memorable about my pregnancy was my friend. Even though she didn’t have to, she would come over during lunch or after school just to rub my back and stuff ‘cause I didn’t have anyone to do that” (Age 15, DSAM). Others discussed select family members as their primary support system. Although often endowed with emotional turmoil, familial support was considered especially important when the teen’s pregnancy

was so stigmatized that no one planned a baby shower—a critical source of material support. As Mary Anne explained: “Every few paycheck my parents would go out and buy different sizes of diapers and wipes. And then [sad pause], well, no one threw me a baby shower, and so my mom went and bought consignment stuff they felt [the baby] would need” (Age 19, NDSAM).

Support in getting ready for the baby (materially and emotionally), and for growing a healthy baby (maternal nutrition, medical care) was often pieced together through other community and social service sources as well, ranging from donation centers to parenting programs and state funded initiatives like WIC, SNAPs, and public insurance. However, many participants found it difficult to successfully obtain these much-needed services:

WIC was just a giant pain. I loved my WIC nurse, when she came it was wonderful. She was so nice, but going into the building, ugh. If I had to change appointments they would be like “well obviously this isn’t a priority for you” and it’s like I’m pregnant, I’m going to school, I’m going to work. I have all of these other things and there is such a thing as pregnancy brain and sometimes I just forget about things, so cut me some slack. Like I rescheduled an appointment twice and they told me if I did it again I would be dropped. (Carla, Age 17, DSAM)

Carla’s experience was all too common. One of the primary structural constraints on young mothers is the need for additional resource help, but within a framework of limited time often confounded by transportation barriers. Thus, the ability to successfully access services was inhibited by the collision between youth reality (school, limited transportation) with adult expectations (employment, economic stability) and the added demands of pregnancy (pregnancy brain, midwifery or obstetric visits). Yet, young

mothers were the first to recognize their need for extra help, as illustrated in Renee's description:

Teen parents may need more support not because they're incompetent or because they're teens, but they just have less resources at that point in time. Some of them can't get jobs, some can't get their license because they're only 14 or 15, some families or kids live in a household of drugs and violence and things so they don't want to go home and they don't want to bring up a child in that home and so being able to have support is huge. (Age 17, DSAM)

When support and services were not provisioned in such a way that accounts for the social-structural context of teen childbearing, young mothers often, in turn, felt further judged and internalized messages of "not doing good enough." This can be seen in Carla's experience where because of her chaotic life and need to reschedule, she was told her mothering was not a priority, or with Renee, she was quick to explain that the extra help needed was not due to innate incompetence, but because of different circumstances from which their motherhood arises. When resources were provided in a way that felt supportive and non-judgmental, different horizons opened for these young mothers. However, when services were delivered along with a healthy serving of stigma, and what teens experienced as a "desire to punish," participants felt stranded in their motherhood conjuncture.

Critical Moment – "I felt set up to fail"

They're [DHS] rude, they're discriminating, they don't help you at all, they totally set you up for failure...they discouraged me and put me down more and didn't help me be positive to get my kid back. It just made it worse and made my life harder than it already was. Because now I lost everything. (Faith, Age 15, NDSAM)

Faith was one of four moms in this study that, at the time of the interview, no longer had legal custody of their child. These participants felt that if their caseworkers at

the Department of Human Services (DHS)—among others in their social network—had cared for them and not judged them, then their worlds would look much different. Katrina explained how her internal motivation to be a “good mother” was at odds with the structural reality around her—a reality of no support:

My world was falling apart, but in my mind I was going to be the best mom possible. I was not going to give up...I felt like I might not be perfect, but I could do it. Then DHS broke me. They drilled into my head that I was a bad mom so much I started to believe it. Ultimately, I wanted my daughter to have a better life, and I believed I was a bad mom, and so I believed that life wasn't with me. (Age 15, NDSAM)

The stories of Faith and Katrina demonstrate the horizons that manifest at the vital conjunctures of young motherhood when support is withheld or, even worse, when offering “support” becomes an opportunity to abuse. While not as extreme, other participants in this study echoed the experience of “feeling set up to fail” due to their mal-treatment by social services, most notably, DHS. Isabella's experience serves to illustrate:

The DHS office, I just kind of felt like they looked at you like “oh another teen mom, [rolls eyes] pregnant trying to get benefits.” You know. Like we're hopeless or something. So I never really liked going there. I just felt like they looked at you like “oh we deal with these every day” and just wrote you off. (Age 14, DSAM)

Young mothers also described tension experienced with support services not just due to poor treatment, but due to rules that were set-up for adult mothers, not underage mothers. In the research locale, state laws dictated that while public insurance and WIC could go directly to the mother, SNAPS (food assistance) and TANF (a cash bridge program) must go through their legal guardian if the teen was in any way under their care. However, simply “living with” a guardian does not equate to being supported, and

“living with” can mean anything from sleeping there when you have nowhere else to go to storing some of your things in a parent or guardian’s home. Participants commonly cited theft or withholding by their guardians of the support they were supposed to receive. The need for such resources was not only a matter of economical support, but was also crucial for facilitating the young women in feeling like capable mothers able to provide for their child. Maria recounted the resulting feelings of guilt:

One of my biggest stressors was the thought, I don’t know, I just had this thought in the back of my head, like I didn’t feel she was mine sometimes because I wasn’t financially supporting her...I was ashamed that I had this beautiful child, but I couldn’t financially take care of her. (Age 16, NDSAM)

The tension young mothers felt between “needing support” and “doing it by myself” powerfully shaped their mothering identities. Further, internalized messages of being “less than” as mothers was exacerbated by their treatment during medical interactions, where they often felt disrespected, not listened to, and uncared for. Rachel expressed with anger:

I hated my OB. First appointment I ever had, she found out I was pregnant and I was a young teen mom and she did not like that at all, and she was not shy about telling me how disappointed she was that I was pregnant at all. And she really wanted me to put him up for adoption...And her referral for me to do adoption was watch Juno^v, the movie. That was what she said, “watch Juno, I think that will give you a great idea as to why you should adopt”....it made me angry...This person I’m basically putting my life and my child’s life, you know, in their hands, I’m wanting to trust her, to talk to her, I have a problem, run to her and talk to her, I don’t know what’s going on, I feel this and that, so it was horrible to feel that I couldn’t even trust the person who is supposed to deliver my baby. (Age 15, NDSAM)

Not only did mistrust and disrespect surface as common themes, but this kind of overt ostracism actually led to poor care and delayed diagnoses in some cases. When young women felt they were being punished by medical personnel for their pregnancies, they

were less likely to disclose symptoms and complications. Even when they did, they often experienced silencing through uncaring, discriminatory attitudes. Gabriella disclosed:

After birth, I was really dizzy and she [the nurse] was just like “So? Get up, go home and start doing the dishes or something”...and I felt like she was doing that just because I was a young mom, because of that. I just felt like she was saying well “you’re dumb, you shouldn’t have done this, now you see the consequences.” Like it was my fault and I needed to suck it up. I have these little stairs and I was like “I can’t do it, the stairs” and she was like “Go home, no one cares.” (Age 15, NDSAM)

In contrast, medical professionals cited in positive manners had three characteristics in common: 1) they explained all procedures/tests and made the young mother’s power to consent or decline explicit; 2) they respected the mother and did not judge; and 3) they genuinely came off like they cared about both baby *and* mom.

Young mothers also understood the importance of auxiliary care such as childbirth education classes. They craved education and knowledge about pregnancy and parenting, and linked knowledge to improved mothering capabilities and confidence (see also: Coren, Barlow, and Stewart-Brown 2003). Indeed, education that instilled parenting confidence allowed different horizons to come into view. However, many did not feel comfortable with engaging regular childbirth classes because of the stigma attached to their experiences as young mothers combined, often, with a lack of support from the father of the baby. Maria recounted:

It [going to classes by herself] was embarrassing. I felt shameful, especially the birthing class. I was the only one that was young. Everyone had their other person and I was by myself. My mom didn’t want to come with me, he didn’t want to come with me, so I just went by myself. And there were times where I did cry a little bit because I saw these couples, these moms and dads and their unborn child, and they were married and seemed so happy and they were doing these classes *together* and that’s what I wanted. I wanted a family. So it was tough to go to those classes sometimes, but what was I going to do? I wanted to learn too. (Age 16, NDSAM)

Critical Moment – “Birth is a day you’ll never forget”

The vital conjunctures of young motherhood solidify in an entirely new way the day these women give birth. Participants told their birth stories passionately—sometimes that passion stemmed from sadness, other times from anger, and at times from excitement and pride. Birth served for many as a rite of passage into social recognition as a mother, and not just as a pregnant teen. In Lorelei’s words: “Getting her placed on me. Like this is my little person now. It made me feel like you’re not a little kid. It showed me that I had a responsibility and people would recognize that responsibility. I think because being pregnant as a teen is a lot different than being a mother as a teen” (Age 16, DSAM). Molly described her emergence into motherhood with her partner this way: “It wasn’t like we were playing big kid roles in little kid bodies. It was like we WERE those big kids, and we BECAME those people” (Age 17, DSAM).

Birth experiences and their emergence into social motherhood differed for participants who experienced a medically managed delivery and felt no control relative to those who felt in control during the process, often birthing without pharmacologic pain management. In the former, stories were laced with experiences of induction, augmentation, epidurals, and a lack of explanation and consent. Many felt that birth was something that was done to them, and not something they had accomplished themselves; the language of their birth stories was often more passive than active, with overtones of victimization rather than empowerment. Faith recounted her birth story with both apprehension and apathy: “I just wanted them to get this kid the hell out of me. I was in pain. I was in a daze. I was tired, and I was confused. I wanted her out. I wanted it to be *over*. And I wanted the hell out of that place” (Age 15, NDSAM). These experiences

often left them feeling disrespected, stripped of control and undervalued, as though they were not worth even the slightest gesture of kindness, encouragement or informed consent. Grace described her experience with defeat:

I would have let them do whatever to me because I was so uneducated. No one explained anything to me. All of a sudden it was time to push. I was so scared. I didn't understand what was happening. I just wanted someone to look me in the eyes and say "You can do this! Your body is made to do this! You got this!" But no one did (Age 18, NDSAM).

Grace's experience stands in stark contrast to those teens who felt respected and in control during birth; those with this latter experience were much more likely to be connected with doula care—a critical moment further delineated below. In particular, those young mothers who completed the birth without pharmacologic pain relief (epidural or narcotics) described their birth as one of the most empowering experiences of their lives. Maria described the significance of her un-medicated childbirth: "I kind of enjoyed the pain. I felt empowered, and I had a lot of energy, like I can do this by myself. I don't need medicine. So after that, if something happens to her or me, I'm like 'I can do this!' I just put it in my head. I can do this. So my birth matters even to this day" (Age 16, NDSAM). Feelings of confidence during birth expanded the parenting horizons the young women perceived as possible: "I am really proud of my natural birth. Knowing I trusted myself and my body. If I could do natural childbirth, I knew I could do breastfeeding. I knew I could be a mother" (Emily, Age 19, DSAM). Ultimately, their births marked the thresholds by which they moved into the next critical moment of their conjunctures: early parenting.

Critical Moment: Early Parenting – “It was a lot, it was too much”

Early parenting was a critical moment discussed by participants as being deeply influenced by their sense of maternal capability, their relationships, and a daily life permeated by instability. Many negotiated their new mother identity from a position of fear. Rachel expressed: “Being a new mom was scary...I took that baby home by myself...I was scared to even touch him, I was so scared I was going to break him. He seemed so fragile” (Age 15, NDSAM). For others, they struggled with bonding, often connected with postpartum depression. Sofia described her feelings postpartum through tears: “It sounds horrible when I say it, but I feel like she was dropped off on my door step...it was such a mix of feeling like alone and sad and like the happiest person ever because obviously I just had my baby” (Age 15, DSAM).

Stress culminated for many as they “tried to balance it all,” and even when they did have support, they often internalized that the onus was on them, feeling like they had “more to prove” because they were teen mothers. Moreover, given experiences of previous stigma and judgment, they were often scared to reach out for help (see also: Gray 2002; Mantovani and Thomas 2014). One of the most daunting stressors involved was trying to balance so much as not only a new mom, but as a teen who still had school/work and lacked a certain level of control over their lives, from transportation barriers, to little economic self-sufficiency, to challenging FOB/partner relationships. This often resulted in maternal guilt for having no time with their baby. Katie described:

It was hard. It was really really really hard. I was in a crappy relationship that I was in because we had a baby and I felt like we needed to be together because we had a baby. And then I was finishing high school, I ended up working like 38 hours a week so like I could take care of my baby, and then I felt like I wasn't

getting any time with my baby between school and work so it was extremely stressful. (Age 15, DSAM)

Katie's narrative draws attention to the challenges of navigating their relationships during early parenting as both a mother *and* a partner. For some, they felt "stuck" with the father of the baby, while for others, even when in supportive relationships, profound change came with the birth of the baby. Olivia recounted: "The hardest parts for me were adjusting to parenthood while learning how to live in a house for the first time with your significant other...It was basically a crash course on everything. We just kind of threw it all in, and it was kind of chaotic" (Age 17, DSAM). Whether in a supportive relationship or not, tension with the partner in early parenting often came in the form of sexual changes alongside feeling alone in the celebration of the baby. In Carla's words:

It felt like everything was so exciting to me all the time, and for him [FOB] it just like wore off. So I felt pretty much like a single mom after the first month. And I was cleaning the house. I was going to work and I was making sure I had all these extra hours. And I was making doctor's appointments and making sure I was taken care of and going to my 6 week check-up and making sure that everything had healed right. The only thing that he seemed to care about was "are you okay to have sex now?" Like [big sigh] "no, I'm not. I just had a baby I'm still not feeling too hot. I don't feel very sexy and the last time we had sex I got pregnant, so no." (Age 17, DSAM)

The most extreme cases of both stress and change in early parenting came when young mothers recognized they were in abusive, coercive or otherwise unhealthy relationships. The birth and bringing a young infant home to a house that now felt unsafe was often a catalyst for major transformation. Instead of worrying about how to keep the relationship with the FOB, they needed to find a safe way out. Carrie described how fear combined with love for her child to initiate such a change:

I felt so scared for her...He could have killed her [the baby] because he was on drugs and he could have shaken her to death because he couldn't handle the crying...or, especially when we lived alone together. I was like, "He's gonna do something to her just so it would hurt me." I just constantly worried about that. I was like, "How am I gonna get out of this without causing anybody hurt?" But then I did get out of it because her birth really changed my perspective a lot. Like, "What the fuck am I doing to my child?" I knew I had to leave (Age 17, DSAM).

Even with newly found motivation for change, abusive relationships were often difficult to escape because FOBs commonly served as a source of economic support, and participants often felt it was their "duty" to make it work, not wanting their baby to be "a bastard child" and feeling guilt ridden for making decisions that might hurt others—their families, the FOBs and their often mutual sets of friends. Additionally, they were unlikely to view social service agencies and lawful authority figures as sources of help because of the stigma ascribed to their previous (and ongoing) experiences of support seeking. Through pieced together help and motivation emerging from deep love for their child, new horizons were constructed. Loretta described her long struggle with an abusive relationship that hit a turning point after birth:

He [the child] was the one good thing that made it worth it. He pulled me out [of the abusive situation]. With his birth, I was completely sure that I needed to leave my husband because I would do anything and everything to protect him [child]. And he still does make me want to be the very best person I can be. (Age 19, NDSAM)

In early parenting narratives, then, we also see a critical moment emerge around personal growth experienced through their child, a set of changing horizons that came into view and were negotiated via their new identity as a mother.

Critical Moment – "Having my child saved my life"

As the young women in this study reflected on their conjunctures of motherhood, their narratives describe significant identity transformations, and often a glimmer of hope

(sometimes the first in the narrative to this point) around being a mother. Much of the positivity came with the simple, but profound joys of mothering. “Watching them grow” and “getting snuggles” were the most commonly repeated phrase when recounting the best parts of being a new mother. This sentiment was connected with their own changing identity, where participants spoke of receiving “gifts” from the child in the form of love, confidence, and a new way of being in the world (see also: Peterson 2006; Shanok and Miller 2007; SmithBattle 2005). Cassidy recounted the resolve she felt: “I really liked just the identity of it [being a mom]. Having a purpose...If I didn’t have him to get my act together, I never would have gotten my act together. I think I would still be floundering around unsure of what to do. But because I had him, I have a reason to do everything” (Age 16, DSAM).

Cassidy’s narrative describes a common and deeply held sentiment—having a child as a teen not only made them grow up, but actually changed their life horizons for the better. Renee explained:

I look at my past and going to college and finishing high school and having my job. All of that would have been way easier had I not had a child. At the same time I was going down a road of partying every weekend, skipping school, getting bad grades because, you know, I’m just being a teenager and living with my boyfriend at 16 and had no family support. So honestly I feel like becoming a teen mom saved my life and turned my life around for the better and made me make more positive choices. (Age 17, DSAM)

The positive aspects of change were echoed by participants with pride. Many also found solace in the idea that “things happen for a reason”. Esther explained:

I used to find it so weird that I got pregnant. But I think I believe that things happen for a reason. So maybe I got pregnant and I got married young because that was the plan. [The plan] was for my mom to see her only daughter have her first child and get married. So I am like more at peace” (Age 16, NDSAM).

In Esther's case, both her parents died tragically soon after the birth of her child. Here, we poignantly see the ways in which the vital conjunctures of others in her life intersected with her own to (re)construct her young pregnancy and parenting experiences.

The critical moment of individual growth was not without tension, however. When recounting their experiences, this growth was often marked by conflict because of their concurrent identities as still-developing adolescents and mothers with adult responsibilities, yet limited resources as their age, class, and racial/ethnic identity often intersected to produce deep inequities (see also: Erdmans and Black 2015). As Leanne expressed: "I had to grow up and learn how to parent a child and learn how to parent myself at the same time" (Age 16, DSAM). Participants also struggled with the idea of where they fit into the puzzle of new motherhood, often feeling "invisible" and internalizing tension between "support" and "doing it by myself." Such conflict stemmed in large part from feeling like a "burden" that made a "mistake." This message of young-pregnancy-as-mistake conflicted with the lived reality of a beloved child. Further, participants described a mixed message being sent from societal discourse that says they need to "grow up, get a job, become an adult," but without the resources to accomplish exactly that, still being treated like a child both conceptually and physically.

We are teen moms. We have to go to school, we have to graduate, go to college, start a career, but at the same time we have all these challenges. We don't only have to focus on our children, but we also have to focus on our future...I feel like not only do attitudes [towards teen pregnancy] have to change, but programs. We need more help. We need more support...It would be nice if we got more help, not just with diapers and formula and baby food, but also being able to make a future, and not feel stuck. (Maria, Age 16, NDSAM)

Despite these structural, relationship, and individual challenges, overwhelmingly, participants described the growth they experienced through their child, the unconditional

love, and the positive horizons that emerged from these unexpected conjunctures in their lives. In particular, being able to create a new horizon of family, and often to do so in stark contrast to their own upbringing, was cited as one of the best parts of becoming a mother. Ultimately, they took pride in their new maternal identity—an identity that came with struggle, stigma and often an insufficient patchwork of support, but still, an identity as a mother above all else. Molly expressed with great satisfaction:

Just enjoying every smile and every milestone and just knowing that there's nothing you wouldn't do for this teeny tiny baby. And even though you are sleep deprived and you are crazy and you haven't peed alone in forever, there's nothing you wouldn't do for them. It's just like, the prize of the whole thing... We were awesome. We rocked teen parenthood to the core. Because we just didn't stop. (Age 17, DSAM)

Critical Moment – “I’m a Mom Too”

Finally, as participants told their stories and reflected back on their conjunctures of motherhood, an “all moms” narrative emerged. This narrative positioned their young motherhood identity—both for themselves and society at-large—as different, but not lesser than. To accomplish this, they capitalized on their identity as moms above their identity as youth—they were not just “teen moms” but “moms who are also teens.”

I see moms who are older who have a hard time. I mean, parenting is hard whether you're young or old, but I feel like some older people don't realize that we're going through the same thing. Maybe it's a little bit different, but don't look down on me because I'm a mom, because you're a mom too!” (Angelina, Age 18, DSAM).

Olivia described this “all moms” discourse relative to her experiences of support and stigma: “Basically realizing that whether you're 40 or like 15, every mom needs support. So when we stigmatize these moms at such an early age, you're setting them up for instant failure. And the whole point of creating a next generation is you always want

better. And these are kids having kids, so they're going to need all the help they can get" (Age 17, DSAM). Interestingly, Olivia uses the phrase "kids having kids." While this phrase is most often used to problematize teen pregnancy, Olivia co-opted it to highlight the need for extra support. Participants echoed the importance of more support with less judgment by creating an "all moms" discourse for themselves and those around them. In Roberta's words: "It's just like being a mom, just like any other age mom. You might have different needs, but you're still a mom" (Age 14, NDSAM).

Critical Moments of Doula Care – "Without my doula, everything would be different"

A doula is your mother, and your partner, and your doctor, all rolled into one compassionate, caring person, who helps you with whatever you need, and talks you through it. She's your cheerleader to help you have the best most successful experience, and she is your advocate too. (Lorelei, Age 16, DSAM)

Thus far, I have discussed the range of experiences around shared critical moments during the vital conjunctures of young motherhood, as expressed by both doula-supported and non-doula supported adolescent mothers. For the doula cohort, however, these critical moments were often mediated, re-worked, and resisted through the medium of doula support. Two fundamental and interrelated critical moments emerged in the narratives of doula-supported mothers that demonstrate the pivotal role doula care can play in altering conjunctures of adolescent motherhood. In these critical moments, we see how doulas opened up additional horizons for young mothers to consider as they nurtured feelings of worth, capability, and confidence in the women they cared for. In turn, the young mothers began envisioning different trajectories for their individual story that moved beyond surviving to thriving as they experienced stress reduction and improved support, and were able to access the tools necessary to resist daily encounters of stigma

and break through structural constraints.

Critical Moment – “They believed in me, so I believed in me”

Doulas and the teen-centered childbirth classes they led were discussed with great enthusiasm by participants in terms of education, confidence-building, maternal capability, and empowerment. Education was reported by young mother as crucial for their ability to understand the physical and emotional changes of childbearing. This, in turn, allowed young mothers to gain a sense of control and to reduce their fears. Descriptions of being “clueless” about everything ranging from pregnancy to birth to parenting created deep unknowns for the young women, and with the unknowns came anxiety, stress and an inability to cope effectively. In Alisha’s words: “It [doula care] gave me more knowledge to just know what was going to happen during the pregnancy, and as scary as it was, it helped me not to be so scared” (Age 15). Carla said: “She [the doula] provided me with so much knowledge that I felt empowered. I could do this on my own” (Age 17). Doulas as sources of support and encouragement, during an otherwise stressful and disjointed experience, was a sentiment echoed by many. Some called them a “stop gap measure” while others emphasized doulas as “being a bright spot in an otherwise dark experience” (Patti, Age 15).

Moreover, young mothers passionately described how the education they received from doulas significantly influenced their ability to know their options, and make decisions that were best for them. In Tanya’s words: “Doula education helped me know my options field and my legal rights” (Age 17). This was significant for participants because it placed the locus of control back into their hands, giving them tools to resist the stigmatizing processes that contribute to their silencing, mal-treatment, and neglect by

others in their lives. Katie illustrated the power of education as it related to decision-making during the birth:

Birth is the biggest day of your life. And so I think that you should be able to experience it to the fullest and how *you* want to. It's a day that you're gonna think about every day. So it should all be decided by you and if you don't know that you have the options, then you're not gonna have that control. (Age 15)

Renee echoed: "I had talked so much with my doula so I understood that I have the right to speak my opinion. The doula explained to me in the beginning that you're gonna have some nurses and doctors that are gonna wanna push stuff on you and have it their way. But you need to understand that it's not their birth, it's your birth" (Age 17).

Participants also discussed how the chaos of their lives combined with a rigid medical system (e.g., fixed office hours, fifteen minute prenatal visits) often interfered with their ability to get questions answered, to understand how to ease discomforts or concerns, and to otherwise communicate about their options and the tremendous changes happening in their bodies and lives. Doulas, in contrast, were pivotal in overcoming this structural barrier to knowledge, largely because of their ease in access. Doulas would text, have phone calls at all hours of the day and night, visit mothers in their homes, and otherwise meet them where they were at—emotionally and logistically. Doulas also built a level of rapport and trust with their clients that the mothers did not feel they had anywhere else in their lives. As Violet explained: "For me, a doula was another source of information. If I didn't want to ask my doctor or mom about something, or if I was confused, I could call or text my doula whenever. That was very handy and important for me" (Age 18). Carla echoed: "She didn't care what I asked her. It was never 'this is a stupid question' even though I was sure that they were. She didn't care if it was the dirty

questions, like about sex and vaginal stuff...Never once did I feel like she was going to judge me” (Age 17).

