CHAPTER III

RESULTS: INFORMATIONAL SUPPORT

Along with emotional support and physical support, informational support is the most recognized function of birth doula care. Offering this kind of support means supplying the laboring mother and her partner with information through verbal and nonverbal communication processes. Akin to the other labor support functions, this analysis revealed that informational support is more complex than previously expected and involved a number of assessments on the doula's part. However, unlike physical and emotional support, information communicated by the doula was directed towards the mother as well as her labor partner, usually her husband, boyfriend or life partner. (It may also have been the grandmother, close friend or other relative.) Doulas stated that usually the labor partner was also involved in the health care decision making at the birth. For the doulas, they described that part of their role as a guide meant communicating in ways that were easy for laboring mothers to understand and interpret while minimizing interruptions to her labor process. Directing communication toward the mother's trusted partner as well as the mother was helpful in preserving the labor process. This chapter utilized both doula interviews and maternal narratives to outline the functions, processes, and outcomes of informational support. However, the doula interviews exclusively informed the section on the doula's underlying motivations and struggles with this type of support.

Functions of Informational Support

Analysis of the interviews revealed that one of the simplest functions of information support was to rephrase medical terms and procedures in language that was easily understood by the mother and her partner. Common explanations were of medical terms, procedures, interventions, the usual course of labor, normal sensations associated with labor, and the side

effects of medications or suggested interventions. One mother, Jeanne, stated, "Having kind of an open, a walking encyclopedia when it came to birth and things was just so comforting to me." Gail recalled an incident from during her labor: "I'm shaking! I'm just shaking like this! Why am I shaking?' [Her doula responded] 'That's because you're in transition.' 'Oh, my gosh! Really?!"

Oftentimes, caregiver behavior was confusing or anxiety producing for parents. Both doulas and mothers offered a variety of examples. A mother, Moira, recalled, "We were getting nervous and so she could tell Owen [husband], 'This is just protocol. Nothing's really wrong." Another way that giving information alleviated anxiety and fear was by previewing interventions that careproviders might recommend in a particular situation, such as fetal heart tones that showed distress or a non-progressing labor (dystocia). This gave parents more time to ponder over the intervention rather than being alarmed by the suggestion or demand that the intervention be done right away. As Ashley, a doula recalled:

> "Finally the midwife says, "Look, let's break your waters." And I had mentioned this to the mom about ten minutes earlier. That's what was strange, I called every shot before, ten minutes, fifteen minutes before it happened. And I'd explain it to them, and I'd say, 'Look this might be what's coming next.'… [I] hate it when a mom gets overly alarmed. You know, I really just—she needs to be feeling like she's being taken care of… so five minutes later the midwife walks in and says, "Look, we've got to change something here. I'm going to suggest an epidural." And they went, "Oh, yeah."

Besides alleviating anxiety or other emotions, informational support was found to have strategic functions. In the previous example, Ashley gave the parents more time to make a decision and to be prepared with questions about an intervention by the time it was suggested by the midwife. Sometimes doulas explained a caregiver's concerns while subtly reminding the mother she was the primary decision maker. Near the end of her labor, Moira remembered when

her midwife wanted to cut an episiotomy[1]. Her doula stated her options, what the caregiver was concerned about, and reiterated that the decision of what to do was up to her. "So I remember I asked [the doula], "Is this okay?" or, "Should I let them do this?" And she was like, "It's up to you, but it will help you get the baby out if that's what you want, and that's what they seem to think you need right now is to get the baby out."

In addition, doulas expanded on information provided by medical staff. Almost all doula and mother participants recounted incidents where they felt the implications of suggested interventions had been minimized by careproviders. Doula Lydia detailed what she termed a typical interaction with a client:

> "So we go to the hospital about 8:30 p.m. or so. Then her doc comes in at 11:00 p.m. and says, 'Well, you haven't slept all day and I'd really like to rupture your membranes and get this labor going so you don't labor all night long and then be too tired to push your baby out." Basically that if I rupture your membranes it'll speed up later. "And then we'll talk about Pitocin later because you're only three centimeters. I'm going to change into scrubs and I'll be back.' Because he came in his street clothes…
> He left the room and I took my birth ball and I rolled it out to the foot of the bed and I said, "Okay, if he ruptures your membranes your labor might go faster. It might. There's no guarantee but it might. However the baby's going to lose its cushion, you're going to be open to the risk of infection, you're gonna be on the twenty four hour clock. The contractions may or may not be more painful because you've lost that cushion. So just, you know, make your decision. I'm not going to tell you what to do. I'm not going to tell you to do it or not do it. I just want you to hear all the story, like the pros and the cons. Like it might speed up your labor or it might not. And it will open you to the risk of infection and it does put you on a twenty four hour time clock because in Florida they're really strict about twenty four hours after rupture, you're going to the OR [operating room]. That's why our cesarean rate is so high.' I mean this is one of the better hospitals in the area and it has a 28% cesarean rate. It's like eww.
> 'This'll happen and they'll have to use the amnio hook and it looks like a long crochet needle' and I'm describing the procedure to her and what would happen. It really wouldn't hurt but they may make her stay in the bed because then she's dribbling fluid and they don't want her to slip and fall in the hospital. Because I've had nurses say that once your water's ruptured that you can't walk the halls because then you're a liability risk because you might slip and fall. Okay fine. So you may not be able to get out of the bed, you'll have to stay on the monitors, all this stuff. When I had done saying my piece, I just went back and I sat in the chair. She wasn't one that wanted a lot of physical

[1] An episiotomy is a surgical incision of the skin and muscles of the vagina and perineum.

> contact. So I sat down and then the doc came in and he says, 'Well, so what did you decide?' And she said, 'I don't think I want that.' And he says, 'Well, if you don't mind I'd like to do a vaginal exam anyway.'

In Lydia's detailed narrative the far reaching implications of the amniotomy were obvious, and extended far beyond the information provided by her doctor. However, it also illustrated several of the strategic outcomes of information support. First, informational support offered parents an additional perspective on the issue besides the one offered by the medical care provider. It also outlined additional options in certain situations. In this case, doing nothing was not presented as an option by the doctor but it was given as a possibility by the doula. Further, because of her experience with other caregivers and other facilities, the doula offered a unique perspective comparing what this mother's careprovider was suggesting versus what might be done by other careproviders or at other facilities. In this case, Lydia pointed out that she had heard that nurses might not let mothers walk the halls once their water has broken although she does not know whether that was true for that hospital at that time.

According to participants, one of the other functions of informational support was to provide a more detailed description of medical procedures and their implications. The majority of doulas in this study