Education departed by doulas was most meaningful to participants because it was done in a non-judgmental manner. “Not feeling judged” was central to young mother’s stories of doula care, and was discussed in their descriptions of both one-on-one appointments and for the teen-centered childbirth classes that doulas led. Valerie recounted:

Even though we’re all teenagers, you’re in a class full of teenagers, the doulas aren’t treating you like you’re just some incompetent teen. They don’t even be like “you’re young so we’re gonna tell you how you should do this.” It’s more like they just believe in you plain and simple, simple as that. You are just as much of an equal with anyone else who’s going to have a baby. (Age 16)

Valerie’s narrative illustrates how non-judgmental education was crucial for developing a sense of self-worth. Doula care nurtured confidence and a sense of empowerment not only through the information being delivered, but also via the spatial dimensions of peer support that occurred in the childbirth and parenting classes. Cassidy recounted her experience with peer support this way:

I definitely felt really alone a lot, which is why the doula program was so huge because I could just go somewhere and be like “hey I’m having this problem and no one else understands, but everyone here does.” I made some friends that sort of acted like an interim social group. I was in this really specific time in my life. I didn’t have a lot of people who could relate to me, but here we are, we are all just having babies, we have kids, we are dealing with it. (Age 17)

Doula-led, teen-centered classes thus provided a sense of belonging that was desperately needed by so many who had lost friends, were isolated from the “normal” experiences of youth, and felt stigmatized for their teen mothering identity. Leanne echoed:

Those classes meant the world because it’s knowing that you’re not alone. None of my friends were pregnant...they had no idea what I was going through. They

had no idea about the stress involved with it...And that was the one and only place that no one would judge you, and I got to enjoy my pregnancy there. (Age 16)

A profound pivot (or series of pivots) in self-concept occurred for participants as they recounted their experiences of doula care—experiences that instilled in them feelings of maternal confidence. Tanya described her doula care fondly:

The doulas really gave me confidence and empowerment. They really do. Because you're a young mom, you know, there's gonna be a fair share of society that's like [sideways glance] "*That* person has a baby?" but you're surrounded by this group of people who are seriously all for you. Like we are here and you are a teen mom, but you know what? We're gonna make sure that that doesn't define you. (Age 17)

Confidence-building, in turn, facilitated feelings of capability as a new parent. Isabella described: "It was important to have that confidence so you are well prepared. No matter how much you prepare yourself, no one is ever really prepared to take care of a newborn, so my doula doing that for me [imparting confidence], that really played a big part" (Age 14). The critical role of knowledge and confidence for parenting and beyond was echoed with fervor:

My doula did so much for me, it's unreal. And I think doulas need to get way more props for what they do because this woman literally took so much time out of her life to cater to my needs, and help me become the amazing mom that I am now...She did wonders to help me get through it, which was helping me realize *I* could do it. (Leanne, Age 16)

The education and confidence-building received through doula care coalesced to help affirm for young women a message of maternal capability. Such experiences were often juxtaposed with other conflicting social messages. Valerie said: "The doula was like 'ok if you want this done, let's write it up, and let's make it happen.' Which is mind blowing. And I remember being like 'wow, I'm still a child, but people are treating me

like an adult,’ which helped me transition into becoming a mom” (Age 16). Sheila explained: “My doula listened to what I wanted, my wishes, and then supported me in making it actually happen. While everyone else was saying ‘you can’t do it, you’re too young,’ the doulas were there saying ‘yes you can, you’re a mom now’” (Age 19).

Critical Moment – “With my doula, I was a person, not a number”

Doula-supported mothers discussed at length the “so what” consequences of confidence-building and education. Doulas were described by participants as making a deep and everlasting impact on their lives, not only by improving their maternal confidence and feelings of capability, but also by modeling the love and support the young mother would give to her child, and by providing tangible support that was tailored “just for me.” Regina explained how her doula gave her very individualized care combined with empowering words that, she feels, created a new trajectory for her life:

For me as a younger mom, just hearing “You can do it!” made a huge difference. Sometimes you just need to hear that. Also, because there are a lot of resources out there, but sometimes you don’t know about them, and you don’t even know how to ask. By having this person [doula] that comes over to your house, that you meet with, that knows *your* needs and listens to *you*, she will know what resources you can actually use. They don’t just say “here [mimics shoving a piece of paper forward], here are the resources for pregnant moms” and then that’s it. So a doula did change my life. My pregnancy, my whole experience overall. I think without a doula I might have been just like, “okay, I can’t do this.” Maybe I would just have given up, or ended up with a bunch of stuff I didn’t want, but I didn’t know how to say that, but with my doula I did. (Age 18)

This focus on individualized care increased access to resources, while also helping to develop new horizons the young mother could consider. Being treated “like a person, not a number” stood in stark contrast to the treatment provided by social services, medical providers and educational entities where generalized “support” was offered against a backdrop of stigma and judgment. As Olivia explained: “It [doulas] is basically

like having a social worker without the stigma” (Age 17). Here, she is referring to the expanded scope of care that doulas working with these young mothers gave. Their care was not focused solely or even majorly on just pregnancy and birth, but rather, their care was tailored to the unique life needs of the individual client, ranging from tangible support (such as resource connections and referrals) to emotional support and relationship navigation. Renee described what personalized support by doulas looked like to her:

A lot of teen births are unplanned and so they're not physically, mentally ready for it. So being able to get in their home and talk to them and have visits with them and get them on the right track, help them get their own place, help them get their GED or get hooked up with a school that can accommodate them, get their own place. And if they have drug or alcohol issues, getting that taken care of before you bring the little one into the world I feel is highly important. That's what doulas help you do. (Age 17)

“Talking through relationships” with their doula was cited by participants as a significant source of emotional support that helped them to navigate their other, often hostile (and ever-changing) relationships. Makayla explained: “My doula was such a big support when I was pregnant...If I needed something I would call her or text her and she would talk to me about it, like the whole baby daddy thing. She was always there for me when something went wrong with him, which was always” (Age 18). Young mothers discussed how doulas helped them to establish healthy relationships and to focus on providing a safe, loving environment for their children. This happened through both explicit conversations as well as through modeling nurturing relationships during care provision. Juliana described: “Doula care gave me a good example of what real support looks like...and they opened my eyes to the types of relationships I wanted in my life and my kid's life” (Age 19). Sheila explained how her doula helped her find strength within

herself to leave an abusive situation: “I pulled myself out of that abusive situation, and I knew I could only do it because of the tools the doulas gave me” (Age 19).

Finally, doulas were discussed by participants as one of the only uncomplicated and consistent support systems in their lives. The mother-doula relationship was characterized as incredibly special, being marked by deep bonds and ongoing individualized support. Carrie said of her doula: “I didn’t really develop strong bonds with anybody except for my doula, so that was my only real emotional support” (Age 17). Molly explained the unique bond with her doula this way: “The fact that they’re [doulas] not connected with the doctors or the hospital or anything and they’re solidly there just for the mom. Just like the support that goes into it. You love your client, you love your doula, you have this connection that’s like unbreakable...you bond forever” (Age 17). Through bonds of trust, internalizing messages of capability and power, and in feeling nurtured as valuable individuals, participants were certain that their lives were “forever changed” because of their doula. In Emily’s words: “Doulas help you to be successful not only in your birth plan, but in your life goals. She made it so I knew my resources, knew my options, and she gave me confidence in my decisions that I carry with me to this day” (Age 19).

DISCUSSION

Johnson-Hanks’s (2002:878) positions vital conjunctures as “a model of aspiration” that pays attention to the ways social systems frame conceivable horizons and individual experiences of significant life events. I have developed a theoretical schema (see Figure 2.1) designed to illustrate the negotiation of adolescent motherhood as a vital conjuncture. During the childbearing year, both uncertain futures and (transformed)

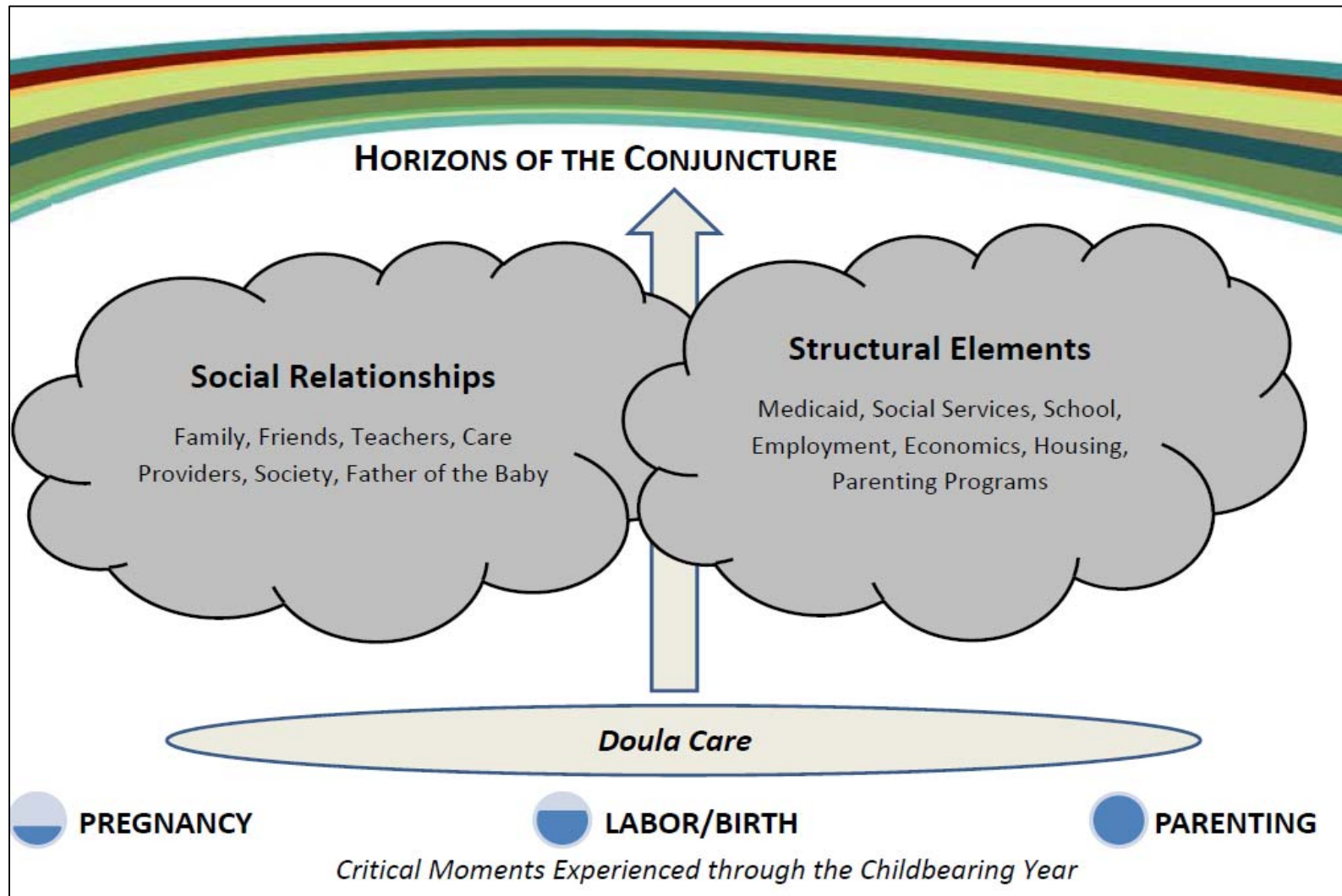


Figure 2.1 Negotiations of adolescent motherhood as a vital conjuncture

identities are at stake for young mothers as they imagine and rework future possibilities (the horizons of the conjuncture). Those possibilities that come into view are largely determined by the intersecting nature of a woman's social relationships and structural context, which are influenced not only by her age, but by other social identities and locations she occupies, including her family of origin, socioeconomic level, partner status, and racial and ethnic identification. In this way, young motherhood serves as an example of "intersectional stigma" (Mantovani and Thomas 2014), where the stigma ascribed to their age intersects with stigmatizing processes attached to other marginalized identities the young women may possess (Luttrell 2011; Mantovani and Thomas 2014; SmithBattle 2005, 2013; Yardley 2008). The social-structural limitations of a young woman's conjuncture, thus, all too often function like cloud cover, obscuring the possible horizons she might achieve. As young mothers move through critical moments during pregnancy, labor, birth and the postpartum periods beneath these clouds of social and institutional constraint, poverty, ageism, and intersectional stigma obscure the visibility of a range of horizons.

In this way, the deeply stigmatized construction of teen pregnancy in the United States helps to create experiences of "mere survival," often reproducing intergenerational cycles of social inequity by constraining young mothers' abilities to move past barriers and into new horizons marked by well-being, confidence, maternal capability and self-worth. Rather than viewing young mothers as social problems themselves, my work highlights a different contributory pathway. The very social relationships and structural systems designed to "help" the "teen mom problem" are, in many cases, functioning to reify the negative consequences of young childbearing by perpetuating the stigma and

institutional obstacles that trap adolescent mothers beneath very limited horizons.

Teenage pregnancy, then, is not a condition of innate risk, but rather, is a product of the constant exposure of young mothers to stigma and insufficient economic and psychosocial support.

However, as this schema also illustrates, there are possibilities for escape, off ramps, or “sunbreaks” that may expose additional horizons. Within conjunctures of adolescent motherhood, doulas can function this way, helping young mothers to break through the clouds and expand imaginable horizons. As doulas empower young women to reject their presumed identities as “damaged goods” or “lost cause” mothers, adolescents can begin to reframe their young mothering story. In examining the mediating effects of doula care on experiences of support, stress, and stigma, I have explored how targeted social support can disrupt processes of social exclusion and create new horizons oriented towards thriving, belonging, and empowerment.

As the model of vital conjunctures grows in application for exploring subjective negotiations and variations within a wide variety of phenomenon—including parental death (Evans 2014), grandmotherhood (Notermans 2004), pregnancy loss (van der Sijpt 2010), migration (Liversage 2009), and youth transitions into adulthood and employment (Esson 2013; Jeffrey 2010)—my research demonstrates the need to investigate targeted social support mechanisms for individuals experiencing a vital conjuncture. Future studies employing this theoretical model may benefit from explicit attention to the ways in which targeted support can work to re-calibrate conjunctures by altering identities, aspirations and support contexts.

Limitations

It should be noted that teens that had negative or even unremarkable experiences with doula care may have been less motivated to volunteer for an interview. I have no way of knowing how their experiences were shaped by doula care, nor how their voices might have influenced my interpretations. Indeed, during participant-observation, I did hear of rare cases in which young women “felt abandoned” by their doulas. If doulas were not “reachable at all times” or otherwise did not “show up” for the teen in their hour of need, mothers’ experiences with doula care may have been less transformative or even harmful. Negative interactions between doulas and young mothers have in fact been documented in one case in a previous study (Rohwer 2010). The lack of negative stories in this study is likely a result of sampling bias, whereby women who had a poor experience were unlikely to self-identify as “doula supported” during recruitment. This is a recognized limitation. The potential for negative or unremarkable doula care experiences also indicates the need to ensure that doula care is consistently high-quality (rather than assuming it will be) during programming and implementation of doula models. In addition, while this study suggests that education, non-judgmental support, expertise at navigating social services, and the ability to help young mothers reframe their stories are critical attributes of doula models, more work is needed to help identify the additional, specific and replicable components of care most likely to open new horizons for young mothers. This study is hopefully just the beginning.

CONCLUSION

In conclusion, I have argued that by positioning adolescent motherhood as a vital conjuncture, the dynamic interplay of institutions with individual agency crystalizes and

underscores the need to reconceive risk constructions of teen pregnancy to account for larger structural constraints that have reified age-based health inequities and maintained systemic barriers to young mothers' well-being. From the first critical moment of "finding out" when their "world stopped spinning" and their conjunctures come alive, through to their emergence into a new maternal identity, their negotiations and the unfolding of imagined horizons are socially constituted and structurally constrained. I have argued that doula care can work to mediate social and institutionalized barriers, and to re-orient young mothers toward long-term well-being and flourishing horizons. In Barbara Katz Rothman's words: "Birth is not only about making babies. Birth is about making mothers—strong, competent, capable mothers who trust themselves and know their inner strength." As a targeted form of social support, doulas have the potential to cultivate not only transformed futures, but transformed maternal identities of confidence, capability, and worth—identities that can carry young mothers beyond their birth plans to life plans marked by thriving possibilities and success.

NOTES

ⁱ All names used in this article are pseudonyms to protect the identity of participants.

ⁱⁱ In this article, I use the term “childbearing” to denote the childbearing year, including the prenatal, labor/birth, and immediate postpartum period.

ⁱⁱⁱ Due to the sensitive and highly personal nature of material disclosed in interviews, specific locations are not given so as to maintain the anonymity of participants, their families, and wider communities.

^{iv} Because pregnancy is a lengthy process of nine plus months of gestation, mothers are likely to have an age change between the time of conception and the time of delivery. For the purposes of this study, either pregnancy and/or birth must have occurred between the ages of 15 and 19, meaning that mothers who conceived at 14, but gave birth 15 are included, as well as mothers who conceived at 19, but gave birth at 20. The age given for a participant in quotes denotes the age at pregnancy.

^v Juno is an American movie released in 2009 about a 16-year old suburban girl facing an unplanned pregnancy who, after almost getting an abortion, chooses instead to place her baby for adoption.

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Chapter 3:
Respected (Adolescent) Motherhood: Doula Care as Narrative Repair

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INTRODUCTION

Adolescent childbearing women in the United States experience negative maternal-child health (MCH) outcomes with an increased risk of lifelong social inequities within and across generations (Martin et al. 2015; Smithbattle 2007; Savio Beers and Hollo 2009; Ventura, Hamilton, and Matthews 2014). Young childbearing women are also subject to intense social stigma as the legitimacy of their motherhood is perpetually questioned (Barcelos 2014; Bute and Russell 2012; Rodriguez 2008; Wilson and Huntington 2006), and experiences of stigma have profound consequences for identity formation and the development of future aspirations (Mantovani and Thomas 2014; McDermott and Graham 2005; Porter and Holness 2011). Conversely, supportive relationships can help overcome negative impacts of stigma, foster positive self-concepts, and promote the attainment of long-term well-being (Brubaker and Wright 2006; Silver 2010; Smithbattle, Lorenz, and Leander 2013).

Doula care has been advocated as a cost-effective strategy for improving maternal-child health and perinatalⁱ experiences, especially among marginalized communities (HealthConnect One 2014; Gruber, Cupito, and Dobson 2013; Kozhimannil et al. 2013; Steel et al. 2015). Doulas are non-medical, childbirth professionals that provide emotional, physical, educational, and advocacy support to a woman and her family during the prenatal, birth and immediate postpartum periods (DONA International 2012). The successes of doula support (such as reduced cesarean sections, increased breastfeeding rates, and improved parenting skills) are argued to reside within the relationship-based nature of this care model—a model that capitalizes on the growth and

change potential of the perinatal period (Gentry et al. 2010; HealthConnect One 2014; Phillips and Kelly 2014; Strauss, Giessler, and McAllister 2014).

The purpose of this project was to examine the models, practices, and desired outcomes held by a voluntary sample of doulas serving pregnant and parenting adolescents in the Northwestern United States. Specifically, I aimed to describe the doula-mother relationship and to generate hypotheses regarding the effects of doula care on the psychosocial and clinical well-being of young mothers. In this article, I explore the ways doulas construct their philosophical models of care in explicit opposition to stigmatizing meta-narratives that they see as perpetuating the social exclusion and discrimination of young mothers (Mantovani and Thomas 2014). I describe how the care practices of doulas are grounded in the provision of targeted social support and a relationship of non-judgment and empathy. Through departing “knowledge as power,” maternal confidence-building and empowerment, I argue that doulas facilitate narrative repair of young maternal identities. I use narrative repair here to refer to the processes by which doulas use narrative to challenge and reframe the stigmatizing experiences of young pregnancy, and subsequently promote a more positive sense of self that young mothers can employ in resisting cultural constructions of “damaged identities” (Brubaker and Wright 2006; Nelson 2001) and “deviant mothers” (Wilson and Huntington 2006)—constructs that contribute to the social exclusion and ongoing marginalization of childbearing adolescents (Nahar and van der Geest 2014; Yardley 2009). By viewing doula care as narrative repair, I argue that doulas create a critical opening for young mothers to navigate maternal identity formation and aspirations from a framework of respected, rather than illegitimate, motherhood.

THEORETICAL FRAMEWORK

Narrative theory has been used across disciplines to investigate how stories shape human experiences and the ways people negotiate, construct and make sense of their lives (Charmaz 1999; Herman et al. 2012; Mattingly and Garro 2000; Ochs and Capps 1996). In this article, I employ three key concepts from narrative theory: 1) meta-narratives; 2) counter-narratives; and 3) narrative repair. Meta-narratives refer to the grand stories that perpetuate cultural phenomena, and appear, due to socialization, as (nearly) universal truths. Meta-narratives often function to uphold power structures by subjugating persons that do not conform to or uphold culturally normative meta-narratives (Barcelos 2014; Somers 1994). Counter-narratives are stories developed in opposition to meta-narratives, or those that resist assumptions of meta-narratives and, in so doing, create a space for new ways of understanding or being (Bamberg and Andrews 2004; Bute and Russell 2012; Lyotard and Jameson 1984). Drawing on the notion that narratives pattern experiences and notions of the self (Ochs and Capps 1996), investigations of narrative repair explore the role meta- and counter-narratives play in identity formation, as well as the ways in which individuals may come to reject socially constituted selves and construct alternative identities through the production of new stories with new endings or trajectories (Nelson 2001).

Previous research with young mothers has documented the impact of narratives on maternal identity formation, wherein young women rely on messages communicated by others to steer their emergence into motherhood (Brubaker and Wright 2006; Mantovani and Thomas 2014; McDermott and Graham 2005; Porter and Holness 2011; Rodriguez 2008; Silver 2010; Smithbattle, Lorenz, and Leander 2013; Wenham 2011).

Judith Butler (1993, 1997, 2006) claims that performative acts and recognizable or socially sanctioned behaviors constitute identity—that is, motherhood itself does not exist as an ontological category or “essence” that is fixed and natural; it must be performed. Motherhood identities are, thus, constituted through the performance of mothering actions, and the subjective experiences of becoming a mother are powerfully shaped by institutions, relationships, and social norms.

For young mothers, the social and structural “supports” available are, on the whole, guided by a pathologizing meta-narrative (Brubaker and Wright 2006; McDermott and Graham 2005; Silver 2008; Silver 2010; Smithbattle, Lorenz, and Leander 2013), leaving them little to no option but to perform “wrong” (mothering) norms (Butler 1997, 2006) by virtue of their age and socioeconomic status. In this meta-narrative, adolescent women experience stereotyping as “lost cause” mothers, and this stereotype then serves to “other” young women during the process of maternal identity formation (McDermott and Graham 2005; Nahar and van der Geest 2014; Rodriguez 2008; Silver 2010; Smithbattle, Lorenz, and Leander 2013). Subsequently, oppressive meta-narratives situate pregnant adolescents outside the bounds of “acceptable” motherhood, and the social exclusion they then experience contributes to feelings of disempowerment, incapability, and low self-worth.

Brubaker and Wright (2006) have argued that childbearing constitutes a “turning point” (Charmaz 1999) in the lives and identities of adolescent women—a point at which resiliency, self-efficacy and resistance to stigmatizing meta-narratives can be fostered to enhance the well-being of young mothers and their families (Nahar and van der Geest 2014; McDermott and Graham 2005; Porter and Holness 2011; Rodriguez 2008; Silver

2008). Resiliency is the ability to recover from adverse situations and to avoid being crushed by hardship; resiliency is a coping mechanism (Nahar and van der Geest 2014; Porter and Holness 2011; Silver 2008). Self-efficacy is the internally held belief in one's own ability to triage challenges that present and to successfully achieve desired goals (Gruber, Cupito, and Dobson 2013; Porter and Holness 2011; Rodriguez 2008). The concept of self-efficacy is similar to, and arguably a form of, agency, or the ability to influence (to some degree) one's own life course (Nahar and van der Geest 2014). Like agency, however, self-efficacy is structurally constrained by social forces that position women as "neither free agents nor passive victims" (Ellison 2003:324).

Resistance brings together self-efficacy and resiliency to account for the ways in which individuals and communities challenge oppressive meta-narratives (Brubaker and Wright 2006; Mantovani and Thomas 2014; McDermott and Graham 2005; Nahar and van der Geest 2014; Rodriguez 2008; Smithbattle, Lorenz, and Leander 2013). Crucial to note is that neither resiliency nor self-efficacy are inherent psychological traits; rather, the development of these characteristics are externally based, relying on cues from and interactions with institutions, family, peers, and media. Their enactment is also structurally constrained, and their effects on the formation of self-concept and life trajectories significant (Brubaker and Wright 2006; Nahar and van der Geest 2014; Porter and Holness 2011; Silver 2008, 2010; Smithbattle, Lorenz, and Leander 2013). As such, in the absence of a recognition of the ways in which resiliency, self-efficacy and resistance are socially mediated and constructed, a "blame the victim" rhetoric can emerge that makes invisible the underlying structural conditions of inequity that maintain the social exclusion of young mothers as "lost causes." By exploring how these processes

are socially constituted through narrative, institutions, and relationships, I describe a distinct model of doula care aimed at improving the well-being of young families through narrative repair.

METHODS

In order to examine the philosophical models, care practices, and desired outcomes that guide the work of doulas who serve young mothers, I combined qualitative interviewing with extensive participant-observation (Bernard 2011; DeWalt and DeWalt 2010; Green and Thorogood 2013). During the fieldwork years of 2010 to 2015, I volunteered as a birth doula, perinatal health educator, and applied anthropologist among community agencies, school-based teen parent programs, and perinatal task forces that served young mothers in the Pacific Northwest. Most notably, I worked closely with a community-based non-profit that provided *pro bono* doula services to young mothers, as well as teen-centered childbirth education classes and parenting groups. Through this organization, I provided direct doula services to adolescent mothers, and helped facilitate the program's teen-centered childbirth education classes and parenting groups. From 2010 to 2012, I also coordinated the agency's outreach and referral system, matching doulas with clients, overseeing the day-to-day operations of the doula program, and publicizing services among local school- and community-based teen parent programs. My positionality as both a medical anthropologist and doula allowed me to witness firsthand many of the narratives, models of care, and identity formation processes described by participants in this article.

For the qualitative interviewing portion of this study, I employed a modified grounded theory approach using the methodology proposed by Charmaz (2006, 2011).

Following approval by the Institutional Review Board (IRB) at Oregon State University, I elicited semi-structured, open-ended interviews from a voluntary cohort of doulas (n=15) in three research locales across the Pacific Northwestⁱⁱ between April 2014 and March 2015. To be eligible for this study, potential participants must have self-identified as a doula and have provided care to at least two teenage mothers in the seven years prior to the study period. Doulas were recruited from three sites: community-based agencies that delivered *pro bono* doula services to young mothers; schools and public health departments serving pregnant and parenting adolescents; and online social media platforms (e.g., Facebook) where local doula networks are active. Doulas that were willing to participate self-identified by contacting me using the information provided on the recruitment flier. Participants chose the time and location for the interviews.

I started interviews by asking participants to tell me the story of how and why they became doulas serving the young childbearing population. I then asked them to describe the type of care they gave to childbearing adolescents; the challenges, as well as opportunities, they witness their clients experiencing; and the roles they perceive doulas as playing in the lives of young mothers. I concluded interviews by asking participants to share their advice on what could be done to improve experiences for young mothers. Interviews were audio-recorded with participant permission and hand-written notes taken to help document the non-verbal as well as verbal structure of their narratives (Charmaz 2006; DeVault 2003; Green and Thorogood 2013).

In accordance with a grounded theory approach, I performed preliminary coding and thematic analysis on a small portion of initial interviews (n=3), and then refined the interview guide to reflect emerging preliminary themes. Initial interviews reflected two

emerging themes: 1) the pervasive stigma doulas saw as reinforcing the poor, even abusive, treatment of young mothers; and 2) frustration with the lack of social services and supports for childbearing adolescents, which doulas described as integral to acquiring confidence as a mother. Subsequent interviews (n=12) were conducted with a refined guide designed to elicit elaboration of these emerging themes. Theoretical sampling and concept saturation were used to determine the final sample size (n=15) (Charmaz, 2006, 2011; Glaser 2001). While the details of each doula narrative varied, especially around what “called” them to work with young mothers, I stopped interviewing at n=15 when no new data informing theory building was being generated. All interviews were transcribed and narratives analyzed using QSR NVivo 10 software to code for commonly recurring themes in the final sample (Charmaz 2006, 2011; Glaser 2001; Corbin and Strauss 2007).

RESULTS

Participant Characteristics

Select characteristics of study participants are outlined in Table 3.1. All doulas provided their care *pro bono*, citing a commitment to service, feminism, and/or social justice as the impetus for their involvement with young mothers. The majority of participants were involved with youth in other roles as well, including as middle school or high school teachers, at-risk youth shelter staff, teen parent program coordinators, and community youth programming staff, volunteers, or directors. Two of the participants identified as previous teen mothers themselves, and the majority cited personal experiences with young mothers in their lives (friends, siblings, daughters) as ongoing motivation for the care they provided.

Table 3.1 Participant characteristics: Doulas

Characteristic	
Age in years at time of interview, mean (SD)	35 (6.48)
Race/Ethnicity, % (n)	
Women of color	20 (3)
White, non-Hispanic	80 (12)
Number of years providing doula care^a to adolescent mothers, mean (SD)	9 (4.94)
Minimum	1
Maximum	20
Total number of adolescent mothers served as a doula, mean (SD)	32 (35.68)
Minimum	4
Maximum	140

^a May not have been an active doula for all years

Narratives of Care

The narratives of doulas revealed three predominant themes that participants felt encapsulated the models of care they strive to provide for young mothers: (a) overt rejection of the “bad teen mom” cultural attitude; (b) compassionate support as praxis; and (c) nurturing respected motherhood. These themes comprise a distinct care model aimed at achieving maternal well-being. Respectively, these themes describe the philosophies of care, central practices, and desired outcomes held by doulas that serve young families.

Cultural Attitudes and the “Bad Teen Mom”: Interrupting Meta-Narratives

Theme one describes the values and convictions that motivate doulas’ philosophies of care. Participants were intimately aware of the stigmatization that characterizes the treatment of young mothers by family, friends, teachers, social services agencies, medical providers, and society at-large—sometimes because they themselves

had felt victimized by ostracizing rhetoric or because someone close to them had suffered. Doulas, angered by these pathologizing frameworks, explicitly aim to interrupt the “bad teen mom” normative meta-narratives as they build relationships with young clients. Lanaⁱⁱⁱ explained:

I don't think that our culture looks on young moms in a positive way at all. They don't often look at them as moms even. They still look at them as kids. You know that all changes the day they see that positive pregnancy test. But no one sees that. They only have negative stereotypes and a lot of stigma that comes with it.

Another participant, Eva, expanded:

I think there is a need for a cultural shift that supports teen parents in a different way. They are often looked down upon, they are marginalized. They are young kids having sex and that's a bad thing, and that means they weren't responsible. It means they were stupid. It means a lot of things that in reality aren't the case. I mean rapes happen, condoms break, whatever the situation, it's often not the situation that society sees.

This notion of being an (irresponsible) child, and not a (capable) mom, framed doulas' care narratives, and resulted in a focus on the importance of maternal identity development. Doulas refer to their clients, for example, as “mothers” and “women” rather than as “pregnant teens” or “girls.” These language cues are part of a symbolic interactionism (Blumer 1986) that guides the doulas' models of care. Symbolic interactionism is the theory that human communication is facilitated by gestures, words and other symbols that take on conventionalized meanings. Doulas capitalize on this as they engage in verbal and non-verbal practices intentionally designed to reshape specific meanings of adolescent motherhood. Participants hope that young women will come to rely on the counter-cues provided by doulas (rather than oppressive meta-narratives) to make sense of their stories (Blumer 1986; Brubaker and Wright 2006; Charmaz 1999).

In effect, participants attempted to interrupt meta-narratives of “less than” mothers with “invisible” childbearing (Rodriguez 2008) by actively nurturing positive maternal identity construction. Doulas felt this was crucial to instilling in the young women feelings of capability and control:

I think a big piece of it is [supporting teen moms] is having that one person that no matter what anyone else does in your medical care, your family, your friends, you have one person who sees you as a mother, that trusts you to make your own decisions, and that will only ever try to help inform and support you in those decisions, not take away your power. The doula is often the *one* person who already sees you as mom and sees you as in charge....And that's really powerful (Abigail).

Abigail's narrative illustrates how by capitalizing on the maternal story (McDermott and Graham 2005), doulas can help counter experiences of distrust and incompetence that young women are subjected to as their youth and mothering identities collide. Moreover, doulas assert that recognition as a mom, rather than as a “delinquent teen,” during pregnancy and birth makes a difference for parenting. Sydney said: “If they don't feel empowered as a mom, they inherently enter parenthood from this position of insecurity. I try to help them identify as a mom so they can take ownership of their body, their child, their lives.” Instilling autonomy and control was, thus, seen by doulas as critical for fostering a young woman's sense of self-efficacy, resiliency, and her ability to resist or challenge stigma. Doulas described this process as powerful for their clients, as “providing an awakening,” the birth of a nascent gender, age and/or race consciousness, as a “game changer” that young mothers recognized as vastly different from the treatment they receive by others assigned to “help” them.

Participants discussed how the stigmatization and lack of control that young mothers face crystalizes during medical treatment, recounting poignant stories of how age

discrimination combined with authoritative biomedical models of care (Jordan 1992; Davis-Floyd 1992) to neglect, punish and/or abuse, young women. Abigail described an all too common scenario:

The mom tried to ask a question and the nurse just dismissed her. Then she said to another nurse “she’s only 15” and “ugh, these teenage moms” and they were rolling their eyes. There’s this overarching attitude that she [the mom] made these choices and now she is just going to have to deal with the pain deal and deal with the abuse and the fear that she’s feeling. Rather than this nurse wanting to help comfort her and bring her fear level down, she was very much saying “sorry you’re scared honey, but you had sex and now you’re pregnant. Deal with it.” So that was just a very blatant example of how that cultural attitude [stigmatizing meta-narratives] is pulled right into the hospital.

This punitive attitude led to outright medical abuse in many cases, or what Perez D’Gregorio (2010) has termed “obstetric violence” to denote the dehumanizing treatment of women by medical providers through appropriation of the body, unnecessary intervention, and dismissal of autonomy and informed choice. Participants had multiple examples of obstetric violence. Lily described: “The worst two abuses that stand out to me happened with two different moms. One was breaking of water without consent, and one was an episiotomy without consent.”

Medical abuses were noted by participant as especially harmful when one considers the past sexual abuse and neglect many young women have faced prior to becoming pregnant (Noll, Shenk, and Putnam 2009). In response to ongoing maltreatment, doulas described a philosophy of care guided by “support as healing” as they proactively work to help their clients avoid being (re)traumatized. For example, Carolyn described her care model as aiming to, “interrupt trauma with empowerment” because “trauma impacts a mom’s ability to parent and bond with her infant.” Previous research (Anderson and McGuinness 2008) has documented that young women

commonly experience childbirth as traumatic due to both past abuse and/or due to the lack of explanations and choices offered by providers. Where meta-narratives position young mothers as “irresponsible children,” medical providers may see little need to engage in information exchange or shared decision making with their patients.

In turn, traumatic childbirths among young mothers are associated with increased risks of both postpartum depression and posttraumatic stress—two intertwined conditions that, as Carolyn noted above, impacts bonding and postpartum mental health (Anderson and McGuinness 2008; Cox et al. 2008). Doulas, therefore, endorse a “knowledge as power” care philosophy, one grounded in the simple, but profound notion that young mothers have the same rights to choice and bodily autonomy as older women. Sydney explained: “No one ever asks them what kind of experience they want to have. There is power in asking that *and* honoring that. It helps them make the transition into their role as confident mothers.”

Finally, in describing their philosophy of care, doulas believed that filling in life gaps, serving as a compassionate adult figure, and countering daily experiences of discrimination were central for nurturing maternal confidence and self-worth. Participants explained how the young women they serve often come from low socioeconomic families and abusive or neglectful home environments with lacking role models. Participants delineated in great length the day-to-day challenges of young mothers’ lives, citing food insecurity, unstable housing, the absence of reliable transportation, hostile or inconsistent relationships, and educational barriers (staying in school/going back to school) as foundational structural stressors in their lives.

Thus, doulas' motivations to serve young mothers often arose from a sort of "fury with the system" in tandem with an explicit rejection of the "bad teen mom" meta-narrative. Doulas asserted that, "there is nothing innately bad about being a young mom." Rather, they saw the difficulties young moms face in creating positive maternal identities and futures as a consequence of stigma and the lack of both emotional and structural support for self-actualization as a parent. Lily explained: "People assume that young parenthood means a disaster. But it's not always a terrible thing in somebody's life. It can be amazing. They just need more help and support, not just criticism."

In response, doulas took a philosophical stance of "meeting moms where they are, not where we want them to be," and this was argued to lead to effective, even transformative, care. Eva, one of the mentor doulas in a community-based doula program serving teen moms, explained:

We really modeled when doulas mentored with us this idea that we were going to create what this client needed within their own framework. That allowed us to be more flexible and effective. Rather than this idea of "okay so we're going to visit three times at 21, 26, and 40 weeks, and we are going to meet in the afternoon at your house, and this is what we are going to talk to you about," it was really "Oh okay, so you need a food box? Let's figure that out. Oh you want to switch providers? What does that look like? Just being really available for *them*."

Compassionate Support as Praxis: Constructing Counter-narratives

The second theme, compassionate support as praxis, describes what doulas do in practice during the provision of care. The philosophical underpinnings delineated in theme one lead doulas to employ three targeted support strategies (education, emotional, and material) aimed at meeting the material and psychosocial needs of young mothers, while simultaneously communicating a counter-narrative of respect, empowerment, and worth. Participants' descriptions of their doula work also revealed the importance of non-

judgment and egalitarian relationships, which they see as “forming the foundation” of their three-fold support strategy.

Participants described at great length how they, first and foremost, attempt to build a relationship of trust and collaboration. Doulas begin trying to create this non-judgmental relationship from the very first time they meet a client, approaching young mothers with a calm tone and emphasizing that “the mother is in charge” of the relationship. Lana describes her initial care as follows:

I try to be relaxed and comfortable and friendly and not approach them like I think a lot of other adults in their life are approaching them during that time of their life, which is telling them what to do. Instead, I try to be their ally and their buddy. I just sit and chat with them about everything and anything that they want to chat about for our first few meetings. I don’t dictate. I support.

Doulas’ support practices emphasize an inversion of social hierarchies as they attempt to create a relationship premised on equality. For example, doulas again employ symbolic interactionism via non-verbal communication in an effort to convey messages of esteem and empowerment. Jane explained:

Just having someone sit down and talk to them face-to-face, on an equal level, is huge. To do this, to make them feel they are in charge, I use a technique where I would always sit on the floor so that they didn’t feel like I was towering over them or telling them what they had to do. So I was actually looking up to them, physically, because your body language communicates a lot. No one else ever *looks up* to them.

Doulas also described how they try to be responsive to the young mother’s needs, as well as to her disposition, ways of communicating, and feelings as she processes an enormous shift in her identity and future. Eva discussed the “mirroring” technique she used and attempted to impart to other doulas:

I remember always feeling the need to be really intuitive and sharp. So am I going to walk in and this is going to be somebody that is shy, so do I need to tone down

some of my hand gestures, my tone of voice? Is this someone who is really animated and loud, and do I need to be loud too? There was a lot of mirroring so they felt comfortable with me. I think that as doulas we do that well in the birth room too. Not necessarily mirroring quiet for quiet because sometimes that's not what they need, but just reading someone with a lot of cues that don't have anything to do necessarily with what they are saying.

Vivian described her support strategy this way: "My goal was to create a trusting relationship. To be there with them as another person, being equals through our shared humanity. It is about not judging. It is about creating a comfortable space and simply asking "how are you?" In effect, doulas create "therapeutic relationships," or relationships that are responsive to feelings, behaviors, and individualized ways of being in the world—a technique that has been documented as particularly effective among marginalized and stigmatized mothers (Porr, Drummond, and Olson 2012; SmithBattle, Lorenz, and Leander 2013).

From this relational stance of compassion arose three targeted support strategies that guided the practices of doulas in their care of young mothers and enabled the construction of counter-narratives. The first dimension described in doulas' narratives was that of educational support, grounded in the philosophical belief of "knowledge as power." Participants described tailoring educational support to the unique community they were working with. As Lauren explained: "It's [doula care with young moms] a lot about education. Helping them deal with the unknowns. Making sure there are no unanswered questions. This takes away fear." As discussed in the first theme, traumatic childbearing experiences often result from the "unknowns" (Anderson and McGuinness 2008), and doulas consistently cited the importance of education for decreasing fear and, in turn, decreasing stress and improving health outcomes and experiences.

Doulas often informally discussed existing literature on the effects of embodied stress for health outcomes (see: Baibazarova et al. 2013; Cederbaum et al. 2013; Entringer et al. 2011; Hobel, Goldstein, and Barrett 2008; Spicer et al. 2013), and emphasized the importance of education for making healthy and empowered choices. In their practice descriptions of educational support, doulas focused on communicating options and legal rights, often in direct opposition to the medical abuses and cursory explanations young mothers received. Vivian said: “We know the medical abuse of young moms happens, and we know they [medical providers] often don’t get consent. I try to make sure they know their options and feel confident in speaking their options. That’s their right!”

Doulas described educational support as critical for providing young women with the tools and knowledge necessary to stand up against discrimination and make their own choices. Betsy noted: “Given options, young moms will make the best choice for themselves.” Ellen expanded:

Starting off with the education. Making sure they understand what their choices and their options are. That’s going to give them the power to make good healthy choices for their child and their life in general because they are finally given permission to make choices and be in charge of the situation.

As Ellen’s quote illustrates, participants connected choice in childbearing with the ongoing ability to exercise autonomous decision-making, noting that it was not just about immediate decisions, but about their long-term self-efficacy as a mother. Kathryn said: “Having them make informed decisions now is so important because it models that they will have to make decisions forever as a parent. Knowing they have rights, and then

communicating that they are capable of acting on those rights. That's huge for motherhood."

In delivering educational support, doulas discussed how recognition for their concurrent identities as youth and emerging mothers was important for insuring success and avoiding alienation. Participants described the careful, empathetic navigation of options with their clients as they fostered the women's new maternal identities:

They are still teenagers, so they are not always making healthy choices. They want to eat with their friends at McDonalds, which makes sense. That's normal for their age, so there can't be judgment. So instead of saying, "no that's bad," it's talking with them about "hey, you're entering a new phase of your life, so let's kind of re-evaluate that and find different options that work for you." (Ellen)

Participants also noted how educational delivery involved repetition and responding to information the mother may have gained in other areas of life (for better or for worse). Specifically, doulas cited using "popular education" techniques to reach young mothers more effectively. As Abigail noted: "I do a lot more reiterating than I would normally do, and a lot more talking about what she's covered in her classes, with her home health nurse, what she knows instinctively, or what has she learned from watching her siblings. It's a different approach to the same information." One participant called this model of educational delivery "listening to educate," implying that in order to be an effective perinatal educator, the doula needs to listen to the mother's own sense of embodied knowledge (Davis-Floyd, Sargent, and Rapp 1997)—a knowledge source recognized as critical to the development of therapeutic relationships and culturally appropriate care (Smithbattle, Lorenz, and Leander 2013; Williamson and Harrison 2010).

Participants were, thus, quick to note that education delivered without contextualization, a trusting relationship, and compassion would always fall short of

transformation. To this end, descriptions of educational support were discussed in tandem with the second targeted support dimension two—emotional support. The passion for emotionally supporting young mothers arose from three intersecting sources: 1) participants believed in the power of emotional support to foster positive maternal identity formation; 2) participants felt spurred on when witnessing a lack of emotional support for young mothers due to their stigmatized identities; and 3) participants believed that doulas were uniquely positioned to deliver much needed emotional support.

Doulas discussed emotional support as a key mechanism for nurturing maternal self-concept. As Abigail explained:

I think emotional support is *really* key because it creates this safe space for you to share in a new way, for a young mom to share from a position of motherhood. Rather than just being this teenage girl talking to her mom or talking to her girlfriends, when they speak to you [the doula], they're speaking as a mother. And that's really big.

Many described how this emotional support was particularly striking against a backdrop of life instability and meta-narratives that disregard their maternal status: “Doula support is a refuge for a lot of young moms. The emotional support we give, just listening, gives them time to reflect. So what we give them is the gift of time. All mothers crave this, the ability to focus on themselves, their pregnancy and their baby” (Camille). Camille went on to explain how listening and patience were key skills for parenting; by demonstrating to young mothers firsthand the benefits of emotional support, she believed they were more likely to go on and model and enact these behaviors with their children as well.

Additionally, the lack of emotional support for young mothers was discussed as both a product of their stigmatized identity and a product of cultural birthing practices in the US at-large. Betsy noted: “They don’t get honest and unconditional love anywhere

else because their pregnancy is seen as shameful, something to be hidden, not celebrated.” Another participant explained how stigmatized teen mother identities exacerbate the “culture of non-support” that characterizes US birthing culture. In response, doula practices of emotional support were intended to instill a level of positivity and celebration into young mothers’ lives:

Everyone is always asking them, “Oh, are you going to keep your baby? Oh, are you going to live with your mom? Oh, are you getting married?” Everyone neglects asking “What are you naming the baby? What are you having? Do you have a crib yet?” The things they ask other moms. And so once they [the young moms] get into the conversation with you around their birth, and what their hopes and dreams are, and how they cope with pain, and how they feel about taking a bath during labor. All these little things that seem so routine to us are *huge* for them. They’re like, “Oh, yeah. I’m a mom. I get to plan my birth. This is my life. I don’t have to just constantly be answering questions about the logistics of this. I can dream and hope too.” And I do see them get excited about that, about becoming a mom. (Abigail)

Jane explained how emotional support helped communicate a message of worth to young mothers, often in stark contrast to their treatment by others:

I try to give emotional support, to make a connection, to respect them. When the teacher’s standing up in front of the class, walking around and looking down at them, and their parents don’t sit down and have a face-to-face conversation with them. They’re doing what I call “drive by” remarks -- when you drive by, walk by and say something to them as a child. They don’t sit down and have real conversations where the other person’s opinion matters. I try to do that.

Young women’s dual identity as mother and youth were recognized by doulas as central to their intensified emotional support needs. Doulas discussed the ways a woman’s changing identity often meant the loss of friends and the social support systems they were accustomed to. Camille said: “At this time in their life [pregnancy], they actually have a loss of social support. They are making a transition, a change in lifestyle and with that comes losing people. That’s why the emotional support we give them is

even more crucial.” Lily expanded on this juxtaposition between the social life of a teen and the isolation of motherhood:

Being a teenager is such a social time in most people’s lives. That’s a huge focus of your existence at that time. And being a parent can be very isolating. So when you put those two things together, it makes it really difficult for teen parents. And some people are judging them and other people just don’t know how to ask or don’t know what to say. Teenage friends might not know how to act around a baby and what might be helpful and what’s not okay. So it becomes a very difficult situation, and this is why the emotional piece is so important.

Doulas worked to fill this emotional support vacuum, celebrating the mother and fostering a counter-narrative of capability through confidence:

It’s very different for somebody to communicate a message of, “You can’t do it” versus “You already are doing it.” Saying to them “you’re such a good mom to this baby already. You changed your diet already so much, like good for you! And you’re getting such good sleep, or, you’ve advocated for yourself in X, Y and Z way, and you’re being such a good mom already.” Or, “you guys are such a good team, you’re growing such a healthy baby.” That’s so important for them to hear, that they are doing this. It’s not happening to them. They are actively doing it. (Abigail)

Messages of capability came not only through affirmative verbal expressions, but also through the doulas’ focus on resources provision and logistical navigation—a practice where they worked to instill self-respect, model life stability, and help mothers move beyond a victimizing “I got through it” experience to a position of maternal empowerment. The third support dimension identified in doula narratives, thus, focused on material support.

Participants’ descriptions of material support as a key element of practice reflected the very real institutionalized constraints and social inequities faced by young women that limit their ability for self-actualization as a mother (Mantovani and Thomas 2014; McDermott and Graham 2005; Silver 2008, 2010). Moreover, doulas understood

that structural stressors have immediate and long-term consequences on the health and well-being of mother and child, where without a sustainable pathway forward and the skills to navigate parenthood and adulthood, the social exclusion young mothers face can (re)produce cycles of social disadvantage. Thus, doulas focused their material support on resource provision and service navigation, helping young mothers to “fill in the gaps” of their lives. Participants spoke of the structural and material support young mothers often needed as a core element that required them to expand their scope of practice as doulas.

Ellen said:

It’s a unique role. It’s not a typical doula role. It’s along the lines of a community health worker for sure. That you have to consider various aspects and not just prenatal education and, you know, a little breastfeeding support. These clients have different views on breasts, different views on what’s okay, what’s normal. I had a client who was a cutter, those sort of things. That’s why so few doulas serve young moms. There is a lot of extra training, patience, and understanding that goes into it.

While doulas believed in “knowledge as power,” they made clear that educational support (as well as emotional support) could not be separated from material support.

Sydney explained: “There is a need for extra support because of the extra challenges they face...when their living environments aren’t safe, for example, then you must triage that first because safety always trumps education.” Sydney’s narrative reflects how education departed in vacuum—as is done in many youth and parenting programs (Rodriguez 2008; Silver 2008; Smithbattle, Lorenz, and Leander 2013)—will not make a fundamental difference in the lives of young families if their day-to-day realities are not secure.

In providing comprehensive logistical support to navigate life “gaps,” doulas often cited an “ethical obligation” to be connected with community resources. Kathryn said: “I feel I have more of an ethical responsibility to be connected with community

resources when serving young moms. It's not just about good birthing classes and where to get breast pads. It's about where to get emergency food. What about temporary shelters? There's abuse going on. You need to know those resources." Notably, doulas cited "finding boundaries" as the number one personal challenge they experienced in providing care to young mothers. Establishing boundaries was not just about the doula's own sense of safety and emotional health, but was positioned as key for long-term parenting success. Jane explained:

There's the challenge of setting your own boundaries with the teen. They don't have a car, they don't have good food, they might not have a safe place to be, and you would like to take them all in and protect them because that's just -- you're a doula. You have that mothering nature, but you can't do it. You have to teach them to do it themselves, but with support – everyone needs support.

Sally expanded: "It's that very fine line between having to recognize that each individual has unique circumstances and a set of challenges, without letting them be defined by their challenges and those stressors. It's about avoiding the savior complex really."

Connecting clients to material resources, departing life navigation skills, and modeling supportive behavior were described by doulas as central to facilitating maternal capability and self-confidence, especially in light of meta-narratives that otherwise set them up to fail:

They [young moms] get looks. They get the comments. They get treated badly at the bank. They get treated badly in the grocery store. I've had to take several moms and teach them how to walk through a grocery store. They don't want to go shopping because they're embarrassed. So you take them to the store and you teach them how to walk and make eye contact with that person. How to hold their head high. How to walk with purpose. How to get their own personal dignity back. (Jane)

Participants described how successfully accessing material support helped young mothers realize that they can ask for help—that they too deserve support. As Betsy noted:

They are scared to ask for help. Everyone tells them they are not capable, so asking for help is viewed as a negative. But when they know they have someone who has their back and shows them how to secure resources, and is not judgmental about it *at all*, then they start to realize they too can ask for help and are entitled to respect.

Doulas believed that in helping the young women to access resources and find support, fundamental life skills for moving forward into motherhood and adulthood were fostered:

I think when everyone is judging your decisions and your choices, it's very simple to say "I'm strong I can do this by myself. I don't need any of you people." When really that's not the way motherhood works. So I think it's a really important lesson to convey. That you actually aren't supposed to do this alone and you have this whole community here. So that's why making resources and social support happen is *sooo* important. So they have people to reach out to now and down the road. (Abigail)

Respected Motherhood: Facilitating Narrative Repair

In this final theme, I describe the desired outcomes of doula care—that is, what doulas hope their philosophical models and care practices will achieve. Throughout themes one and two, participant narratives revealed how doulas actively work to instill maternal empowerment, confidence, capability, and worth in the young women they serve through therapeutic relationships. These elements, in tandem with targeted support strategies, are intended to help young mothers achieve self-efficacy and resiliency, and to resist stigmatizing norms. Doulas' narratives revealed the ways they attempt to capitalize on the opportunities for change afforded by major life transitions like childbearing, as well as what participants identified as "youth energy." Seen as a "turning point" in identity formation (Brubaker and Wright 2006; Charmaz 1999), doulas draw on the existing strengths of young mothers as they encourage their clients to rewrite their stories. As a form of narrative repair, and as an extension of the therapeutic relationship, this aspect of doula care, as participants see it, opens up new horizons for young women

(Everson 2015), as well as new pathways to respected (rather than illegitimate) motherhood; this form of doula care offers nothing short of transformation.

The childbearing year is considered a transformative time in a woman's life as the birth of a baby often significantly alters a woman's life course, her identity(ies), and her aspirations (Brubaker and Wright 2006; Cheyney 2011; Davis-Floyd 1992; Ellison 2003; Gentry et al. 2010; Smithbattle, Lorenz, and Leander 2013; van der Sijpt 2012). The messages communicated to women during the childbearing year can have lasting consequences, as they help to shape how a woman sees herself as mother (Davis-Floyd 1992; Mantovani and Thomas 2014; Porter and Holness 2011; Rodriguez 2008; Rothman 1991). Doulas described seeing young women influenced (and sometimes traumatized) by their birth experiences and, thus, are troubled by the pathologizing frameworks they assert work to "punish" young women for their pregnancies. Such negative messages, doulas argued, preclude the positive transformative potential of childbearing. In contrast, doulas believed that their ongoing messages of capability and respect are solidified during labor and birth, as women cross a threshold from "pregnant teen" to "mother."

Abigail said:

We all know birth is a rite of passage to motherhood. You don't need to frame it in a negative way. It's a positive thing. It should be a positive thing for them [young moms] as well...So I try to make sure moms know that this is their birth, their process, and all those things I tried to communicate during the pregnancy, it solidifies in birth, and then they go on to be these great moms!

Lily echoed:

I wish more people could realize the forming of family that occurs during birth. I wish care providers could realize that, and support it to be a beautiful positive thing for them [young moms] too. That it's not just a medical event. That it's not just an unintended thing that is happening in life, but it can be a transformative and beautiful experience.

In recognizing birth as a “rite of passage” into motherhood, doulas saw their messages of maternal affirmation and worth crystalizing during the birth, noting that when mothers can engage their births with confidence and from a position of empowerment, they then go on to parent from that position of empowerment rather than victimization. Lana explained:

I remember thinking that this birth [of a specific client] was going be super transformative for her. And then I watched it happen on her face when they put her baby in her arms. I was like “that’s it, that’s her change.” She got it, that’s great...It just looks like change. Like you can see that the mom has been born too.

Jane explained what a transformation into respected motherhood looks like long-term as she recounted the successes of previous adolescent clients:

The empowerment and respect we give then plays out when they become parents. I have a teen mom that is now a dental hygienist. I have a teen mom who is the manager of a fitness center. I have a teen mom that is a paralegal, and is moving with her kids soon to get her further [university] education. So, on and on about all these teen moms that have done something with themselves because they went through that whole transformation. The transformation of realizing I can learn, first of all, and I can have a voice.

Ellen echoed: “I really feel that confidence and empowerment make a difference in the parenting experience. Very clearly. It’s like by compassionately supporting them, you’re giving them permission to be good moms, to actualize as mothers with autonomy, with respect, and they loved it and wanted to be that, and then became that.” The notion that maternal empowerment and self-respect can have lasting effects was echoed time and time again by participants. As Lily recounted: “When I felt that the mom got that sense of empowerment, that was so rewarding. ‘I am in charge of my body. I’m in charge of my life. I’m going to be raising this new person’ and feeling confident in that. It’s beautiful.”

In addition to the transformative properties of childbirth, participants discussed the growth and change potential in light of what many deemed “youth strengths” and “youth resiliency.” Abigail explained:

You’re never that confident ever again as you are when you’re a teenager, you know? So use that because you need that when you’re a mom...I love to see them tap into that kind of adolescent invincibility, and use it as real strength. When everyone else is saying they can’t do it because they’re so young, they’re really channeling that [their age] into excellent care for themselves and their babies.

Camille echoed: “Young mothers are amazing. They have a resilience and ability to parent that you don’t see elsewhere.” Participants described holding “mad respect for these women,” and how young mothers’ strengths and resiliency—when fostered rather than quelled—allows them to break cycles of inequity and “legacies of unhealthy parenting behaviors” (Betsy). In Betsy’s words, we see how doulas recognize the pre-pregnancy context of familial disadvantage, and work to help break cycles of poverty and young birth by fanning the flames of “youth energy” during the critical perinatal period as they attempt to foster respected motherhood. Carolyn expanded: “It is so challenging when you witness and recognize the potential for these young moms to perpetuate cycles of dysfunction by no fault of their own, but more their circumstances. So I try to help them break those cycles by building individual resiliency.”

Rodriguez and colleagues (2008:21) have argued that services aimed at parenting adolescents often fail precisely because youth are “denied opportunities for mentoring, self-exploration, and other creative interventions that could have built upon the strengths and assets they themselves brought to the programs.” In failing to draw out and build upon “self-efficacy, self-reliance, self-definition and self-determination” (Rodriguez

2008:21), the chaos and instability of their home environments may be replicated. As a result, young women are more likely to repeat, rather than break, cycles of inequity.

In building upon existing youth strengths—combined with the powerful experiences of childbirth—doulas believed that their model and practices can ultimately achieve a maternal identity transformation. This desired outcome was grounded in moving young women from “feeling stuck” as illegitimate mothers towards a position of respected motherhood—a position infused with the tools, confidence and support necessary to change the trajectory of their story. Ultimately, in facilitating narrative repair of identity, doulas believed that rewriting of the young maternal story would have long-term implications for health and well-being. In Vivian’s words:

I hope that as young women work with me, as we build that relationship, they will come to know their power as mothers. To feel both self-respect, and to command respect from everyone else too as they emerge into mothering feeling confident, capable, and strong. What a difference that can make!

DISCUSSION

The body of literature on young motherhood has demonstrated the critical role of social support for improving maternal-child health outcomes, creating a range of possible futures, nurturing maternal confidence, and breaking intergenerational cycles of teen pregnancy and poverty (Cox et al. 2008; Everson 2015; Gentry et al. 2010; Gruber, Cupito, and Dobson 2013b; Hans et al. 2013; Rodriguez 2008; Smithbattle, Lorenz, and Leander 2013; Strauss, Giessler, and McAllister 2014; Wenham 2011). Findings from this study revealed three overarching themes that describe the philosophies, core practices and desired outcomes of doulas serving adolescent mothers: (a) cultural attitudes and the “bad teen mom”: interrupting meta-narratives (b) compassionate support as praxis:

constructing counter-narratives; and (c) respected motherhood: facilitating narrative repair.

These three themes describe a distinctive model of care that enables us to see the ways doulas construct adolescent pregnancy as they attempt to change outcomes for young mothers by changing the story—that is, the ways they engage, quite self-consciously, in narrative repair of young maternal identities. In accordance with grounded theory (Charmaz 2006, 2011; Corbin and Strauss 2007), I have developed a theoretical schema to illustrate the ways doula care models can function as narrative repair (see Figure 3.1). Doulas construct their philosophies of care in opposition to stigmatizing meta-narratives that subjugate young mothers. These meta-narratives disempower, promote social exclusion processes, and deny young women the opportunity to exit the cycle of adolescent pregnancy and poverty. Multiple barriers thus enclose this circle, bounding young mothers and making it difficult for them to envision (let alone enact) a story different than the ones oppressive meta-narratives create *for* them. Through daily experiences of marginalization and discrimination, women are contained and restrained, their agency bounded. Disapproving looks in grocery stores, medical abuses, discrimination by social service workers, and the near-constant experiences of shame and blame all fortify the fences around this circle.

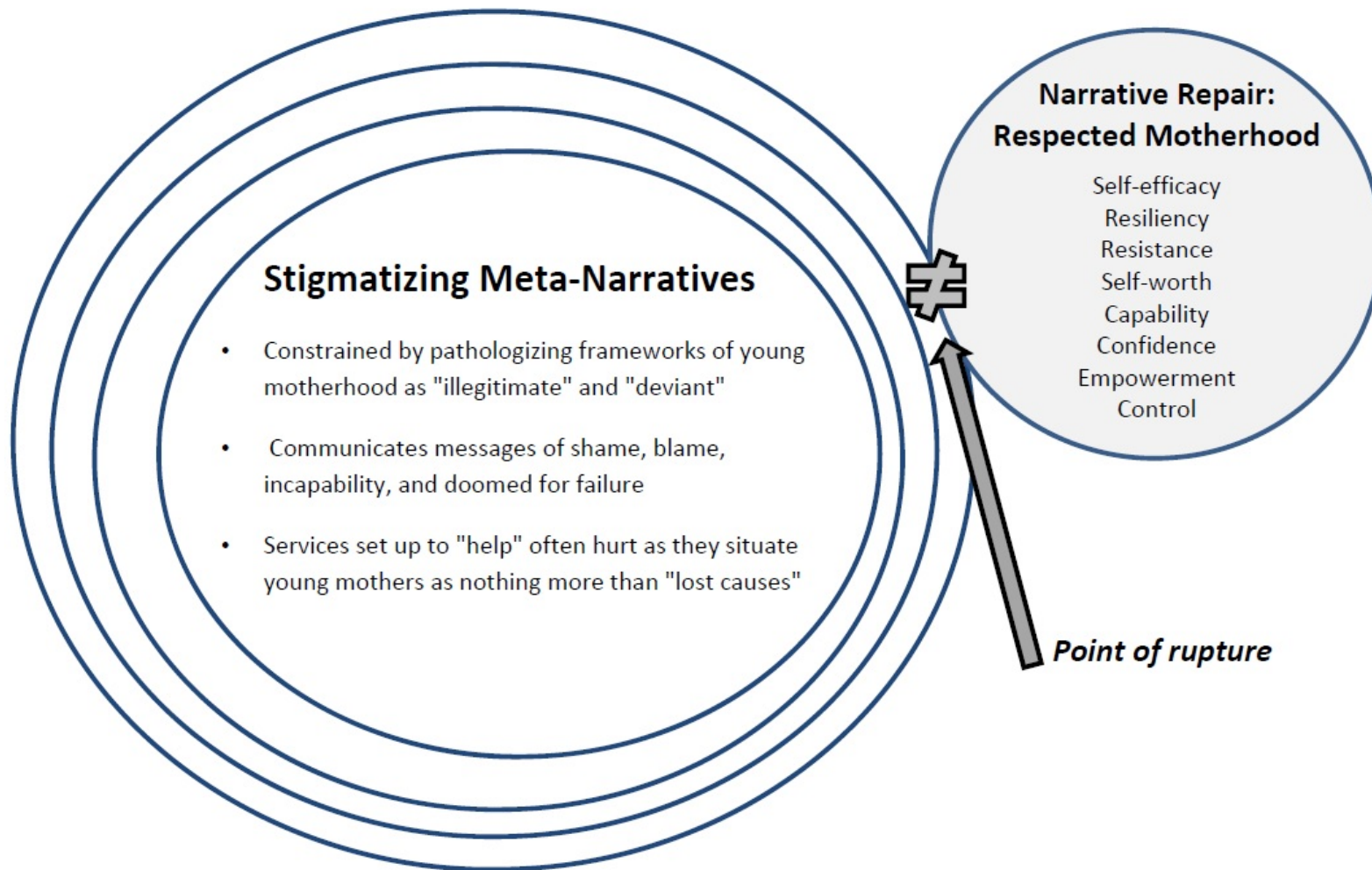


Figure 3.1 Doula care as narrative repair

Doulas who serve young mothers are acutely aware of this cycle, and believe oppressive frameworks can be changed via their model of care. As a result, doulas work to create egalitarian, non-judgmental, and trusting relationships with their clients where the mother is in control. From a relational stance of compassion, doulas interrupt meta-narratives, creating a fissure, a crack, a disruption, through which young women may exit the cycle and begin to re-write their stories. In constructing counter-narratives, the practices of doulas focus on three targeted support strategies—educational, emotional, and material—and capitalize on the power of childbearing and youth strength to foster transformation. Through symbolic interactionism and the creation of therapeutic relationships, doulas strive to communicate messages of worth, capability, and confidence, while also using their power and connections to help you mothers access critical material resources. Importantly, empowerment and a sense of respected motherhood were recognized by doulas as not enough. Significant material support must accompany these if a new trajectory in the mother’s story is to be attained. Collectively, the models and practices doulas depart can facilitate narrative repair of maternal identity, moving young women to a position of respected motherhood—a maternal identity marked by self-efficacy, resiliency and explicit rejection of disempowering meta-narratives.

As doulas facilitate narrative repair, they contribute to the development of individual and collective counter-stories of young motherhood—stories that challenge normative models, promote long-term well-being, and have the potential to disrupt “legacies of disadvantage” (Smithbattle 2007). In figure 3.1, this process is represented by the smaller circle that breaks free from the larger one. Here, within this new teen

mother narrative, resistance flourishes through the engagement of “altered performances” (Weeks 1998), or what Butler (1993, 1997, 2006) calls “slippage” (or the performing of the “wrong” norms that “slip” from normative model expectations). Because the damaged identity of “teen mother as bad mother” is not innate or inherent, but, rather, is constituted through (constrained) performative acts, the possibility for misperformance of social norms is always present. In this way, young motherhood subjectivity is open for resignification as narratives can rupture at multiple points, revealing spaces for alternative constructions. It is at these points of rupture that adolescent mothers may resist meta-narratives that otherwise work to “reinforce and reproduce existing health and social inequalities” (Barcelos 2014:476).

In this article, I have argued that through the process of narrative repair, doulas construct counter-narratives that help young mothers resist stigmatizing processes. However, it should be noted that the distinctive model of doula care described here emerged from surprisingly uniform narratives as doulas in this sample sought to explain their philosophies and practices. This is very likely a function of a relatively homogenous doula community in the research locales, where those doulas serving young mothers tend to be well connected with one another, and take advantage of the same professional development opportunities, for example, that help them to (re)create their care models. Such uniformity suggests the need for further research in additional communities that would illuminate the diversity of doula care models, practices and desired outcomes for young mothers.

CONCLUSION

In conclusion, I have explored the effects of narrative repair on social exclusion and marginalization processes among young mothers, and theorized the potential contributions of doula models of care. I have argued that through the processes of interrupting oppressive meta-narratives, constructing counter-narratives grounded in the provision of targeted social support (educational, emotional and material), and by facilitating narrative repair of identity, doulas help young mothers to envision new horizons. Doula care, as a unique form of social support, has the potential to transform, to break cycles of inequity, and to help young mothers write a new story characterized by self-efficacy, resiliency and resistance. In the words of one participant: “Families are our future. If we don’t support them, it’s like we’re not supporting the future. Doulas can help be that bridge to a brighter, transformed future—a future where young mothers are respected mothers.”

NOTES

ⁱ The perinatal period refers to the time at and around birth, and commonly includes the late antenatal, labor/birth, and immediate postpartum period.

ⁱⁱ Due to the sensitive and private nature of material disclosed in interviews, specific locations are not given so as to maintain the anonymity of participants, the young mothers they serve, and wider communities in which they reside.

ⁱⁱⁱ All names used in this article are pseudonyms to protect the identity of participants.

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**Chapter 4: Outcomes of Care for 1,892 Doula-supported Adolescent Mothers: The
DONA International Data Project, 2000 to 2013**

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IMPLICATONS & CONTRIBUTION STATEMENT

This is the largest study to-date to report on outcomes of care for a national sample of doula-supported adolescent births (n=1892). Results from this study strengthen the case for doula care as a cost-effective strategy for improving maternal-child health outcomes among adolescent childbearing women.

INTRODUCTION

The United States (US) holds the highest teenage birth rate of all industrialized countries at 26.5 live births per 1000 population (Kearney and Levine 2012; Martin et al. 2015; Sedgh et al. 2015), and young women in the US experience alarmingly negative maternal-child health (MCH) outcomes. For example, women between the ages of 15 and 19 have some of the highest preterm delivery rates (12.98%), low birth weight rates (9.31%), and fetal demise rates (7.19/1000) relative to all other age groups (Martin et al. 2015; MacDorman, Kirmeyer, and Wilson 2012; McCracken and Loveless 2014). Women under the age of twenty also experience high rates of intervention during birth, including a 21.8% cesarean section rate and a 63.5% epidural rate (Martin et al. 2015; Osterman and Martin 2011). Initial breastfeeding rates are also worryingly low at only 50.7% (National Center for Health Statistics 2015). These statistics highlight the health inequities young childbearing women face, and the lifelong health implications for neonates associated with a less than optimal start at birth.

Doulas are non-medical, childbirth support professionals that provide emotional, physical, educational, and advocacy support to women and their families during the prenatal, birth and immediate postpartum period (DONA International 2012). Previous research suggests that continuous support during the perinatal period by someone who is

neither part of the clinical care team nor part of the immediate childbearing family (i.e., a doula) may lead to: 1) improved clinical outcomes for both the woman and newborn; 2) cost savings through decreased interventions; and 3) improved mother-infant bonding and parenting experiences (Chapple et al. 2013; HealthConnect One 2014; Hodnett et al. 2013; Katy Backes Kozhimannil et al. 2013a; Phillips and Kelly 2014; Pilliod et al. 2013; Sauls 2002; Steel et al. 2015; Strauss, Giessler, and McAllister 2014).

Doula care and continuous labor support has been found effective, to varying degrees, for the following variables: decreased average lengths of labor (Campbell et al. 2006; Hodnett et al. 2013; Nommsen-Rivers et al. 2009); reduced rates of instrumental vaginal delivery (forceps and vacuum extraction), cesarean section, and pharmacologic pain management (Campbell et al. 2006; Gruber, Cupito, and Dobson 2013; Hodnett et al. 2013; Katy Backes Kozhimannil et al. 2013a; Nommsen-Rivers et al. 2009; McGrath and Kennell 2008; Paterno et al. 2012); increased breastfeeding rates, maternal-infant bonding/positive interactions, and positive childbearing experiences (Campbell et al. 2007; Edwards et al. 2013; Gruber, Cupito, and Dobson 2013; Hans et al. 2013; Hodnett et al. 2013; Katy B. Kozhimannil et al. 2013b; Mottl-Santiago et al. 2008; Nommsen-Rivers et al. 2009; Vonderheid et al. 2011); and decreased rates of low birth weight, preterm delivery, and low 5-minute Apgar scores (Campbell et al. 2006; Gruber, Cupito, and Dobson 2013; Hodnett et al. 2013; Katy Backes Kozhimannil et al. 2013a). Thus, in their 2013 Cochrane systematic review on continuous labor support, Hodnett and colleagues conclude by stating that, “continuous support during labour should be the norm, rather than the exception...Given the clear benefits and absence of adverse effects

of continuous labour support, policy makers should consider including it as a covered service for all women” (16).

Furthermore, doula support may be especially beneficial for historically underserved and marginalized communities experiencing significant health inequities, including immigrant women (Kang 2014), racial and ethnic minority women (Edwards et al. 2013; Hans et al. 2013; HealthConnect One 2014), low-income women (Campbell et al. 2006; Katy Backes Kozhimannil et al. 2013a; Nommsen-Rivers et al. 2009), and childbearing adolescents (Breedlove 2005; Edwards et al. 2013; Gentry et al. 2010; Gruber, Cupito, and Dobson 2013; Hans et al. 2013; Vonderheid et al. 2011; HealthConnect One 2014). These studies have universally suggested positive effects of doula support for marginalized communities, but have methodologic shortcomings, including small sample sizes and location- or program-specific results. This study describes outcomes from a national sample of adolescent births (n=1892) attended by a Doula of North America (DONA) International doula using data recorded on the DONA International birth doula data collection form from 2000 to 2013. This is the largest study to-date examining the effects of doula care for young childbearing women, and remains one of the few doula studies at-large to report on outcomes from a national sample.

METHODS

Data Collection

Data were collected between 2000 and 2013 using the DONA International birth doula data collection form, developed in 1995 to gather data on doula-supported birth outcomes. The data collection form includes approximately 30 demographic and perinatal health variables. Participation in the data collection process is voluntary, and data may be

submitted by DONA International certification candidates, uncertified doulas, or certified doulas. The data collection form is completed by the doula following a client's birth, and then is sent to the DONA International headquarters. Data are entered by DONA volunteers into a Master (electronic) Data File. The DONA Master Data File is jointly managed by DONA International and researchers at University of North Carolina (UNC) at Chapel Hill. A data use agreement was established between UNC, DONA, and Oregon State University for provision of the adolescent dataset, defined here as all women in the DONA Master Data File who were between the ages of 15 and 19 at the time of birth. All analyses using the adolescent dataset were approved by the Institutional Review Board at Oregon State University. All women whose data are included in the DONA dataset signed a "Client Confidentiality Release" form that gave their doula permission to send de-identified data to DONA International for use in research.

Inclusion Criteria

The 2000 to 2013 DONA Master Data File contains 35,645 observations, of which 2046 were for women between the ages of 15 and 19. After 74 duplicates were removed, the complete adolescent dataset contained 1968 births (n=1972 neonates; four sets of twins). Births with a known location outside of the United States were then excluded (n=57) as well as births with location unspecified (n=19). Thus, the final sample for this study consisted of n=1892 women (1896 neonates).

Data Analysis

The objective of this study was to describe outcomes associated with doula support for adolescent women. As such, analyses focused on basic frequencies, measures of central tendency, and measures of variance, as applicable. For all analyses,

denominators are limited to those women and neonates that were at risk for the given outcome. For example, the denominator for birth weight is all liveborn neonates, meaning stillbirths are excluded. I include the actual denominators (i.e., the denominator of women or liveborn neonates less missing data for a given variable) throughout. All analyses were conducted using IBM SPSS Version 22.0 (IBM Corporation, Armonk, NY).

RESULTS

Participant Characteristics

Data on 1892 adolescents (1896 neonates) were contributed by 574 different DONA International doulas. Adolescent participant characteristics are reported in Table 4.1. Women of color comprised over half the sample (54.2%). The mean maternal age was 17.8 (standard deviation, SD, 1.20). Just over half (52.7%) of the women were referred to their doula by the hospital, while “other” comprised 45.2% of referrals; the specifics of these referral sources are unknown. Payment for doula services varied with the majority (64.8%) of doulas indicating the hospital as their payment source, followed by volunteerism (22.8%), private pay (6.1%), third party reimbursement (3.3%), and “other” sources (2.9%).

Prenatal Risk Profile

Ninety percent of clients were nulliparous. Fourteen percent of the sample was identified by the doula as having a higher-risk pregnancy, including risk factors such as pregnancy-induced hypertension (3.7%) or gestational diabetes mellitus (1.2%). An additional 3.1% were marked “high-risk” and 6.3% had “other” pregnancy-related risk

factors without further specification. These categories were not mutually exclusive. Four sets of twins (n=8 neonates) are included in this sample (Table 4.1).

Maternity Care

The vast majority of women in this sample received care from an obstetrician (64.7%), followed by midwives (16.8%), family practice doctors (13.0%), and combination care (5.5%), which means that the woman received co-care from more than one type of provider during the antenatal period. Delivery occurred in hospitals for 87.8% of the sample, while a smaller portion birthed in a birth center (11.5%) or at home (0.7%). Given that 90% of the women in the sample were nulliparous, the rate of attendance at childbirth education classes was remarkably low at only 38% (Table 4.1).

Table 4.1 Demographic characteristics and pregnancy occurrences for 1,892 adolescent women in the DONA International dataset

Characteristics	n (%)
Race/Ethnicity^{a, b}	
White	860 (45.9)
Black	387 (20.7)
Hispanic or Latino	437 (23.3)
Asian	99 (5.3)
Native American	28 (1.5)
Other	63 (3.4)
Maternal age at birth (years)	
15	102 (5.4)
16	211 (11.2)
17	362 (19.1)
18	543 (28.7)
19	674 (35.6)
Referral source^c	
DONA International	38 (2.0)
Hospital	984 (52.7)
Other	844 (45.2)
Place of birth^d	

Home	13 (0.7)
Hospital	1655 (87.8)
Birth center	217 (11.5)
Other	1 (0.1)
Clinical care provider^e	
Midwife	313 (16.8)
Obstetrician/Gynecologist	1206 (64.7)
Combination	103 (5.5)
Family practice doctor	243 (13.0)
Method of payment for doula^f	
Private pay	112 (6.1)
Third party reimbursement	61 (3.3)
Volunteer	419 (22.8)
Hospital	1191 (64.8)
Other	54 (2.9)
Childbirth education classes attended ^g	
Yes	693 (38.0)
No	1131 (62.0)
Parity^h	
Nulliparous	1690 (90.3)
Multiparous	182 (9.7)
Pregnancy Occurrencesⁱ	
Pregnancy-induced hypertension	67 (3.7)
Gestational diabetes mellitus	22 (1.2)
High risk ^j	56 (3.1)
Other (unspecified)	114 (6.3)
Multiple gestation	4 (0.2)

^a As identified by the doula contributor

^b Missing data for 18 women

^c Missing data for 26 women

^d Missing data for 6 women

^e Missing data for 27 women

^f Missing data for 55 women

^g Missing data for 68 women

^h Missing data for 20 women

ⁱ Missing data for 83 women

^j No definition is given for what constitutes a “high risk” pregnancy on the data form

Induction and Augmentation

Thirty percent of women in this sample began labor via pharmacological induction (i.e., prostaglandins, synthetic oxytocin, misoprostol), and 35.4% experienced augmentation of labor via synthetic oxytocin. These categories were not mutually exclusive. Forty-three percent of women birthed without either pharmacological induction or augmentation. Artificial rupture of membranes (AROM) occurred for 47.5% of women. Continuous, external electronic fetal monitoring was used for 64% of labors, while 17.2% of women had intermittent fetal monitoring (either by Doppler or electronic fetal monitoring), and the remaining 18.6% had internal electronic fetal monitoring (Table 4.2).

Table 4.2 Labor interventions and occurrences for 1,892 adolescent women in the DONA International dataset

Outcome	
Labor length in hours, median (IQR)	
Maternal perception (self-report) of length of labor ^a	12.0 (8.0 - 18.0)
Length of labor from admission to birth ^b	10.0 (7.0 - 15.1)
Labor length in hours for births without pharmacological induction, median (IQR)	
Maternal perception (self-report) of length of labor ^c	13.0 (9.0 – 18.69)
Length of labor from admission to birth ^d	9.5 (6.17 – 14.0)
Labor length in hours for births without pharmacological induction or augmentation, median (IQR)	
Maternal perception (self-report) of length of labor ^e	12.0 (8.0 – 17.0)
Length of labor from admission to birth ^f	8.0 (5.0 – 12.0)
Length of doula support in hours, ^g median (IQR)	8.0 (5.0 – 12.0)
Pharmacologic Pain Relief,^{h,i} n (%)	
Epidural before 5cm	507 (27.5)
Epidural after 5 cm	509 (27.6)
IV Pain Medications	988 (53.6)
Other (unspecified)	159 (8.6)

Interventions,^{h,i} n (%)	
Pharmacological induction	548 (29.7)
Artificial rupture of membranes	875 (47.5)
Synthetic oxytocin augmentation	653 (35.4)
Monitoring^j	
Intermittent fetal monitoring	295 (17.2)
Continuous fetal monitoring	1096 (64.1)
Internal fetal monitoring	318 (18.6)

Abbreviations: IQR, interquartile range; IV, intravenous

^a Missing data for 395 women

^b Missing data for 292 women

^c Missing data for 287 women

^d Missing data for 215 women

^e Missing data for 190 women

^f Missing data for 140 women

^g Missing data for 84 women

^h These categories are not mutually exclusive.

ⁱ These questions were not asked as discrete variables (yes/no). Rather, only the presence of the intervention was noted. As such, blank cells in the dataset could indicate either “no” or “unknown”. In order to estimate the number of unknown cases, I averaged the number of missing data points from six variables with high degrees of apparent reliability in the dataset: ethnicity, place of birth, method of birth, labor doula hours, NICU admission, and breastfeeding. Using this approach, I estimate the unknown rate for this variable to be n=30. Because main interventions and pharmacologic pain relief choices are generally well known by doulas given their focus on supporting physiologic birth, I believe this rate to be reasonable.

^j Missing data for 164 women

Length of Labor & Doula Support

The median length of doula support for the sample was 8.0 hours (IQR, 5.0 - 12.0

h). Length of labor is reported in this dataset via two variables: maternal self-report of labor duration, and from time of admission until time of birth (Table 4.2). The median length of labor for the sample according to maternal self-report was 12.0 hours (interquartile range, IQR, 8.0 - 18.0 h). The median length of labor from admission to birth was 10.0 hours (IQR, 7.0 - 15.1 h). If the sample is limited to spontaneous labors

only (i.e., no pharmacological induction), the median length according to maternal self-report was 13.0 hours (IQR, 9.0 - 18.69 h), and the median length from time of admission to birth was 9.50 hours (IQR, 6.17 - 14.0 h). If the sample is further limited to spontaneous labors that also did not have pharmacological augmentation, the median length of labor according to maternal self-report was 12.0 hours (IQR, 8.0 - 17.0 h), and the median length from time of admission to birth was 8.0 hours (IQR, 5.0 - 12.0).

Pharmacologic Pain Relief

Just over half (55.1%) of the women in this sample had epidural anesthesia during labor, split roughly evenly between administration before 5cm dilated (27.5%) and after 5cm dilated (27.6%). Additionally, 53.6% of the women in this sample received intravenous (IV) pain medications, and 8.6% received another, unspecified form of pharmacologic pain relief. These categories were not mutually exclusive. Only 17% of women birthed with no pharmacologic pain medication or anesthesia (Table 4.2).

Mode of Birth

The spontaneous vaginal birth (SVB) rate for the entire sample was 79.3%. An additional 8.1% of women had an assisted vaginal birth (forceps or vacuum extraction), and 12.6% gave birth via cesarean section. Almost all (97.5%) of the cesareans were unplanned, and nine of the multiparas had “vaginal birth after cesarean” (VBAC) listed as their mode of delivery. However, previous cesarean delivery was not asked on the data collection form under obstetric history and, thus, VBAC success rates cannot be calculated. When the sample was limited to term, singleton, liveborn neonates only, the rates of SVB, assisted vaginal, and cesarean remained congruent with the overall sample

(see Table 4.3). Of the four sets of twins included in this sample, three sets were born vaginally and one set was born via unplanned cesarean.

Gestational Age and Birth Weight

Ninety-two percent of neonates were considered full term at birth, while 4.9% were premature and 3.1% were postterm (>42 weeks). The median birth weight was 3193 grams (IQR, 2762 g - 3243 g). Ten percent of neonates were born low birth weight (LBW, <2500 grams) and 6.7% were macrosomic (>4000 grams). When the sample was limited to term, singleton neonates, the median was 3197 grams (IQR, 2771 g - 3628 g); 7.0% of term, singleton neonates were LBW and 7.0% were macrosomic (Table 4.3).

Fetal and Neonatal Mortality and Morbidity

Nine percent of neonates in the sample experienced immediate health concerns, and 5.6% were admitted to the neonatal intensive care unit (NICU). This dataset contains a total of ten stillbirths, for a fetal demise rate of 5.27/1000 (95% confidence interval, CI, 2.53 - 9.69). There were additionally nine missing entries for the stillbirth variable; none of these missing entries included any post-birth outcomes (e.g., breastfeeding or NICU admission). The data collection form does not specify the timing of demise, nor does it provide cause of death. However, from free-text “notes” fields and other variables in the dataset, it can be determined that all fetal demises were delivered vaginally. Birth weights for seven of the ten ranged from 1 – 6lbs at birth. Of these, one fetus was premature, and one woman had pre-eclampsia. The final three fetuses were delivered vaginally with no known birth weights; one pregnancy was indicated as “high risk” by the doula, but no further information was given. In terms of maternal age, two women were fifteen; three women were seventeen; three women were eighteen; and two women were nineteen.

Table 4.3 Birth outcomes for 1,896 neonates born to adolescent women in the DONA International dataset

Outcome	n (%)
Mode of birth^a	
Spontaneous vaginal ^b	1480 (79.3)
Assisted vaginal (forceps or vacuum)	151 (8.1)
Cesarean	236 (12.6)
If cesarean, was this cesarean section planned?	
Yes	6 (2.5)
No	230 (97.5)
Mode of birth for term, singleton, liveborn neonates^c	
Spontaneous vaginal ^d	1390 (79.3)
Assisted vaginal (forceps or vacuum)	142 (8.1)
Cesarean	220 (12.6)
Gestational age at birth^e	
Premature ^f	92 (4.9)
Postterm ^g	56 (3.1)
Gestational age at birth for singletons only	
Premature ^h	88 (4.7)
Postterm ⁱ	52 (2.9)
Birth weight in grams, median (IQR)^j	3193 (2762 – 3243)
Low birth weight (<2500 g)	169 (10.2)
Macrosomic (>4000 g)	111 (6.7)
Birth weight in grams for term, singleton neonates, median (IQR)^k	3197 (2771 - 3628)
Low birth weight (<2500 g)	110 (7.0)
Macrosomic (>4000g)	110 (7.0)
Neonates with mother <30 minutes after birth^l	1148 (61.3)
Neonates with immediate health concerns^m	172 (9.2)
Neonate was admitted to the NICU	106 (5.6)
Initial breastfeedingⁿ	1119 (59.7)
Initial breastfeeding for term, singleton neonates^o	1070 (60.3)

Abbreviations: NICU, neonatal intensive care unit

^a Missing data for 29 women^b Nine of these births were VBACs (vaginal births after cesarean)

^c Missing data for 25 women

^d Nine of these births were VBACs (vaginal births after cesarean)

^e These data come from two questions on the data collection form. The preterm question is asked as “Baby outcome: premature.” The postterm question is asked as “Pregnancy: Gestation >42 weeks.”

^f Missing data for 4 neonates

^g Missing data for 79 neonates

^h Missing data for 4 neonates

ⁱ Missing data for 79 neonates

^j Missing data for 224 neonates

^k Missing data for 214 neonates

^l Missing data for 4 neonates

^m Missing data for 8 neonates

ⁿ Missing data for 4 neonates

^o Missing data for 3 neonates

Breastfeeding & Immediate Contact

The initial breastfeeding rate for the entire sample was 59.7%. For term, singleton neonates only, the initial breastfeeding rate was 60.3%. Over half (61.3%) of neonates were united with their mother within thirty minutes of birth.

DISCUSSION

In this sample of doula-supported adolescent births, key outcomes are improved relative to national statistics for adolescent deliveries in the United States (MacDorman, Kirmeyer, and Wilson 2012; Martin et al. 2015; National Center for Health Statistics 2015; Osterman and Martin 2011), and are consistent with previously reported data on outcomes of doula support for socially marginalized communities (Campbell et al. 2006; Gruber, Cupito, and Dobson 2013; Katy Backes Kozhimannil et al. 2013a; Nommsen-Rivers et al. 2009). Rates of cesarean section (12.6%) and prematurity (4.9%) are substantially lower than rates reported nationally for adolescent childbearing women (21.8% for cesarean, 12.98% for prematurity), as is the epidural anesthesia rate for vaginal births (45.8% versus 63.5%) (Martin et al. 2015; Osterman and Martin 2011).

Doula-supported women in this sample also experienced a 60% initial breastfeeding rate, which is improved relative to rates reported nationally for adolescents (50.7%) (National Center for Health Statistics 2015). Sixty-one percent of neonates were with their mothers within thirty minutes of the birth, and such immediate contact is a known correlate of breastfeeding success and immediate bonding (Moore et al. 2012). These comparisons are summarized in Table 4.4.

Additionally, when benchmarked against Healthy People 2020, outcomes from doula-supported adolescent women in this sample are exceeding key maternal, infant and child health population-level targets, including cesarean (12.6% vs. 23.9% target) and preterm delivery (4.9% vs. 11.4%) (Maternal, Infant, and Child Health | Healthy People 2020 n.d.). The fetal demise rate of this sample (5.27/1000) is on par with the target objective of 5.6/1000, and is lower than the fetal demise rate for adolescents nationally (7.19/1000) (MacDorman, Kirmeyer, and Wilson 2012; Maternal, Infant, and Child Health | Healthy People 2020 n.d.). The low birth weight rate of this sample (10.2%), however, remains higher than the 7.8% Healthy People 2020 target, yet is on par with national statistics for adolescent childbearing women (9.31%) (Martin et al. 2015). Additionally, the initial breastfeeding rate in this sample (59.7%), while improved relative to adolescents nationally, is still far below the Healthy People 2020 ever breastfed goal of 81.9%.

When compared to previously published data on outcomes associated with doula-support for adult women (Gruber, Cupito, and Dobson 2013), adolescent women (Gruber, Cupito, and Dobson 2013), and low-income women (Campbell et al. 2007; Nommsen-Rivers et al. 2009; Katy Backes Kozhimannil et al. 2013a), key outcomes from this

Table 4.4 Comparison of select outcomes between 1,892 adolescent births (1,896 neonates) in the DONA International dataset with national adolescent datasets and existing doula care studies

	National data for adolescent women in the US^a	Gruber et al. (2013)^c – adult women with doulas	Gruber et al. (2013)^c – adolescent women with doulas	Kozhimannil et al. (2013a)^d – doula cohort	Nommsen-Rivers et al. (2009)^e – doula cohort	Campbell et al. (2006)^f – doula cohort	Everson (2015) – this study
Sample size (n)	Varies	n=51	n=46	n=1079	n=44	n=298	n=1892
Focus	Adolescents, national statistics	Adults enrolled in a childbirth program in North Carolina	Adolescents enrolled in a childbirth program in North Carolina	Medicaid recipients enrolled in a community-based doula program in Minnesota	Low-income women in a regional hospital of northern California	Low-income women in an ambulatory care center in New Jersey	Adolescents, national sample
Cesarean section	21.8%	21.6%	17.4%	22.3%	27.3%	18.9%	12.6%
Preterm delivery	12.98%	ND	ND	6.1%	ND	ND	4.9% (all) 4.7% (singleton)
Low birth weight	9.31%	3.9%	0.0%	4.2% (singleton)	3374g ± 526	3341g ± 546 (term, singleton)	10.2% (7.0% term, singleton). 3116g ± 499 (all); 3159g ± 462 (term, singleton)
Pregnancy-induced hypertension	ND	ND	ND	3.8%	4.6%	ND	3.7%
Gestational	ND	ND	ND	5.8%	4.6%	ND	1.2%

diabetes					(gestational or chronic)		
Fetal death rate	7.19/1000 ^b	ND	ND	ND	ND	ND	5.27/1000
Epidural use for singleton deliveries only	63.5% (only vaginal births)	49.0% (only vaginal births)	58.7% (only vaginal births)	27.9%	ND	85.0%	55.1% (all); 45.8% (only vaginal births)
Initial breastfeeding	50.7%	90.2%	67.4%	ND	63.6%	ND	59.7%

^a Data sources: (Martin et al. 2015; National Center for Health Statistics 2015; Osterman and Martin 2011)

^b Fetal death refers to the intrauterine demise of a fetus between 20 weeks gestation through delivery. Data source: (MacDorman, Kirmeyer, and Wilson 2012)

^c Data were collected between January 2008 to December 2010. The program used DONA-trained doulas, not necessarily certified

^d Data were collected between January 2010 and April 2012; only singleton births were included. The program used DONA-trained doulas, not necessarily certified.

^e Data were collected between October 2005 and November 2005; only full gestation, primiparae women were included. Trained lay doula support was utilized by this hospital-based program.

^f Data were collected between 1998 and 2002; only nulliparous, singleton, term, “low-risk” pregnancies were included. Trained lay doula support was utilized by this hospital-based program.

sample are generally consistent or better for cesarean, preterm, and epidural use, but remain lower for breastfeeding and low birth weight. These findings warrant further investigation, as such differences may reflect differential demographics, models of doula care, and/or geographic variation. Comparisons are summarized in Table 4.4.

One of the most significant findings from this study is the notably low rate of cesarean section (12.6%). Given their young age—combined with their largely nulliparous status—women in this sample are at the beginning of the reproductive phase of the life course, and are thus likely to have additional children. Insuring full reproductive options for subsequent births is imperative as the US aspires to reduce the national cesarean rate through the prevention of primary cesareans (American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine 2014; Cunningham et al. 2010; Lowe 2014; Spong et al. 2012). Indeed, in a joint statement released by the American College of Obstetricians & Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine (SMFM) on safe prevention of the primary cesarean delivery, the authors state that: “one of the most effective tools to improve labor and delivery outcomes is the continuous presence of support personnel, such as a doula” (American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine 2014).

Additionally, the prematurity rate is also markedly lower than national rates, and the potential for doula care to decrease preterm delivery rates is significant in terms of both cost savings and human welfare. Babies born premature are at risk of severe health problems and lifelong disabilities (Beck et al. 2010; March of Dimes 2013), and prematurity remains the leading cause of death in children under the age of five (Liu et al.

2015). Furthermore, premature birth costs the US more than \$26.2 billion per year, including 16.9 billion in medical and health care costs for the newborn; 1.9 billion in labor and delivery costs associated with care of the mother; \$611 million for early intervention services delivered between the ages of birth and three years of age; \$1.1 billion for special education services delivered between the ages of three to 21; and \$5.7 billion in lost wages for individuals born prematurely and who suffer lifelong disability and health issues (March of Dimes 2013). A modest investment in doula care has the potential to decrease the substantial costs associated with poor clinical health outcomes (e.g., prematurity) as well as providing cost-savings by reducing interventions at birth (e.g., cesarean) (for further cost-effectiveness estimates on doula care, see: Chapple et al. 2013; Katy Backes Kozhimannil et al. 2013a; Pilliod et al. 2013).

Furthermore, this sample of doula-supported adolescent births included a high percentage of home and birth center (12.2%) and midwife-attended (16.8%) deliveries, both of which are also associated with reductions in preterm delivery as well as cesarean section (Cheyney et al. 2014; Sandall et al. 2013). Thus, the notable decreases in cesarean section and prematurity may be a shared impact of both doula and midwifery care—as complementary patient-centered models—being represented in this sample.

Overall, findings from this study indicate the potential for doula care to improve health outcomes among adolescent childbearing women. The demonstrated improvements should also be considered in light of the diverse composition of this sample, where known inequities associated with age intersect with health disparities, such as prematurity, documented along racial and ethnic lines, as over half of the sample is comprised of women of color (Coley et al. 2015; Luttrell 2011). It is also important to

consider the generally positive results achieved in light of the low rate of childbirth education attendance among women in this sample, given the known associations between antenatal education and improved health outcomes and behaviors (Grady and Bloom 2004; Hollowell et al. 2011; Klima 2003; Manant and Dodgson 2011; Stoll and Hall 2012). However, despite improved outcomes relative to national datasets of adolescents and a tendency for doula-supported adolescent births to meet or exceed Healthy People 2020 objectives, rates of low birth weight, prematurity, fetal demise and breastfeeding are still far from optimal. Larger social determinants of health prior to and during the childbearing year must be addressed if we are to achieve excellent outcomes for all young childbearing families (Luttrell 2011; Maternal, Infant, and Child Health | Healthy People 2020 n.d.; Quesada, Hart, and Bourgois 2011).

Limitations

Limitations on this study are multiple. First, the DONA birth doula data collection form was not designed by researchers, and the data project was initially conceived of as an internal evaluation mechanism, not a formal research database. As such, there are limitations related to the data collection tool itself, particularly in the way questions were asked, as has been noted throughout. Further, data were entered first by contributing doulas (who do not have clinical training, and must rely on information provided by the primary clinician or the woman for documentation), and then secondarily, entered into a master data file by DONA International volunteers. Thus, data entry errors at either point in the process can be assumed, albeit these transcription errors into the master data file were likely random and not systematic (Aday and Cornelius 2006; Arts, de Keizer, and Scheffer 2002). Additional analyses of potential benefit—such as examining outcomes by

gestational age or fetal presentation (i.e., breech vs. vertex)—are also limited because key variables were not included on the data collection form. Demise data are also problematic. Since exact gestational age information is not available, the timing of any demises cannot be inferred. It is also difficult to ascertain the confounding effects midwifery-led care and out-of-hospital birth may have on decreased intervention rates and improved health outcomes demonstrated in this study. Finally, it is difficult to make conclusive remarks regarding the effects of doula care without the benefit of an adequately-powered study with an appropriate comparison group. Additional research should investigate the effectiveness of doulas and continuous labor support by care model type, understanding the ways in which duration, timing, support elements, and training levels may differentially impact outcomes.

CONCLUSION

In 2008, Berghella and colleagues published guidelines for the evidence-based management of labor and delivery. The authors reviewed 41 birth practices and of these, only three received a Grade “A” recommendation, meaning that the US Preventative Services Task Force “strongly recommends that clinicians provide [the service] to eligible patients” (Berghella, Baxter, and Chauhan 2008:447). Doula care was one of the three to receive this high recommendation. Following, in a report released by leading advocacy organization, Childbirth Connection (a program of the National Partnership for Women and Families), on evidence-based maternity care, doulas were cited as an effective strategy for optimizing outcomes within a best value framework (Sakala and Corry 2008).

The growing body of research on the efficacy of doula care, especially for at-risk populations—combined with positive preliminary results demonstrated in this study—make a strong case for further exploring doulas as a cost-effective strategy for improving maternal-child health outcomes and decreasing disparities among childbearing adolescents. Programs and policies should thus consider utilizing doulas to advance health equity and improve experiences for young childbearing women. This study demonstrates the promising potential of doulas as an evidence-based strategy in maternity reform initiative, especially for historically marginalized and underserved communities.

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**Chapter 5: Between Two Worlds: Doula Care, Liminality and
the Power of Mandorla Spaces**

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INTRODUCTION

In recent years, a growing call for the support of normal, physiologic birth practices has developed in the United States in response to the negative maternal-infant health outcomes and experiences of disempowerment described by women as birth has become increasingly medicalized (ACNM, MANA, NACPM 2012; Amnesty International 2011; Declercq et al. 2013; Martin et al. 2015). In 2013, the U.S. cesarean section rate was 32.7%, more than 2 to 3 times what is estimated to be safe for women and babies (Althabe and Belizán 2006; Martin et al. 2015). Further, the United States ranks 33rd on the 2015 Mother's Index—a global index that evaluates the overall well-being of mothers and children by nation (Save the Children 2015). Tragically, the US lags behind despite the fact that we spend more than any other nation per capita on maternity care (Amnesty International 2011). Add to this women's narratives describing dehumanization, victimization and disempowerment in childbirth, and a clear need for a more nuanced conversation around maternity care reform emerges (Machizawa and Hayashi 2012; Wagner 2008).

Both doula care and homebirth midwifery have arisen as movements focused on re-humanizing childbirth via the support of normal physiologic birth and women's autonomy in birth place decision-making. As such, they serve as cultural windows into the contentious arena of maternity care reform and place of birth debate discourses. However, these movements—seemingly allied in many core beliefs—have not always operated in solidarity. This may be tied to their differential locations within the obstetric hierarchy. While homebirth midwifery remains highly contested in the place of birth debate (Cheyney, Everson, and Burcher 2014; Sandall, McCandlish, and Bick 2012),

doulas, in contrast, are at once intimately part of, and marginalized within, the obstetric community (Emad 2003; Morton and Clift 2014; Norman and Rothman 2007). In this chapter, we explore doula care as a mandorla space between hospital-based obstetrics and homebirth midwifery, examining how the liminal position of doulas allows for the negotiation of power and resistance within US childbirth reform. Here we define liminality as a ritualized, transitional space located between two states of being (Turner 1967; van Gennep 1960), and a mandorla space as the almond-shaped intersection created when two spheres overlap. We argue that although doulas primarily work within the obstetric system, their tacit threat lies in the recognition that doula care can constitute a vital common ground—and perhaps a critical opening—in larger place of birth and maternity care reform debates.

BACKGROUND: MIDWIFERY, DOULA AND MEDICAL MODELS OF CARE

In 1982, sociologist Barbara Katz Rothman outlined the essential elements of what she deemed the “midwifery model” of care, contrasting it with the “medical model” and arguing that the fundamental differences in these two approaches to birth matter deeply for a woman’s transition to motherhood. At the heart of the differences are opposing views on the mother-fetus relationship. In midwifery modelsⁱ, the mother and fetus are viewed as an “organic whole” (Rothman 1991:276), or a symbiotic dyad, whereas in medical models, the mother and fetus are viewed as separate entities engaged in a parasitic or competitive relationship. Midwifery models position mothers as autonomous decision-makers, in contrast to more patriarchal, medical models where physicians, by virtue of their ascribed knowledge and power, hold ultimate decision-making authority.

In 1992, anthropologist Robbie Davis-Floyd expanded Rothman's earlier work and proposed the "wholistic" and "technocratic" models of birth. The wholistic approach is woman-centered with family as a significant social unit; with woman as active subject; mother and child as one; home as nurturing environment; and bodily, experiential, and emotional knowledge as highly valued. Childbearing is understood as a healthy, normal process best supported by low-tech, high-touch techniques with a midwife as "skillful guide" (Davis-Floyd 1992:160-161). Technocratic models, in contrast, are male-centered with social support regarded as unimportant or secondary to primary clinical concerns; with woman as passive object; hospital as "factory" and babies as "products"; and technical, scientific knowledge as the only knowledge of value. Childbearing is understood as dysfunctional, even pathological, and best controlled by interventions led by an obstetrician as "manager/skilled technician" (1992:160-161).

Collectively, Rothman and Davis-Floyd's work with care models has provided a key platform for US childbirth movements today, essentially allowing disparate sides of maternity debates to identify with and rally around one approach, while using the opposing model to distance the other. Moreover, these models have frequently been aligned with distinct places of birth—midwifery models with home and birth centers, medical models with hospitals. Importantly, when Rothman first conceived of and named these juxtaposed models, she intentionally did not name them with respect to site of delivery, claiming that such a move would be "too restricting" (1991:25). "Doctors can bring the medical model right into the home...And a midwife can bring much of the alternative [midwifery] model into the hospital" (Rothman 1991:25). It is this potential for overlap that allows for the production of liminality in the performativity of doula

care—a conceptual mandorla space, at once betwixt and between. Situated within the in-between, doulas may find themselves metaphorically and theoretically stateless, between two worlds, suspended in limbo. However, they may also capitalize on the ritual power of the in-between (Turner 1967; Rayner 2011), and in so doing, expose conceptual spaces where dominant biomedical discourses of childbirth may be challenged.

METHODS

In order to identify and describe the position of doulas within the US maternity care landscape, we combined content analysis (Creswell 2012; Hays and Singh 2011) of published literature on doula professional standards, core competencies, scopes of practice, and care philosophies (Table 5.1) with extensive participant-observation. We reviewed literature from three national childbirth/doula professional organizations—Childbirth and Postpartum Professional Association (CAPP), Doulas of North America (DONA International), International Childbirth Education Association (ICEA)—and two maternity care advocacy organizations—Lamaze International (Lamaze) and Childbirth Connection (CC)—who have published materials that met two criteria: 1) the publicly available document describes the scope and intended impact of doula care; and 2) the document is designed to reach a national audience (i.e., they are not documents created for a specific doula practice or hospital-based program). Each of the selected texts were systematically analyzed for emergent themes, using consensus coding of core values and concepts (i.e., *in vivo* codes) that reoccurred across multiple documents (Creswell 2012; Hays and Singh 2011). Our goal was to identify essential elements of doula care models as formalized in official documents and position statements that could then be discussed

and interpreted through the lens of our own lived experiences of researching, observing, and providing doula and midwifery care over the last 15 years.

Table 5.1 Documents analyzed for content analysis of the essential elements of doula care models

Organizational Author		Document(s) Title	Available at
Professional Doula Organizations	Childbirth and Postpartum Professional Association (CAPPA)	<ul style="list-style-type: none"> • CAPPA Position Paper: Evidence-based Labor Doula Care • Labor Doula Scope of Practice 	www.cappa.net
	Doulas of North America International (DONA)	<ul style="list-style-type: none"> • DONA Position Paper: The Birth Doula's Contribution to Modern Maternity Care • Birth Doula Standards of Practice 	www.dona.org
	International Childbirth Education Association (ICEA)	<ul style="list-style-type: none"> • ICEA Position Paper: The Role and Scope of Birth Doula Practice • ICEA Position Paper: Physiologic Birth 	www.icea.org
Childbirth Advocacy Organizations	Childbirth Connection	<ul style="list-style-type: none"> • Childbirth Connection's Pregnancy Topic on Labor Support: Resources for Labor Support During Pregnancy and Childbirth 	www.childbirthconnection.org
	Lamaze International	<ul style="list-style-type: none"> • Healthy Birth Practice #3: Bring a Loved One, Friend, or Doula for Continuous Support 	www.lamazeinternational.org

We also re-examined field notes collected during multisite ethnographic research with both homebirth midwives and doulas. Our dual positionalities as a birth doula and medical anthropologist (Everson), and homebirth midwife and medical anthropologist (Cheyney), have allowed for extensive participant- and contributing-observation (Creswell 2012; DeWalt and DeWalt 2010b) across multiple models of care and birth settings (home, hospital and birth center), as well as at numerous professional

conferences, birth worker meetings, community outreach events, and legislative hearings and rallies. Throughout these activities, we have spoken formally and informally with dozens of midwives, doulas, and physicians about their professional philosophies, care beliefs, and attitudes towards maternity reform.

This combination of content analysis and participant-observation enabled us to situate the results of our textual inquiry against the backdrop of larger childbearing belief systems, relying on Davis-Floyd (1992) and Rothman's (1991) conceptualization of technocratic/medical and holistic/midwifery models as guiding frameworks. Collectively, our findings help to characterize the intersections and discordances between medical and midwifery paradigms—a mandorla space where, we argue, mothers and doulas engage in forms of resistance that challenge dominant biomedical discourses of childbirth and reveal the potential for systems-wide transformation.

RESULTS: (RE)CONCEIVING DOULA MODELS OF CARE

Content analysis of published literature revealed five commonly recurring themes that form the core components of doula models of care. At a foundational level, a birth doula can be described as a non-medical, support professional that provides emotional, physical, educational, and advocacy support to a woman and her family during the prenatal, birth and immediate postpartum period. Professional organizations posit doulas as complementary to health care providers and who ideally operate as integrated members of the maternity team—one attuned to the holistic needs of childbearing women. In the pages that follow, we describe five themes that emerged from our analyses: 1) specialists in the psychosocial needs of childbearing women; 2) support of physiologic birth; 3) provision of individualized, evidence-based support; 4) facilitation

of communication and relationships; and 5) continuous companionship. These key themes form the essential elements of doula models, while also revealing both the liminal nature of the mandorla space created between childbearing paradigms (medical and midwifery), and the negotiation of doula models within it.

Theme 1: Specialists in the psychosocial needs of childbearing women

Doulas—as non-medical labor support companions—have largely carved out their niche on the maternity care team through their emphasis on the psychosocial needs of childbearing women. Position papers and scopes of practice set forth by professional doula and advocacy organizations extensively discuss the significant emotional and social aspects of birth. As DONA International explains: “Perhaps the most crucial role of the doula is providing continuous emotional reassurance and comfort for the entire labor” (2012:1). The core of this emotional support dimension lies in the commonly repeated phrase, “mothering the mother” (Childbirth Connection 2014; Klaus 1993), meaning that the doula aims to serve as a calm and nurturing presence who provides the woman with the emotional reassurance and encouragement necessary to birth from a position of confidence. As CAPPa notes: “they [laboring women] require emotional support, information, reassurance, encouragement, respect and love...a labor doula can meet many of these non-medical needs” (2011:1). Birthing with support—and the experiences of nurturing care received—then translates into improved confidence in parenting and enhanced bonding between mother and baby. CAPPa states: “One of the most important roles of the labor doula is to attend to the mother’s emotional needs during labor, birth, and immediate postpartum as positive emotional care can strengthen bonding with her infant” (2011:1). DONA similarly echoes the importance of emotional support and its

translation to enhanced parenting: “The quality of emotional care received by the mother during labor, birth and immediately afterwards is one vital factor that can strengthen or weaken the emotional ties between mother and child” (2012:1).

Childbirth is constructed in these documents as a highly psychosocially and spiritually open period for women, and memories of the birth are believed to impact self-image and parenting behaviors of the new mother throughout her life. As CAPPA explains: “Having a baby is an experience that is remembered forever by the woman and her family...the way a birth unfolds will affect a woman’s confidence as a person and mother, her self-esteem, and her relationships with others” (2011:1). These memories are influenced by the emotional support obtained. Lamaze asserts: “One of the most important roles a doula plays is to help you have the best possible memory of your birth” (Lamaze International, Green, and Hotelling 2007:2). Doula care, thus, is intended to support and enhance the positive psychosocial aspects of birth, while mitigating those that induce stress. In Childbirth Connection’s (2014) words: “Labor is an intense physical and emotional experience. It's comforting to be reassured that what's happening is normal and healthy and to get feedback about your progress in labor.” When psychosocial needs are met, labor is allowed to progress uninterrupted which, in turn, facilitates normal, physiologic birth.

Theme 2: Support of physiological birth

Doula models of care espouse an understanding of birth as a physiologic, rather than purely medical, process; in CAPPA’s words: “Childbirth is not simply a medical event” (2011:1). Normal physiologic childbearing is described as “one that is powered by the innate human capacity of the woman and fetus” (ACNM, MANA, NACPM 2012:2),

meaning that birth is allowed to unfold without interventions that may disrupt underlying physiologic mechanisms and processes. As ICEA defines it: “Physiologic birth is a birth where the baby is birthed vaginally following a labor which has not been modified by medical intervention” (ICEA 2014). Doula models of care aim to support physiologic birth through physical and emotional comfort measures during labor that promote cervical dilation and fetal decent, and help to avoid the cascade of interventions that disrupt normal birth. ICEA explains that: “A doula physically supports the mother in a variety of ways. She will suggest alternative (upright and gravity positive) positions for the mother, remind her to maintain her fluid intake, make sure she goes to the bathroom frequently, or offer the use of heat/cold therapy for stress and pain relief (ICEA 2014). Similarly, CAPPa states: “She [the doula] will assist the mother and her partner to find the best methods to relax and encourage labor, including helping with maternal position change, breathing, relaxation, imagery, massage, acupressure, and other comfort measures” (2011:1). DONA echoes: “The doula offers help and advice on comfort measures such as breathing, relaxation, movement and positioning, and comforts the woman with touch, hot or cold packs, beverages, warm baths and showers, and other comforting gestures” (2012:1).

Lamaze International and Childbirth Connection both highlight research on the benefits of continuous labor support measures, citing the Cochrane Review on labor support (Hodnett et al. 2013) as the best evidence to-date, wherein women without continuous labor support were more likely to: use an epidural, other "regional" analgesia, or other medications (including narcotics) to manage pain; give birth via cesarean section or assisted with vacuum extraction or forceps; give birth to a baby with a low 5-minute

Apgar score; and to be dissatisfied with or negatively rate their childbirth experience (Childbirth Connection 2014). The physical comfort measures doulas administer—in tandem with support of psychosocial needs—provide a foundation for facilitating normal physiologic birth, an evidence-based approach to achieving safe and healthy births for all women.

Theme 3: Provision of individualized, evidence-based support

Individualized and evidence-based care strategies are the central tenants of the educational support dimension provided by doulas. ICEA (2014b:1-2) notes that:

The doula should offer evidence-based information in a manner as unbiased as possible. Referring the client to reliable sources so that she can make her own decisions imparts confidence that she can draw upon during labor...[doulas] provide information that helps the woman make informed decisions in conjunction with her healthcare providers”

Similarly, DONA echoes the educational support role of doulas: “the doula helps her [the mother] to become informed about various options, including the risks, benefits and accompanying precautions or interventions for safety” (2012:2). Resources and educational guidance assist a mother in learning about perinatal health and parenting practices and, in turn, facilitate feelings of empowerment and mothering confidence.

Further, the provision of evidence-based educational support occurs within an individualized context where culturally safe practices are honored, or as ICEA (2014b:2) writes:

A doula provides culturally appropriate emotional support to the laboring woman, helping her to cope with labor in her own way. The doula, as a servant, lays aside any preconceived ideas she may have and supports the mother in the way that the mother chooses to labor.

In doula models of care, each mother and her family are recognized as unique, holding values and desires for their birth that distinctly fit their life contexts and worldviews. As CAPPA explains: “Each woman will have different needs, both medically and emotionally due to her individual situation and desires” (2011:1). DONA echoes these sentiments: “They [pregnant/laboring women] need individualized care based on their circumstances and preferences” (2012:1). In response, doulas work to provide such individualized care and assist a mother in integrating evidence-based information with her own personal beliefs and values. Central to this theme is the recognition that individualized support means support of the mother regardless of what the doula might choose for herself and no matter how the birth ends up unfolding. As ICEA explains: “Since the core of the doula’s belief is to make this the very best birth experience for a woman, the doula can be a benefit regardless of the particular circumstances surrounding a birth” (2014b:2).

Theme Four: Facilitation of communication and relationships

Respect for a woman and her family’s individualized needs and desires can be communicated to other members of the birth team with the goal of facilitating multiple relationships during the childbearing experience. Doula models aim to enhance communication between the mother and her health care providers—that is, not speaking “for women,” but rather, supporting the mother as she self-advocates for her own unique birth preferences. As DONA explains: “The doula helps ensure that these nonmedical needs are met while enhancing communication and understanding between the woman or couple and the staff” (2012:2).

Doula models, thus, seek to nurture collaborative birthing environments by helping to make childbearing wishes known to all members of the maternity care team, or as the CAPPA (2014) Scope of Practice notes:

She [the doula] facilitates and promotes self-advocacy, informed choice, and effective communication between the family and care providers. She [the doula] seeks to foster a cooperative, respectful and positive atmosphere with all members of the birth team so that the mother can birth with confidence.

The doula encourages the mother to ask questions about her care, express her wishes, and elicit further clarification as the pregnancy, labor and birth progress. When unexpected occurrences arise, the doula works with the mother to negotiate changes in a way that respects the mother's overarching needs, or in Lamaze's words: "If your labor takes a different path than expected, a doula can help you sort out your feelings and discuss your choices" (2007:2). ICEA echoes: "In many cases, when clients have questions about medical issues, the doula can consider it an opportunity to facilitate communication between the client and her caregivers" (2014b:2). Similarly, Childbirth Connection (2014) asserts: "She [the doula] can also help you communicate your needs to hospital staff and support decisions that you and your partner have made." This ability to successfully advocate with the mother for her individualized wishes arises largely from the ongoing nature of the relationship—a relationship of intimate and continuous support that is difficult or impossible to achieve by other members of the care team.

Theme Five: Continuous companionship

Continuity of care is an essential and distinctive element of doula models of care, and conceptual definitions of the "birth doula" are frequently modified by the word "continuous." DONA, for example, defines a doula's primary task this way: "Doulas

provide continuous physical and emotional support and assistance in gathering information for women and their partners during labor and birth” (2012:1), while ICEA succinctly states: “A doula provides continuous care” (2014b:2). Professional organizations and advocacy groups consistently speak to the importance of continuous support for safe and healthy physiologic birth. Indeed, “Continuous Support” is among the six *Healthy Birth Practices* documented by Lamaze (Lamaze International, Green, and Hotelling 2007), and CAPPA explains that: “Labor doulas improve the outcome, both medically and emotionally, for the mother and her partner as well as the baby. One of the most critical roles of the labor doula is providing continuous reassurance, comfort, and emotional support during labor and birth” (2011:4). ICEA further echoes this stance: “Continuous labor support has been shown to have positive pregnancy outcome benefits...ICEA, therefore, believes that birth doula care should be available to every woman who needs or wants continuous labor support” (2014b:3).

While labor support can and should come from a variety of sources—including partners, family/friends, nurses, doctors and midwives—doula models claim that doulas play a distinct role in their ability to provide knowledgeable and continuous support. Because of the benefits attributed specifically to the continuous care provided by doulas, Childbirth Connection (2014) contends that, “a trained labor support specialist is likely to be your best option for optimal labor support.” They go on to explain that while family and friends, for example, may be able to provide consistent support, they may not be able to provide maximum benefits for several reasons, including: inexperience with support measures; uncertainty about the physiology of labor/birth; impact of (fear-based) media discourses; and difficulties with providing care in an unfamiliar environment (Childbirth

Connection 2014). Further, CAPPA claims that doulas and family/friends/partners hold complementary, but unique roles: “The partner...knows the mother intimately and possesses a love that can come from no one else. The labor doula can offer unique help to the partner and friends by providing suggestions for him/her, and allow the partner, loved ones, and friends to participate at their comfort level” (2011:2).

Additionally, health care providers may all desire to provide continuous support to laboring women, but they often hold other obligations—not the least of which is ultimate attention and responsibility for the clinical outcomes of birth. As DONA explains: “Medical providers must assess the condition of the mother and fetus, diagnose, and treat complications as they arise, and focus on the safe delivery of the baby. These priorities rightly take precedence over the nonmedical psychosocial needs of laboring women” (2012:2). Childbirth Connection (2014) cites three primary reasons why hospital-based providers and staff face barriers in providing optimal support, including: lack of education in labor support techniques; responsibility to other clients, tasks, and clinical monitoring; and shift disruptions that inhibit continuous and personalized support. Because of such institutionalized constraints, as well as barriers faced by friends/family, Lamaze asserts that: “Many women find hiring a doula is the best way to ensure they will have continuous labor support” (2007:2).

DISCUSSION: LIMINALITY AND MANDORLA SPACES IN DOULA CARE

Collectively, these five elements outline a doula model(s) of care that fulfill(s) a unique and complementary role on the care team, one of continuous companionship that is specialized, individualized, and grounded in the intertwined physiologic and psychosocial needs of childbearing women. As Rothman notes: “Birthing is something

that women can do, but usually require emotional support and teaching to do well—that is, to the mother’s own satisfaction” (1992:181). Arguably, the targeted social support dimensions provided by doula care can occur in any site of delivery—home, birth center or hospital—and with any primary clinical care provider in attendance—midwife or obstetrician. As such, doulas can provide support to all families regardless of provider type, delivery site, birth wishes, or perinatal occurrences, but, concurrently, the very nature of this fluidity leaves them betwixt and between, neither fully belonging to homebirth midwifery nor hospital-based obstetrics—enter the mandorla space (see Figure 5.1).

Within the mandorla space that doula models of care occupy, elements of each of the parent circles (midwifery and medical care models, respectively) are represented. Here, the continuity of space and fluidity of boundaries allows each source to flow into and out from the other as dynamically distinct, but not definitively discrete (Rayner 2011). The mandorla is, thus, a liminal space—a threshold—where symbolism is received by the transitional being, or “liminal persona” (Turner 1967:47), as they make the passage from one state of being to another. This liminality allows for transformation, dissolution or reversal of social orders, traditions, and cultural paradigms (Turner 1967). We argue, then, that doulas serve as a type of transitional birthing professional, mediating between the two parent models of care that engulf and press against the mandorla. Doulas hold open a space where the power of the in-between may be co-opted and used to instigate social transformation. But, how is this in-between generated and how can it be operationalized as a form of resistance?

Tension with Hospital-based Obstetrics

Doulas primarily find work supporting families that choose to birth in the hospital, often with obstetricians (Declercq et al. 2013; Morton and Clift 2014). In large part, this is due to current US birthing culture where only about 1% of all births occur outside the hospital (MacDorman, Matthews, and Declercq 2014). As such, doulas are at once intimately part of, and marginalized within, the obstetric hierarchy. While doulas operate primarily within hospital-based obstetrics underscored by a medical/technocratic model, they find many intersections with the midwifery/holistic model of care, grounding their beliefs in the emotional and physiologic needs of childbearing women. Yet doulas do not—and likely cannot—outright reject technocratic birth, for they rely on good relations with medical staff to be able to serve families and advocate for humanizing reform within the system. Doula models, then, hold high potential “to open the technocratic system, from the inside, to the possibility of widespread reform” (Davis-Floyd 2001:S10).

Thus, while doula care is on the rise overall, and more hospitals are exploring doula programs for higher risk or under-supported mothers, the position of doulas remains tenuous. The politics of childbirth in the US and the role doula care may play within it is evident, for example, in the media frenzy surrounding a March 2008 *New York Times* article entitled: “And the doula makes four” (Paul 2008). This article reported on a phenomenon called “doula discord,” whereby doulas were posited as interfering with the authoritative knowledge of physicians and, at times, even threatening the health and safety of the birthing mother and baby. The article describes a case where a doula was so opposed to medical intervention that she adamantly insisted on “alternatives” to

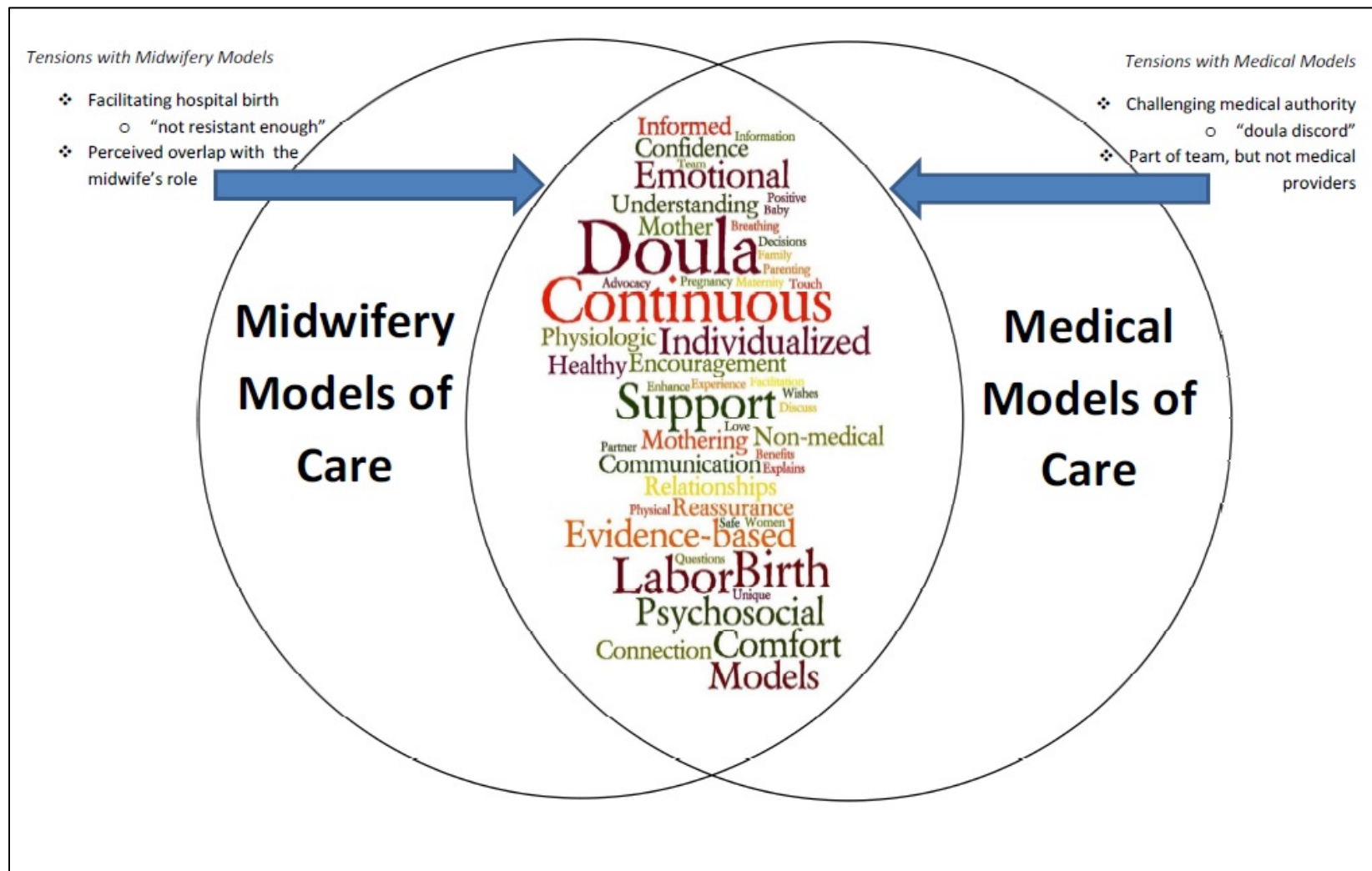


Figure 5.1 Birthing models of care and the mandorla space

IVs, surgical delivery and pharmacologic pain relief despite the recommendations of the obstetrician and the wishes of the mother. On the surface, this case can be seen as exceptional, an example of the media capitalizing on a rare and extreme occurrence to sell the news. What is enlightening here is that this case gave voice to a fear expressed in some hospitals—that doulas, by virtue of their relationship with the mother who has the right to decline procedures, may undermine the (unquestioned) authority of technocratic providers. Doulas thus become one venue by which bodily knowledge, authoritative medical discourse, and maternity care practices may be contested. This case disrupts the notion of doula as team member, revealing the potential for doula as agitator.

Tension with Homebirth Midwives

Despite the central domains of overlap between midwifery and doula models of care—such as their shared focus on the importance of uninterrupted physiologic birth practices, continuous physical and emotional support, full informed consent, and respect for women’s individualized decision-making power—doulas and homebirth midwives may still experience relationships marked by uneasy tension. While most midwives are doulas (especially following intrapartum transfer), most doulas are not midwives. This acknowledgment can produce a wedge, an ambiguity, where friction can be generated between midwives and doulas. We have, for example, heard some midwives question the value of doulas, essentially arguing that doulas enable women to avoid fully rejecting an obstetrician-led, technocratic hospital birth. Because unlike the midwife, the doula cannot also provide clinical care and, therefore, claim a sphere all her own, doulas may be constructed by midwives as “hospital birth facilitators.” In a climate where place of birth has become contentious with very few standing in the middle ground (Cheyney, Burcher,

and Vedam 2014), doulas may be perceived as part of the opposition. Concurrently, although doulas share care philosophies with midwives, the former may still be seen as ancillary or redundant (at best) or disruptive (at worst) in the homebirth setting. In essence, doulas' liminality is enforced by the fact that they also cannot be fully embraced by homebirth midwives because they facilitate hospital birth, and/or claim to advocate for the mother—a role midwives see themselves as fulfilling. This means doulas risk, and sometimes experience, friction with the provider group that, in theory, might be their closest ally.

Homebirth midwives may also claim that doulas are not “resistant enough”—that their models of care, with its majority focus on within-hospital reform, is ultimately a manifestation of systems-correcting praxis, rather than systems-challenging praxis (Cheyney 2008; Singer 1995). Midwives argue that at best, the doula gives technocratic care a softer face through its humanizing efforts, and at worst, doulas allow the oppressive system of biomedicine in childbirth to endure. Such midwives contend that doulas essentially help to mystify the unnecessary, even violent (Pérez D'Gregorio 2010), practices and outcomes associated with medical/technocratic models of care. Norman and Rothman have similarly argued that while doulas, “have tried to elicit change quietly from within...the overall result has been an enabling effect. That is, in trying to make quiet waves, doulas ultimately help along the current medicalized system of birth” (2007:280). Doulas—in contrast and in response—claim that they are working to transform the system from the inside out, bringing elements of holistic care into medical spaces. Midwives, however, often claim that doulas may easily become co-opted by this

system given their liminal status as at once intimately part of, and marginalized within, hospital-based obstetrics.

The often uneasy relationship between doulas and homebirth midwives can be witnessed in online articles and blog posts that address the working relationships (or lack thereof) between midwives and doulas. For example, a 2014 guest article on the Midwives Alliance blog, entitled “Nine Tips to Help Midwives and Doulas Work Together” (Muza 2014), aimed to address the issues that midwives and doulas encounter in supporting birthing families. Similarly, Citizens for Midwifery ran a thread on their blog and Facebook page in 2011 entitled “Doula & Homebirth” (Remer 2011). Doulas, parents, and homebirth midwives all weighed in with their perspectives. Midwives often echoed the theme that “every midwife is a doula, but not every doula is a midwife.” For example, one midwife wrote: “I have had a couple interviews where a woman has asked if she should have a doula at her homebirth. If someone wants to hire me and a doula, I will not try to talk them out of it. But I see my work as being a doula plus a midwife.” In contrast, doulas wrote in about how they view their role in a homebirth:

Providing support for long labors so the midwife can conserve her energy for the important work she might need to do during the actual birth and immediately after. I find myself doula-ing the birth team. Making tea, providing support to the dad, taking pics and of course, supporting the mom as she wishes.

Experiences of mothers who had both—doulas at their home and hospital births—were also present, demonstrating how doulas can move fluidly to support families across the spectrum:

I had the same doula at both my hospital birth and my homebirth and it was well worth it in both cases. At the homebirth she obviously didn't have to function as a warrior/advocate like she did at the hospital birth, but it was still wonderful to have her there in a supportive role. Having a doula there for mental and physical

support provided comfort and assurance, while allowing my husband to be “in the moment” with me while my midwife could focus on the particulars of the labor and delivery themselves.

This series of remarks ended with these words by article author Molly Remer (2011):

“Here’s to beautiful, empowering, healthy, fulfilling births for all women, in all settings, with the birth companions of their heart’s desire.” How, then, can doula and midwifery models of care be strategically aligned to insure greater choice for families across birth settings?

The Power of the Mandorla Space

Doula models of care occupy a mandorla space that is one of uncertain liminality, a transitional space between the two worlds of midwifery/holistic care and medical/technocratic care. This liminal space is not unlike the liminality laboring women experience as they make the physical and psychosocial transition from their pregnant to mothering identities. During these transformative times, women are open to the messages communicated to them by care providers and system models, and begin to perform the norms they have received (Butler 2006). The authoritative knowledge valued within medical models of care communicates messages of women’s dependency on life saving technologies and the physicians who deliver them. In contrast, midwifery models of care attempt to communicate messages of empowerment and confidence by constructing women as active subjects and autonomous agents, birthing under the power of their own bodies. Doula models of care sit between these paradigms, bringing elements of one (midwifery care) into the space of another (medical care). Doulas, then, serve as a bridge between these two worlds.

Ultimately, it is within these conceptual and material mandorla spaces that doulas and mothers may engage in forms of resistance that challenge dominant biomedical discourses of childbirth, and reveal the potential for transformation. Yet, Norman and Rothman have asked the important question: are doulas “making birth better for women, or just making women feel better about their births?” (2007:262). Ultimately, Norman and Rothman argue that “doulas are in no position to make a revolution” (2007:263), questioning whether their positions as “second-class” or even “fourth-class birth workers” (2007:267) ultimately limits their ability to engage in radical change of birthing systems. On the whole, we fundamentally agree that doulas—by the very nature of their liminal position as transitional birthing professionals—are constrained in their potential for resistance. Yet, we see a fissure, an opening, through which doula-attended hospital birth as gendered performance might “slip” (Butler 2006).

As laboring women receive messages of compassion and individualized support through their doulas, they may begin a process of unlearning and relearning, emerging confident in the power of their own bodies, of physiologic birth, and of the role women caring for women can play in cesarean reduction and healthy outcomes for mother and baby (Cheyney 2008; Kozhimannil et al. 2014). This may have a profound influence on subsequent birth choices. In this way, hospital-based doula care may unsettle the boundaries of medical models, thus providing a critical opening—a stepping stone—toward midwife-led home and birth center births as women move through the process of undoing decades of socialization into “birth as medical event” meta-narratives. Indeed, the very presence of a doula may disrupt the “business as usual” routine of hospital procedures, moving obstetricians and nurses (even if only temporarily) into a mandorla

space where the presumed wisdom of everyday practice may be questioned. While we both see doula care as valuable in its own right, perhaps if we can also reconceive the liminality of doula care as a potential step toward home and birth center births, it may be possible to ameliorate some of the friction between midwives and doulas, finding common ground in the power of the mandorla to initiate fundamental reform in childbirth.

CONCLUSION

In conclusion, content analyses of published literature, informed by our ethnographic work as researchers and birth workers, generated five recurring themes that constitute the heart of doula models of care: 1) specialists in the psychosocial needs of childbearing women; 2) support of physiologic birth; 3) provision of individualized, evidence-based support; 4) facilitation of communication and relationships; and 5) continuous companionship. We have argued that doula care occupies a position of liminality, one betwixt and between medical and midwifery models of care. It is in this mandorla space that the potential for systems-wide change occurs as the authoritative knowledge of biomedicine is questioned, and birthing power is placed back into the hands of women.

Thus, the strategic alignment of doula and midwifery models of care can be found in the reconceiving of resistance. Rather than constructing resistance discourses against a dichotomous backdrop of home versus hospital, or midwife versus physician—wherein doulas (and families) hover between two worlds, unsure of where their contribution and acceptance lies—we contend that both doula and midwifery models of care can work together to relocate choice and power back to women. Doulas serve as a bridge, holding

open the mandorla space where US childbearing models may be negotiated, resisted and, ultimately, transformed. In this way, doula care may enable a widespread shift from hospital-based, medical dominated systems to one predicated on home and birth center birth and midwifery-led care for clinically low-risk women. As Michel Odent argues: “If we want to find safe alternatives to obstetrics, we must rediscover midwifery. To rediscover midwifery is the same as giving back childbirth to women.” Doulas facilitate such re-discovery through the power of the mandorla space.

NOTES

ⁱ Throughout this paper, we pluralize the term “model” to acknowledge the diversity existing within varying childbearing models of care, including: midwifery, medical and doula.

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Chapter 6: General Conclusion

There is this divide between the “let’s prevent teen pregnancy because it’s bad” world, and this other side that’s supporting young moms, but looked at often as actually encouraging teen pregnancy through support. I think that there needs to be more integration between those two sides; they’re not mutually exclusive. I think that we can work to prevent teen pregnancy and still support young women who do become pregnant in the same breath. Because it’s exactly the same—its choice, education, access to medical care, empowerment, and those things cannot be separated. That’s part of the conversation that needs to continue.

~Eva, Doula participant

COLLECTIVE REVIEW

In this dissertation, I have examined doula care in the lives of pregnant and parenting adolescent mothers from four vantage points: perspectives of young mothers; perspectives of doulas; maternal-child health outcomes for doula-supported adolescent women; and professional positioning of doulas in the wider maternity care landscape via content analysis of published doula literature. Through four manuscripts I have highlighted—from these varying angles—the relationships between psychosocial stress, social support, institutionalized constraints, and their impacts on health and well-being among adolescent mothers in the Northwestern United States. Collectively, this work informs biocultural perspectives on the interactions between psychosocial, sociocultural and political-economic determinants of well-being, and provides triangulations of results across data sources, methods and positions (Mertens and Hesse-Biber 2012). Through exploration of the synergies between micro- and macro-level elements, I have argued that doula care, as a targeted form of social support, can serve as an effective pathway for advancing health equity and long-term social well-being for young mothers and their families.

In Chapter 2 (article one)—“It felt like everyone’s world kept spinning, but mine had stopped” – Negotiating Shifting Horizons at the Vital Conjunction of Adolescent Motherhood—I positioned adolescent motherhood as a vital conjunction, and examined the social-structural contexts of young pregnancy, birth and parenting experiences through a series of critical moments shared by doula-supported and non-doula supported adolescent mothers. Informed by their narratives, I described how participants’ maternal self-concepts and future possibilities are both structurally bound and integrally intertwined with experiences of social support and psychosocial stress. I situated doula care as its own critical moment, and argued that doula care works to mediate social and institutionalized barriers, introducing transformed maternal identities and an array of horizons that can emerge from their re-calibrated conjunctions. I concluded with the assertion that risk constructions of teen pregnancy in the United States must be reconceived to account for larger structural constraints that have reified age-based health inequities and maintained systemic barriers to young mothers’ well-being.

In Chapter 3 (article two)—Respected (Adolescent) Motherhood: Doula Care as Narrative Repair—I explored how current meta-narratives of teenage motherhood function to regulate and subjugate pregnant and parenting adolescents via pathologizing frameworks that position young mothers as incapable, deviant, and doomed for failure. Drawing on narratives of care from doulas serving young mothers, I described how doulas explicitly construct their philosophies of care in opposition to stigmatizing meta-narratives, communicating a counter-narrative of maternal capability, confidence-building and empowerment. Through this model of care, doulas foster resiliency, self-efficacy and resistance aimed at enabling young mothers to rewrite their stories. I end by

arguing that in positioning doula care as narrative repair, doulas can be seen as creating a critical opening for young women to navigate maternal identity formation and aspirations from a framework of respected, rather than illegitimate, motherhood.

In Chapter 4 (article three)—Outcomes of Care for 1,892 Doula-supported Adolescent Mothers: The DONA International Data Project, 2000 to 2013—I described outcomes of care for a national, voluntary sample (n=1892) of doula-supported adolescent births (ages 15 to 19). Results from this study suggest that key health outcomes are improved relative to national statistics for adolescent deliveries in the United States, and are consistent with previously reported data on the effects of doula care during childbearing for socially marginalized communities. I conclude with the assertion that as the largest study to-date to report on outcomes of care for a national sample of doula-supported adolescent births, findings strengthen the case for doula care as a cost-effective strategy for improving maternal-child health outcomes and decreasing inequities among adolescent childbearing women.

In Chapter 5 (article four)—Between Two Worlds: Doula Care, Liminality and the Power of Mandorla Spaces—I explore, with my co-author, doula care as a mandorla space between hospital-based obstetrics and homebirth midwifery. We underscored the core components that comprise doula models of care, and then examined how the liminal position of doulas leaves them metaphorically and theoretically stateless, between two worlds, suspended in limbo. The ritual power of the in-between, however, also allows for the negotiation of power and resistance to dominant, biomedical discourses of childbirth, thus revealing the potential for systems-wide transformation. We end with the contention that although doulas primarily work within the obstetric system, their tacit threat lies in

the recognition that doula care can constitute a common ground—and perhaps a critical opening—in larger place of birth and maternity reform debates.

IMPLICATIONS & DISCUSSION

The holistic framework applied in this dissertation helps to illuminate the dynamic interplay of institutions with individual agency. As such, my research contributes to a more nuanced understanding of the relationships between structural vulnerability, health and equity (Quesada, Hart, and Bourgois 2011). Defined as a “positionality that imposes physical/emotional suffering on specific population groups and individuals in patterned ways,” structural vulnerability has been argued to arise from two complementary forces (Quesada, Hart, and Bourgois 2011:339): 1) the intersecting power-over practices attached to class, race, gender, and age; and 2) systems of structural violence that uphold disciplinary discourses of personal unworthiness. For many young mothers, structural vulnerability to poor health outcomes, and lasting experiences of marginalization, begins in the pre-pregnancy context and then persists through their lives (and often their children’s lives) as a result of the stigmatizing processes attached to young motherhood (Smithbattle 2007; SmithBattle 2013; Wiemann et al. 2005; Wilson and Huntington 2006; Yardley 2008).

As Yardley (2008:672) notes: “the problematisation of teenage motherhood is, by conceptual definition, stigma.” Stigma is argued to be a primary underlying factor in the production of health inequities, social exclusion processes, and negative self-concepts during identity formation (Barcelos 2014; Luttrell 2011; Quesada, Hart, and Bourgois 2011; SmithBattle 2013; Spangler 2011; Wenham 2011; Whitley and Kirmayer 2008; Yardley 2008). In studies of stigma and health, attention must be paid to the role of

intersecting social identities and locations in producing variations in the experiences and effects of stigma. Mantovani and Thomas (2014) refer to these interconnecting and overlapping factors as “intersectional stigma.” Findings from this research add to the literature on intersectional stigma through a focus on the social-structural dimensions of young mothering experiences, where the stigma ascribed to their age intersects with stigmatizing processes attached to their (presumed) identities as single, racial/ethnic minorities with low literacy and low socioeconomic status, dependent on public assistance programs (Luttrell 2011; Mantovani and Thomas 2014; SmithBattle 2005, 2013; Yardley 2008).

As such, this work contributes to the body of literature on the ways in which stigma manifests, and is then resisted and reworked during major life transitions, such as the social transformation from teenager to (young) mother (McDermott and Graham 2005; Nahar and van der Geest 2014; Rodriguez 2008; Silver 2008). Drawing on Scambler (2006, 2009) and Scambler and Paoli's (2008) notions of felt, enacted and project stigma, the stories of adolescent mothers and doulas, combined with outcomes-based clinical data, allows us to see the variable manifestations of stigma in the lives of young mothers, and the very real impact stigma has for social well-being, embodied inequality, and maternal identity formation (Brubaker and Wright 2006; Luttrell 2011; Smithbattle, Lorenz, and Leander 2013; Spangler 2011; Quesada, Hart, and Bourgois 2011). In felt stigma, an individual internalizes notions of shame associated with her condition or position, which leads to deep fears about being discriminated against. Felt stigma, thus, impacts her self-concept, and may also lead to behaviors (such as non-disclosure, avoidance) that circumvent potentially stigmatizing situations. In enacted

stigma, an individual is the target of discrimination by others and subsequently experiences unequal treatment. In project stigma, an individual either rejects or actively resists ascriptions of shame—in other words, the ascription of stigma is neither fully internalized nor accommodated. Mantovani and Thomas (2014:58) claim that, “felt, enacted and project stigma may coexist in individual biographical accounts.”

My research has explored manifestations of all three forms, and highlighted the special role “project stigma” plays as young mothers find personal transformation through their pregnancy, birth and parenting experiences, often capitalizing on an “all moms” discourse whereby they refuse to have their maternal identity devalued. Their ability to resist stigmatizing processes, however, is constrained by the social-structural nature of their conjunctures (Langevang 2008; Scambler and Paoli 2008; Yardley 2008) and, thus, young mothers must navigate a limited or “bounded agency” (Evans 2002). Within this context, doulas work to amplify the agency of adolescent mothers and endorse project stigma by nurturing self-worth, maternal capability and confidence. By constructing powerful counter-narratives during the childbearing year and by providing highly individualized support, doula care operates as a form of “incitement” (Sewell 2005:221) that disrupts stigma, structural vulnerability, and embodied stress.

This research suggest that doulas are effective for two primary reasons: 1) doulas decrease psychosocial stress (a known determinant of negative health outcomes, such as prematurity), while also improving support (a known factor of positive health outcomes, such as breastfeeding) (Boath, Henshaw, and Bradley 2013; Dominguez et al. 2008; Coley et al. 2015; Edwards et al. 2013; Feldman et al. 2000; Hobel, Goldstein, and Barrett 2008; Katy B. Kozhimannil et al. 2013b; McDonell, Limber, and Connor-Godbey

2007; Pires, Araújo-Pedrosa, and Canavarro 2014; Thoits 2010; Zachariah 2009); and 2) doula care capitalizes on the transformative nature of childbearing to foster positive maternal identities and reveal new horizons via the formation of therapeutic relationships (Brubaker and Wright 2006; Mattingly 2010; McDermott and Graham 2005; Porr, Drummond, and Olson 2012; Porter and Holness 2011; Rodriguez 2008; Smithbattle, Lorenz, and Leander 2013). Through knowledge sharing, increasing access to resources, and empowerment in the form of narrative repair, doulas can infuse in young mothers a sense of respected motherhood that helps them to navigate not only immediate decision-making during childbearing, but also long-term life and parenting prospects. The efficacy of doula care, thus, lies in how doulas mediate psychosocial and structural impacts of political-economic, cultural and biological factors that create the patterns of (poor) health and well-being characterizing young motherhood in the United States today.

Quesada and colleagues (2011:5) contend that anthropological approaches to health are deeply needed—approaches that consider the institutionally constrained, socially patterned nature of social and health inequality. They state that, “theoretically informed documentation of the larger contexts for intimate suffering can facilitate the design and implementation of upstream structural interventions that improve health outcomes” (Quesada, Hart, and Bourgois 2011:5). Findings from this work demonstrate the potential for doulas to serve as such an upstream intervention, as they intercede for young mothers, improve prospects for babies born to childbearing adolescents, and help the young women to see and ultimately occupy horizons that move beyond merely surviving to thriving.

Finally, in examining the location of doula care within larger childbearing paradigms—occupying a place of liminality between obstetric and midwifery models of care—my co-author and I have explored how doulas have the potential to create critical openings from which larger maternity care reform debates may emerge. In illuminating the power of the mandorla space to instigate change, doula care may facilitate additional “upstream interventions” such as home and birth center birth, midwifery, and Center Pregnancy (Klima 2003; Manant and Dodgson 2011) as the US re-conceives maternity care in light of the Affordable Care Act’s “triple aim” and a growing call for the support of normal, physiologic birth practices (ACNM, MANA, NACPM 2012; Berwick, Nolan, and Whittington 2008; Romano and Lothian 2008; Strauss, Giessler, and McAllister 2014).

FUTURE RESEARCH

Collectively, in looking back across all four manuscripts, I see several directions for future research as well as areas ripe for intervention—that is, where the balance of evidence is such that we might proceed immediately with some concrete next steps towards implementing doulas care as *the* standard of care for all young mothers in the US (as opposed to continuing to spin the wheels of “ongoing research” as an excuse for non-movement). I conclude this chapter with my suggestions for future research and with four specific applied recommendations, two coming from doulas and two from young mothers.

First, future research should further nuance the pathways and processes by which doula support mitigates health outcomes and improves well-being by parsing out and examining discrete models of doula care. With increasing efforts being put towards

community-based doula programs, hospital-based doula programs, and insurance reimbursement for doulas (HealthConnect One 2014; Joint Special Committee on Health Care Transformation n.d.; Katy Backes Kozhimannil et al. 2013a; Mottl-Santiago et al. 2008; Strauss, Giessler, and McAllister 2014), it is critical that we understand which models are most effective, for whom, and why. The timing of doula care (early or late onset), as well as the duration of doula care (prolonged postpartum support) may prove to be critical elements associated with improvements in health outcomes like prematurity, low birth weight, breastfeeding, and perinatal mood disorders. Additionally, attention must be paid in future studies to the development of a diverse, sustainable, and professionally recognized workforce of doulas. Without these elements, the transformative potential for doulas in advancing health equity will be limited by systemic constraints related to compensation, inclusivity, and integration in maternity care reform.

Second, an essential perspective missing from this work is the voices of adolescent fathers. Young fathers have the potential to lower stress, while improving support for young mothers (Shah, Gee, and Theall 2014), and deserve to be similarly nurtured as respected parents and contributors to their children's lives. Understanding their experiences of stress, stigma, and support during emergence into young fatherhood is nearly completely absent from current anthropological literature on teenage parenthood. Young fathers remain a critical (missing) piece of the puzzle (Wilkes, Mannix, and Jackson 2012).

Finally, longitudinal studies on the health and social outcomes of doula-supported young mothers and their children are needed to help identify the long-term impacts of doula care. Longitudinal studies will also further understandings of the cost-savings that

doulas may provide, not only through decreased interventions at birth, but also through reduced childhood morbidity and mortality as breastfeeding rates increase, parenting confidence improves, and greater economic stability is established.

APPLIED RECOMMENDATIONS

At the close of each interview, I asked doula and young mother participants: “If you could dream big, what would you do to improve experiences for young mothers?” Collectively, the recommendations made can help policy makers, community-based organizations, social service providers, school-based programs, and clinicians chart a course forward.

Recommendations from young mothers

Two recommendations emerged from young mothering narratives. Adolescent mother participants believed that: 1) more support with less judgement was necessary; and 2) that more sexual health education in the schools preconception was necessary, as well as more teen-centered education around childbearing once pregnant. For the first recommendation, young mothers noted that support needed to take the form of not just immediate, logistical support such as diapers and clothes, but also emotional and material care from their social networks and structural support systems that would help them achieve social and financial stability in their lives. This means knowing where they are going to live, who is going to safely care for their child while at school or work, and where the next meal will come from. Moreover, this means implementing programs and having role models that genuinely care about them, their feelings, and their emotional well-being. Young mothers ultimately want non-judgmental care that helps them to

achieve a sense of social belonging, as well as a safe and secure environment that reduces stressors associated with social exclusion and unstable lives.

School-based teen parent programs were cited as an important source of both emotional and structural support, but participants felt they could be expanded to: 1) include transportation both prenatally as well as postpartum; 2) ensure that all teen parents had access to the state-funded day care regardless of partner status or income level; and 3) align larger school policies with the protocols of the school-based teen parent programs and onsite daycares. For example, when the daycare calls a young mother out of class to pick up her child because the baby is sick and must go home, the schools often count the mother as “truant” and their educational record receives a negative mark. Participants requested that school policies and protocols comprehensively recognize and respect their unique status as teen-parents.

Adolescent participants also cited the need for additional structural supports that would help them to meet immediate, as well as long-term economic needs, including changes to state regulations that would allow programs like TANF and SNAPs to go directly to the young mothers instead of their legal guardians. They also requested additional help beyond the high school years in the form of subsidized childcare and financial assistance to attend college or vocational trainings. Well-publicized programs that offer assistance in navigating social services, educational and career prospects were also recommended. Participants requested that medical and social service professionals improve their treatment of young mothers by “judging less and supporting more,” and many indicated that advanced training for nurses was needed.

In their second recommendation, many young mothers felt they did not receive enough education on reproductive and sexual health issues prior to becoming pregnant. They felt that even in schools with so-labeled “comprehensive sexual education programs,” that the information delivered was sparse and overly-simplified. Participants linked pre-conception education not only with improved abilities to make informed reproductive and sexual health choices, and the ability “to take charge” of their bodies, but also to feelings of empowerment as women. They believed that better education (like the kind they felt they received from their doulas) would have enabled them to view their bodies as something to be respected and celebrated, not abused and shamed. Participants also recommended more teen-centered and teen-friendly childbirth and parenting education classes once pregnant, and emphasized the need for extended postpartum support. They asserted that education and support as a new parent were central to their capabilities as mothers, but felt excluded for a multitude of reasons from usual antenatal education programs and parenting groups. Finally, doula-supported adolescent mothers recommended at great length and with great passion the need for doula programs for adolescent moms in every community.

Recommendations from doulas

Recommendations from doulas centered on two main themes: 1) the need for early childhood interventions; and 2) the importance of supporting and respecting adolescents in reproductive decision-making both pre-conception and after they become pregnant. In the first theme, doulas described how many of the inequities young mothers face manifest far before childbearing. Here, they discussed how structural forces like poverty, food insecurity, and dysfunctional familial relationships must be identified and

systematically addressed early in childhood to prevent teen pregnancy and to improve outcomes for young women when they do become pregnant. They felt that without both physically safe and emotionally nurturing home environments, inequities experienced by adolescent mothers would continue to worsen, and doula care would be limited in its effectiveness, serving as a “Band-Aid on a gunshot wound” amidst larger, pre-existing social and economic disadvantages.

Secondarily, doula participants called for a re-conceiving of discussions around adolescent pregnancy and parenting. As the opening quote to this final chapter illustrates, the achievement of equity in health and well-being for young mothers rests not only on improving support and decreasing stigma once pregnant, but on cultivating an overarching culture of respect for young people’s bodily autonomy. Doulas see young women as “rightfully in charge of their bodies and lives.” Doulas believed that the divide between the faction that works tirelessly to prevent teen pregnancy, and the faction that works tirelessly to support pregnant and parenting adolescents, is artificial. They argued that the chasm between these two positions must be bridged if we are to achieve success in developing effective and sustainable support structures for young families.

CLOSING REMARKS

Maya Angelou once said, “I’ve learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.” In this dissertation, I have demonstrated how the oppressive, unequal treatment of young mothers has deep impacts for health and social well-being, influencing the way individual biologies and biographies unfold during the conjunctures of adolescent motherhood. Doula care works to mediate macro- and micro-level forces by helping young mothers

create new trajectories, decrease stress, improve support, and resist stigma. Doula models of care rest on Maya Angelou's words, as doulas open a critical space for young women to emerge into maternal identities with support, confidence, and empowerment. In one young mother's words: "With my doula, I went from feeling like a failing pregnant teen to a mom who *could* do this, who *was* doing this. I realized that I deserve support and respect and recognition just as much as anyone else. Because I'm a mom too!"

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APPENDICES

APPENDIX A IRB Approved Consent Document for Adolescent Mother Cohorts



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CONSENT FORM, STUDY ID 6208

Project Title: Understanding Stress, Social Support & Birth Experiences of Teenage Mothers

Principal Investigator: Melissa Cheyney, PhD, CPM, LDM

Student Researcher: Courtney Everson, MA, ABD

Co-Investigator(s): Marit Bovbjerg, PhD, MS

Sponsor: Internal Funding: School of Language, Culture & Society, OSU

Version Date: April 22, 2014

1. WHAT IS THE PURPOSE OF THIS FORM?

This form contains information you will need to help you decide whether or not to be in this research study. Please read the form carefully and ask the study team member(s) questions about anything that is not clear.

2. WHY IS THIS RESEARCH STUDY BEING DONE?

The purpose of this research study is to explore relationships between stress, social support, doula care, health outcomes and experiences of teenage mothers in the United States. This study is being conducted as part of the dissertation requirements for the student researcher. Results may be published in peer-reviewed journals and may be used to help improve the care of young families during childbirth. Up to 350 individuals may be invited to take part in this study.

3. WHY AM I BEING INVITED TO TAKE PART IN THIS STUDY?

You are being invited to take part in this study because you: (a) gave birth in the last seven years; (b) your pregnancy and childbirth occurred between the ages of 15 – 19; and (c) your child born when you were a teenager is at least 8 weeks old.

4. WHAT WILL HAPPEN IF I TAKE PART IN THIS RESEARCH STUDY?

This is a research study, and the study activity is an open-ended interview with the researchers. During this interview, we will ask you questions about your experiences as a teenage mother, and if you used a doula, your thoughts about doula care. You are free to skip any questions you do not feel comfortable answering, and can end the interview at any time.

Study duration: If you agree to take part in this research study, your involvement will last for about one to two hours, depending on the amount you want to share.
If you agree, the interview and your responses will be tape recorded, transcribed and compared to interviews from other teenage moms participating in this study. If you do not agree to be tape recorded, we will take notes only.

_____ I agree to be audio recorded.
Initials

_____ I do not agree to be audio recorded.
Initials

Storage and Future use of data: Because it is not possible for us to know what studies may be a part of our future work, we ask that you give permission now for us to use your personal information without being contacted about each future study. Future use of your information will be limited to studies about teenage mothers, social support, stress, doulas, health outcomes and experiences.

_____ You may store my interview data for use in future studies.
Initials

_____ You may not store my interview data for use in future studies.
Initials

Future contact: We may contact you in the future for another similar study. You may ask us to stop contacting you at any time.

Study Results: Final results from this study will be made available publically and to you through Oregon State University's ScholarsArchive. This is where the final dissertation resulting from this study will be held. Additionally, publications and presentations may result from this study. You can contact the researchers if you would like to be told about future publications/presentations. You will also be given the opportunity to participate in a focus group about interview findings after we have analyzed interview responses.

WHAT ARE THE RISKS AND POSSIBLE DISCOMFORTS OF THIS STUDY?

It is possible that you could experience some emotional distress or discomfort when talking about your birth and being a teenage mother. There is a chance that we could accidentally disclose information that identifies you. We will take necessary precautions to insure that your information is kept confidential to the extent permitted by law.

WHAT ARE THE BENEFITS OF THIS STUDY?

This study is not designed to benefit you directly.

WILL I BE PAID FOR BEING IN THIS STUDY?

You will be paid for being in this research study. At the end of this interview, you will be provided with a \$20.00 gift card to either Fred Meyer or Target. You can choose to skip questions during the interview or otherwise stop the interview, and you will still be paid in full. If you choose to remove your interview comments from the study before publication, but after the interview is complete, you will keep the gift card.

5. WILL IT COST ME ANYTHING TO BE IN THIS STUDY?

The only potential costs associated with the study are transportation and parking costs. If you paid for parking or transportation to get to this interview, you will not be reimbursed.

WHO IS PAYING FOR THIS STUDY?

The School of Language, Culture and Society at Oregon State University is paying for portions of this research to be done. The School has provided funding so you can be compensated for your time in the form of a gift card.

6. WHO WILL SEE THE INFORMATION I GIVE?

The information you provide during this research study will be kept confidential to the extent permitted by law. Research records will be stored securely and only the researchers will have access to the records. Federal regulatory agencies and the Oregon State University Institutional Review Board (a committee that reviews and approves research studies) may inspect and copy records pertaining to this research. Some of these records could contain information that personally identifies you. If the results of this project are published, your identity will not be made public. While this study is funded, the funders will not see your information.

Under Oregon law, the researchers are required to report to the appropriate authorities any information concerning child abuse or neglect. The researchers may also report threats of harm to self or to others.

7. WHAT OTHER CHOICES DO I HAVE IF I DO NOT TAKE PART IN THIS STUDY?

Participation in this study is voluntary. If you decide to participate, you are free to stop participation at any time without penalty. You will not be treated differently if you decide to stop taking part in the study. You may choose to remove your interview from the study before publication by contacting the researchers listed on this document. You are free to skip any questions you do not feel comfortable answering, and you can end the interview at any time.

8. WHO DO I CONTACT IF I HAVE QUESTIONS?

If you have any questions about this research project, please contact: Melissa Cheyney at Melissa.Cheyney@oregonstate.edu or 541-737-3895, or Courtney Everson at Courtney.Everson@oregonstate.edu or 360-490-0220 (cell/text).

If you have questions about your rights or welfare as a participant, please contact the Oregon State University Institutional Review Board (IRB) Office, at (541) 737-8008 or by email at IRB@oregonstate.edu

WHAT DOES MY SIGNATURE ON THIS CONSENT FORM MEAN?

Your signature indicates that this study has been explained to you, that your questions have been answered, and that you agree to take part in this study. You will receive a copy of this form.

Do not sign after the expiration date: 4/29/2015

Participant's Name (printed): _____

(Signature of Participant)

(Date)

(Signature of Person Obtaining Consent)

(Date)

APPENDIX B IRB Approved Consent Document for Doula Cohort



School of Language, Culture, & Society
Waldo Hall 238, Corvallis, OR 97331
Tel 541-737-4515 | Fax 541-737-3650
<http://oregonstate.edu/cla/anthropology/>

CONSENT FORM, STUDY ID 6208

Project Title: Understanding Stress, Social Support & Birth Experiences of Teenage Mothers
Principal Investigator: Melissa Cheyney, PhD, CPM, LDM
Student Researcher: Courtney Everson, MA, ABD
Co-Investigator(s): Marit Bovbjerg, PhD, MS
Sponsor: Internal Funding: School of Language, Culture & Society, OSU
Version Date: April 22, 2014

1. WHAT IS THE PURPOSE OF THIS FORM?

This form contains information you will need to help you decide whether or not to be in this research study. Please read the form carefully and ask the study team member(s) questions about anything that is not clear.

2. WHY IS THIS RESEARCH STUDY BEING DONE?

The purpose of this research study is to explore relationships between stress, social support, doula care, health outcomes and experiences of teenage mothers in the United States. This study is being conducted as part of the dissertation requirements for the student researcher. Results may be published in peer-reviewed journals and may be used to help improve the care of young families during childbirth. Up to 350 individuals may be invited to take part in this study.

3. WHY AM I BEING INVITED TO TAKE PART IN THIS STUDY?

You are being invited to take part in this study because you: (a) self-identify as a birth doula (active or non-active); and (b) you have provided doula services (paid or pro bono) to at least 2 adolescent mothers during the past seven years.

4. WHAT WILL HAPPEN IF I TAKE PART IN THIS RESEARCH STUDY?

This is a research study, and the study activity is an open-ended interview with the researchers. During this interview, we will ask you to answer questions about your experiences serving young families as a doula. You are free to skip any questions you do not feel comfortable answering, and can end the interview at any time.

Study duration: If you agree to take part in this research study, your involvement will last for about one to two hours, depending on the amount you want to share.

If you agree, the interview and your responses will be tape recorded, transcribed and compared to interviews from other doulas participating in this study. If you do not agree to be tape recorded, we will take notes only.

_____ I agree to be audio recorded.
Initials

_____ I do not agree to be audio recorded.
Initials

Storage and Future use of data: Because it is not possible for us to know what studies may be a part of our future work, we ask that you give permission now for us to use your personal information without being contacted about each future study. Future use of your information will be limited to studies about teenage mothers, social support, stress, doulas, health outcomes and experiences.

_____ You may store my interview data for use in future studies.
Initials

_____ You may not store my interview data for use in future studies.
Initials

Future contact: We may contact you in the future for another similar study. You may ask us to stop contacting you at any time.

Study Results: Final results from this study will be made available publically and to you through Oregon State University's ScholarsArchive. This is where the final dissertation resulting from this study will be held. Additionally, publications and presentations at conferences may result from this study. You can contact the researchers if you would like to be informed of future publications/presentations.

WHAT ARE THE RISKS AND POSSIBLE DISCOMFORTS OF THIS STUDY?

It is possible that you could experience emotional distress when talking about the challenges of working with, and bearing witness to the hardships of, adolescent mothers. There is a chance that we could accidentally disclose information that identifies you. We will take necessary precautions to insure that your information is kept confidential to the extent permitted by law.

WHAT ARE THE BENEFITS OF THIS STUDY?

This study is not designed to benefit you directly.

WILL I BE PAID FOR BEING IN THIS STUDY?

You will not be paid for being in this research study.

5. WILL IT COST ME ANYTHING TO BE IN THIS STUDY?

The only potential costs associated with the study are transportation and parking costs. If you paid for parking or transportation to get to this interview, you will not be reimbursed.

WHO IS PAYING FOR THIS STUDY?

The School of Language, Culture and Society at Oregon State University is paying for portions of this research to be done.

6. WHO WILL SEE THE INFORMATION I GIVE?

The information you provide during this research study will be kept confidential to the extent permitted by law. Research records will be stored securely and only researchers will have access to the records. Federal regulatory agencies and the Oregon State University Institutional Review Board (a committee that reviews and approves research studies) may inspect and copy records pertaining to this research. Some of these records could contain information that personally identifies you. If the results of this project are published, your identity will not be made public.

Under Oregon law, the researchers are required to report to the appropriate authorities any information concerning child abuse or neglect. The researchers may also report threats of harm to self or to others.

7. WHAT OTHER CHOICES DO I HAVE IF I DO NOT TAKE PART IN THIS STUDY?

Participation in this study is voluntary. If you decide to participate, you are free to withdraw at any time without penalty. You will not be treated differently if you decide to stop taking part in the study. You may choose to withdraw your interview text from the study prior to publication by contacting one or more of the researchers listed on this document. You are free to skip any questions you do not feel comfortable answering, and you can end the interview at any time.

8. WHO DO I CONTACT IF I HAVE QUESTIONS?

If you have any questions about this research project, please contact: Melissa Cheyney at Melissa.Cheyney@oregonstate.edu or 541-737-3895, or Courtney Everson at Courtney.Everson@oregonstate.edu or 360-490-0220 (cell/text).

If you have questions about your rights or welfare as a participant, please contact the Oregon State University Institutional Review Board (IRB) Office, at (541) 737-8008 or by email at IRB@oregonstate.edu

WHAT DOES MY SIGNATURE ON THIS CONSENT FORM MEAN?

Your signature indicates that this study has been explained to you, that your questions have been answered, and that you agree to take part in this study. You will receive a copy of this form.

Do not sign after the expiration date: 4/29/2015

Participant's Name (printed): _____

(Signature of Participant)

(Date)

(Signature of Person Obtaining Consent)

(Date)

APPENDIX C IRB Approved Consent Document for Focus Groups with Adolescent Mothers

CONSENT FORM, STUDY ID 6208

Project Title: Understanding Stress, Social Support & Birth Experiences of Teenage Mothers
Principal Investigator: Melissa Cheyney, PhD, CPM, LDM
Student Researcher: Courtney Everson, MA, ABD
Co-Investigator(s): Marit Bovbjerg, PhD, MS
Sponsor: Internal Funding: School of Language, Culture & Society, OSU
Version Date: April 22, 2014

1. WHAT IS THE PURPOSE OF THIS FORM?

This form contains information you will need to help you decide whether or not to be in this research study. Please read the form carefully and ask the study team member(s) questions about anything that is not clear.

2. WHY IS THIS RESEARCH STUDY BEING DONE?

The purpose of this research study is to explore relationships between stress, social support, doula care, health outcomes and experiences of teenage mothers in the United States. This study is being conducted as part of the dissertation requirements for the student researcher. Results may be published in peer-reviewed journals and may be used to help improve the care of young families during childbirth. Up to 350 individuals may be invited to take part in this study.

3. WHY AM I BEING INVITED TO TAKE PART IN THIS STUDY?

You are being invited to take part in this study because you: (a) gave birth in the last seven years; (b) your pregnancy and childbirth occurred between the ages of 15 – 19; (c) your child born when you were a teenager is at least 8 weeks old; and (d) you participated in an interview for this study.

4. WHAT WILL HAPPEN IF I TAKE PART IN THIS RESEARCH STUDY?

This is a research study, and the study activity is a focus group session with the researchers and other young mothers who participated in an interview for this study. During this focus group, you will be provided the interview findings, and the researchers' thoughts on the relationships between social support, stress, and health. You will then be asked to reflect on the findings and if you think they match your experiences, if there are important findings missing, or if you have ideas to add to the results. You are free to skip any questions you do not feel comfortable answering, and can stop participating in the focus group at any time.

Study duration: If you agree to take part in this research study, your involvement will last for about one to two hours, depending on the amount you and other focus group participants wish to share.

If all participants agree, your focus group responses will be tape recorded and transcribed for analysis. If you do not agree to be tape recorded, we will take notes only.

_____ I agree to be audio recorded.

Initials

_____ I do not agree to be audio recorded.

Initials

Storage and Future use of data: Because it is not possible for us to know what studies may be a part of our future work, we ask that you give permission now for us to use your personal information without being contacted about each future study. Future use of your information will be limited to studies about teenage mothers, social support, stress, doulas, health outcomes and experiences.

_____ You may store my focus group data for use in future studies.

Initials

_____ You may not store my focus group data for use in future studies.

Initials

Future contact: We may contact you in the future for another similar study. You may ask us to stop contacting you at any time.

Study Results: Final results from this study will be made available publically and to you through Oregon State University's ScholarsArchive. This is where the final dissertation resulting from this study will be held. Additionally, publications and presentations may result from this study. You can contact the researchers if you would like to be told about future publications/presentations.

WHAT ARE THE RISKS AND POSSIBLE DISCOMFORTS OF THIS STUDY?

It is possible that you could experience some emotional distress or discomfort when talking about your birth and being a teenage mother. There is a chance that we could accidentally disclose information that identifies you. We will take necessary precautions to insure that your information is kept confidential to the extent permitted by law. We will ask everyone participating in the focus group to maintain the confidentiality of comments made during the discussion. However, there is still a risk that comments you make during the discussion may be shared outside of the group.

WHAT ARE THE BENEFITS OF THIS STUDY?

This study is not designed to benefit you directly.

5. WILL I BE PAID FOR BEING IN THIS STUDY?

You will not be paid for being in this research study.

6. WILL IT COST ME ANYTHING TO BE IN THIS STUDY?

The only potential costs associated with the study are transportation and parking costs. If you paid for parking or transportation to get to this focus group, you will not be reimbursed.

WHO IS PAYING FOR THIS STUDY?

The School of Language, Culture and Society at Oregon State University is paying for portions of this research to be done.

7. WHO WILL SEE THE INFORMATION I GIVE?

The information you provide during this research study will be kept confidential to the extent permitted by law. Research records will be stored securely and only the researchers will have access to the records. Federal regulatory agencies and the Oregon State University Institutional Review Board (a committee that reviews and approves research studies) may inspect and copy records pertaining to this research. Some of these records could contain information that personally identifies you. If the results of this project are published, your identity will not be made public.

Under Oregon law, the researchers are required to report to the appropriate authorities any information concerning child abuse or neglect. The researchers may also report threats of harm to self or to others.

8. WHAT OTHER CHOICES DO I HAVE IF I DO NOT TAKE PART IN THIS STUDY?

Participation in this study is voluntary. If you decide to participate, you are free to stop participation at any time without penalty. You will not be treated differently if you decide to stop taking part in the study. You may choose to remove your focus group comments from the study before publication by contacting the researchers listed on this document. You are free to skip any questions you do not feel comfortable answering, and you can stop participating in the focus group at any time.

9. WHO DO I CONTACT IF I HAVE QUESTIONS?

If you have any questions about this research project, please contact: Melissa Cheyney at Melissa.Cheyney@oregonstate.edu or 541-737-3895, or Courtney Everson at Courtney.Everson@oregonstate.edu or 360-490-0220 (cell/text).

If you have questions about your rights or welfare as a participant, please contact the Oregon State University Institutional Review Board (IRB) Office, at (541) 737-8008 or by email at IRB@oregonstate.edu

WHAT DOES MY SIGNATURE ON THIS CONSENT FORM MEAN?

Your signature indicates that this study has been explained to you, that your questions have been answered, and that you agree to take part in this study. You will receive a copy of this form.

Do not sign after the expiration date: 4/29/2015

Participant's Name (printed): _____

(Signature of Participant)

(Date)

(Signature of Person Obtaining Consent)

(Date)

APPENDIX D Sample Interview Guide for DSAM Cohort

Introduction: Greetings, Consent process

Interview Code: _____

1. Please start by telling me the story of your pregnancy. [prompts: How did you find out you were pregnant? How did you feel when you found out you were pregnant? What was pregnancy like? How did people (family, friends, teachers, FOB) react to your pregnancy?]
2. What were the hardest parts of your pregnancy?
3. What were the best parts of your pregnancy?
4. How stressed did you feel during pregnancy? [What caused you stress? How did you cope?]
5. How supported did you feel during pregnancy? [Who supported you? How did they support?]
6. What services did you access during pregnancy? [Prompts: Did you participate in a teen parent program in the schools? Did you attend childbirth classes? Were you on WIC or SNAPs? How did people in these services treat you?]
7. Did you like your primary care provider (your doctor or midwife)? [Why or why not?]
8. Tell me the story of your birth. [How did it start? How did you feel when you realized you were in labor? What was birth like? How did people (clinicians, family, friends, FOB) treat you during your birth?]
9. What were the hardest parts of birth?
10. What were the best parts of birth?
11. How stressed did you feel during birth? [What caused you stress? How did you cope?]
12. How supported did you feel during birth? [Who supported you? How did they support you?]
13. Tell me the story of your early parenting experiences. [What was it like to be a new parent? How did people treat you as a young mother?]
14. What were the hardest parts of early parenting?

15. What were the best parts of early parenting?
16. How stressed did you feel during early parenting? [What caused you stress? How did you cope with the stress?]
17. How supported did you feel during early parenting? [Who supported you? How did they support you?]
18. What services did you access during early parenting? [Prompts: Did you attend parenting classes? Did you access services like Well Mama for the “baby blues”? Did you receive WIC or SNAPS? How did people in these services treat you?]
19. Did you like your baby’s pediatrician? [Why or why not?]
20. Tell me the story of what it was like to work with a doula? [prompts: When did you work with a doula – pregnancy, birth, postpartum, all? How did you find your doula? What did you like about working with a doula? What did you not like about working with a doula?]
21. Looking back, what do you wish you would have had or known during you pregnancy, birth, or early parenting? [prompts: What would you do differently? What could improve young mothers’ childbirth experiences?]
22. Is there anything else you would like to share about what it is like to be a young mother?

Demographics to be collected at the end of the interview:

Key maternal-infant health indicators

1. How many weeks gestation (how far along) were you when you gave birth? ____ weeks
2. Did you give birth vaginally or by cesarean section? _____
3. Did you receive an epidural, spinal block, or IV medications (such as Stadol, Demoral, or Nubain) for pain relief during birth? ____yes ____no _____type
4. What did your baby weigh at birth? ____ lbs, ____ oz
5. Did you ever breastfeed your baby ? ____yes ____no
 - 5a For how long did you ever breastfeed? _____ weeks or _____ months
 - 5b. If yes to the above: Did you breastfeed exclusively? (Exclusively means you

did not introduce formula): _____yes _____no

5c. If yes to the above: For how long did you exclusively breastfeed? _____ weeks
or _____ months

Basic demographics

1. How old were you when you became pregnant? _____ years of age
2. What is your race? __ American Indian or Alaska Native, __ Asian/Pacific Islander,
____ Black or African American, __ Hispanic, __ Two or more races, __ White,
Self-identify as: _____

Doula Care

1. When did you use a doula? _____pregnancy _____ birth _____in the first 8 weeks
postpartum
2. Did you pay your doula or did they provide doula services for free? _____paid
_____ free

Closing: Thank you; Gift Card compensation delivered; Invitation to participate in the
focus group, to be held at a later date

APPENDIX E Sample Interview Guide for NDSAM Cohort

Introduction: Greetings, Consent process

Interview Code: _____

1. Please start by telling me the story of your pregnancy. [prompts: How did you find out you were pregnant? How did you feel when you found out you were pregnant? What was pregnancy like? How did people (family, friends, teachers, FOB) react to your pregnancy?]
2. What were the hardest parts of your pregnancy?
3. What were the best parts of your pregnancy?
4. How stressed did you feel during pregnancy? [What caused you stress? How did you cope?]
5. How supported did you feel during pregnancy? [Who supported you? How did they support?]
6. What services did you access during pregnancy? [Prompts: Did you participate in a teen parent program in the schools? Did you attend childbirth classes? Were you on WIC or SNAPs? How did people in these services treat you?]
7. Did you like your primary care provider (your doctor or midwife)? [Why or why not?]
8. Tell me the story of your birth. [How did it start? How did you feel when you realized you were in labor? What was birth like? How did people (clinicians, family, friends, FOB) treat you during your birth?]
9. What were the hardest parts of birth?
10. What were the best parts of birth?
11. How stressed did you feel during birth? [What caused you stress? How did you cope?]
12. How supported did you feel during birth? [Who supported you? How did they support you?]
13. Tell me the story of your early parenting experiences. [What was it like to be a new parent? How did people treat you as a young mother?]
14. What were the hardest parts of early parenting?

15. What were the best parts of early parenting?
16. How stressed did you feel during early parenting? [What caused you stress? How did you cope with the stress?]
17. How supported did you feel during early parenting? [Who supported you? How did they support you?]
18. What services did you access during early parenting? [Prompts: Did you attend parenting classes? Did you access services like Well Mama for the “baby blues”? Did you receive WIC or SNAPs? How did people in these services treat you?]
19. Did you like your baby’s pediatrician? [Why or why not?]
20. Did you know what a doula was when you were pregnant? [If yes, why did you choose not to work with a doula? If no [explain doula]. Would you have wanted a doula if available?]
21. Looking back, what do you wish you would have had or known during you pregnancy, birth, or early parenting? [prompts: What would you do differently? What could improve young mothers’ childbirth experiences?]
22. Is there anything else you would like to share about what it is like to be a young mother?

Demographics to be collected at the end of the interview:

Key maternal-infant health indicators

1. How many weeks gestation (how far along) were you when you gave birth? ____ weeks
2. Did you give birth vaginally or by cesarean section? _____
3. Did you receive an epidural, spinal block, or IV medications (such as Stadol, Demoral, or Nubain) for pain relief during birth? ____yes ____no _____type
4. What did your baby weigh at birth? ____lbs, ____oz
5. Did you ever breastfeed your baby ? ____yes ____no
 - 5a For how long did you ever breastfeed? _____ weeks or _____ months
 - 5b. If yes to the above: Did you breastfeed exclusively? (Exclusively means you did not introduce formula): ____yes ____no

5c. If yes to the above: For how long did you exclusively breastfeed? ____ weeks
or ____ months

Basic demographics

1. How old were you when you became pregnant? _____ years of age
2. What is your race? __ American Indian or Alaska Native, ____ Asian/Pacific Islander,
____ Black or African American, ____ Hispanic, __ Two or more races, ____ White,
Self-identify as: _____

Closing: Thank you; Gift Card compensation delivered; Invitation to participate in the
focus group, to be held at a later date

APPENDIX F Sample Interview Guide for Doula Cohort

Introduction: Greetings, Consent process

Interview Code: _____

1. Please start by telling me a little bit about yourself as a doula. [prompts: When did you train and how long have you been practicing for? Where did you train? Are you certified? How many births have you attended? What is the primary demographic of families you serve?]
2. How did you get involved with serving adolescent mothers and their families as a doula?
3. Describe the typical care you give to young families. [prompts: How often do you meet with them? What types of things do you talk about/do together? What is your philosophy on or attitude toward caring for young families? Do you generally charge or do the births pro bono?]
4. What are the biggest challenges of serving young mothers as a doula?
5. What are the most rewarding aspects of serving young mothers as a doula?
6. What do you think are the biggest challenges and stressors teen mothers face?
7. What do you think are the largest needs teen mothers have?
8. How important do you think social support is for young families? Please elaborate
9. Do you feel doula care is important for young mothers? Why or why not?
10. Is there anything else you would like to share about what it is like to be a doula that serves adolescent mothers and their families?

Demographics to be collected at the end of the interview:

1. How old are you currently? _____ years of age
2. What is your race? ___ American Indian or Alaska Native, ___ Asian/Pacific Islander, ___ Black or African American, ___ Hispanic, ___ Two or more races, ___ White, Self-identify as: _____
3. How long have you been a doula for (in general)? _____ months or _____ years
4. How long have you served young mothers (specifically)? _____ months or _____ years

5. Approximatley how many young mothers have you served as a doula? _____

Closing: Thank you

APPENDIX G Sample Guide for DSAM Focus Groups

Introduction: Greetings, Consent process, Snacks provided

Presentation of findings: The researchers will present their preliminary findings and interpretations from interviews with DSAM participants; discussion will ensue.

Prompts for group:

1. General reactions to these findings?
2. How accurately do you feel these findings reflect your experiences as a young mother (and with receiving doula care)?
3. Do you disagree with anything? Why or why not?
4. What do you feel is missing from these findings in thinking about what it is like to be a young mother (and with receiving doula care)?
5. Is there anything else you would like to share at this time?

Closing: Thank you

APPENDIX H Sample Guide for NDSAM Focus Groups

Introduction: Greetings, Consent process, Snacks provided

Presentation of findings: The researchers will present their preliminary findings and interpretations from interviews with NDSAM participants; discussion will ensue.

Prompts for group:

1. General reactions to these findings?
2. How accurately do you feel these findings reflect your experiences as a young mother?
3. Do you disagree with anything? Why or why not?
4. What do you feel is missing from these findings in thinking about what it is like to be a young mother?
6. Is there anything else you would like to share at this time?

Closing: Thank you

APPENDIX I DONA International Client Confidentiality Release Form



35 East Wacker Drive • Suite 850 • Chicago, IL 60601
 888-788-DONA (3662)
 Fax: 312-644-8557
 www.DONA.org

CLIENT CONSENT AND HIPAA GUIDELINES

DONA International certification candidates have always been required to get their clients' consent and signatures for release of information in order to use those births for certification purposes. Increasingly DONA International has become aware of instances where doulas (whether certification candidates or not) were not allowed in their clients' rooms for exams or the taking of vital signs and were not allowed to be with their clients during triage, citing HIPAA regulations. The interpretation of HIPAA guidelines and its everyday use vary widely and in a range of ways.

While doulas are not medical care providers, they do gather some personal and health information from their clients to be able to fully serve them. While the permission to have that information may be implied by having hired the doula, and the information may be shared voluntarily, DONA International feels it best to recommend that ALL doulas have their clients sign the *Client Confidentiality Release Form*. In the spirit of being fully compliant with the HIPAA guidelines, DONA International is recommending that the Release Form be signed **before** taking notes about any client. Clients should receive a copy of the form they signed, and the doula should have the original signed Release Form with her at the labor and birth in order to show that she is indeed complying with the HIPAA regulations, if questioned. For current certification candidates, please use the *Client Confidentiality Release Form* for all FUTURE clients. You will not be required to have this form filled out for births you have done in the past.

DONA International is not aware of any legal challenges against doulas at this point. DONA International has always stressed confidentiality of any personal information. While all DONA certified doulas are bound by this Code of Ethics, HIPAA requires a consent signature from the person whose information is being collected. DONA International has developed this form to allow ALL doulas, whether they are uncertified, certification candidates, or DONA certified, to be in compliance with these regulations. DONA International also hopes that it will raise awareness among all doulas about the importance of confidentiality in all instances and in all forums.

While HIPAA is a law only in the United States, all doula clients have the right to privacy and confidentiality and have the right to know what their doulas will do with the information they gather and become aware of during the course of their work. DONA International requires this signature for all certifying births and very strongly recommends that ALL doulas address this issue, discuss it with their clients, and receive each of their *client's* signatures prior to taking any kind of notes in their records.



35 East Wacker Drive • Suite 850 • Chicago, IL 60601
 888-788-DONA (3662)
 Fax: 312-644-8557
 www.DONA.org

Client Confidentiality Release Form

Due to current confidentiality regulations all doulas should have a signed release form from their client *before* taking any notes about her or her labor, birth or postpartum. The best way to be fully compliant would be to get this release signature at the first prenatal visit, or upon first meeting and joining the client.

Certification candidates should have this form signed before taking any notes. The client should receive a copy of the form she signed, and the doula should have her copy with her at all times to be able to show that she is indeed complying with the confidentiality regulations if questioned. **Confidentiality of medical and personal information obtained during the course of the doula's work is of the utmost importance.** Failure to comply with these confidentiality regulations could result in penalties.

I, _____, at _____
 _____ (address), _____ (phone #),
 give my permission for my doula, _____, to take
 notes about me, including personal information I choose to disclose to her, and information
 regarding my labor, birth and postpartum, as well as any information regarding my
 child/ren. I understand that this information may be used for the purpose of doula
 certification or recertification and will be shared with the Certification Committee of
 DONA International. I realize that this information will be shared with the doula that is
 providing backup support. I also understand that this information will anonymously be
 used by the DONA International Data Collection Committee for statistical purposes, and
 that my doula may use this information to provide me with a summary for my own
 personal use.

Signature: _____ Date: _____

APPENDIX J DONA International Birth Doula Data Collection Form



Birth Doula Data Collection Form

Please answer all applicable items in each category. Use one form per birth. Make copies of this form for additional births. Mail or fax the completed form to:

DONA International, 35 East Wacker Drive, Suite 850, Chicago, IL 60601 or fax to 312-644-8557

Your signature implies that, to the best of your knowledge, you have supplied accurate information. Thank you for your efforts to collect data on birth doula support. This form is for data only. Birth stories cannot be entered.

REFERRAL SOURCE

- ☐ DONA International
☐ Hospital
☐ Other

PAYMENT

- ☐ Private pay
☐ 3rd party reimbursement
☐ Volunteer
☐ Hospital
☐ Other

CLIENT RACE

- ☐ African American/Black
☐ Asian
☐ Caucasian/White
☐ Native/Indigenous
☐ Mixed (2 or more)
☐ Other

CLIENT ETHNICITY

- ☐ Hispanic or Latino (any race)
☐ Not Hispanic or Latino

MOTHER'S INFORMATION

- ☐ Married
☐ Single
 Age _____
 Pregnancy # _____
 Birth # _____

ATTENDED BY

- ☐ Partner/baby's father
☐ Family member(s)
☐ Friend(s)
☐ Unaccompanied

PLACE OF BIRTH

- ☐ Home
☐ Hospital
☐ Birth Center
☐ Other

CAREGIVER

- ☐ Midwife
☐ OB doctor
☐ Combination
☐ Family practice doctor
☐ Unattended

PREGNANCY

- ☐ Uncomplicated
☐ Gestational diabetes
☐ Pregnancy induced hypertension (PIH)
☐ Gestation < 38 weeks
☐ Gestation > 42 weeks
☐ High risk
☐ Other

CHILDBIRTH EDUCATION CLASSES

- (past or present)
☐ Yes
☐ No

LENGTH OF LABOR

- ☐ As perceived by mother (hours)
☐ Hospital admission to birth (hours)
☐ Doula's labor hours

INTERVENTIONS

- ☐ Induction
☐ Artificial rupture of membranes
☐ Pitocin augmentation
☐ Doppler (auscultation)
☐ Electronic fetal monitoring
 ☐ continuous ☐ intermittent
☐ IV fluids
☐ Other

MEDICATIONS

- ☐ Pain medications (I/IM)
☐ Epidural before 5 cm
☐ Epidural after 5 cm
☐ Other
☐ Mother's desire for pain medication before birth based on scale of 1-10
 1=No meds 10=Full meds

METHOD OF BIRTH

- ☐ Spontaneous vaginal
☐ Forceps/vacuum
☐ Planned cesarean birth
 ☐ Previous cesarean
 ☐ High risk status
 ☐ Postdates
 ☐ Large baby
 ☐ Maternal choice
☐ Unexpected cesarean birth
 ☐ Failed VBAC attempt
 ☐ Failed induction
 ☐ Fetal distress
 ☐ Maternal distress
 ☐ Other _____
☐ Vaginal birth after cesarean

BABY OUTCOME

- ☐ No immediate health concerns
 Birth weight: _____ lb _____ oz / _____ g
☐ With mother less than 30 minutes in first hour
☐ Premature
☐ Stillbirth/demise
☐ Intensive care (NICU)
☐ Breastfeeding

DOULA'S NAME (PRINT) _____

DOULA'S ZIP/POSTAL CODE _____

CD(DONA) WHILE WORKING WITH THE CLIENT? ☐ YES ☐ NO

DOULA'S SIGNATURE _____

DATE _____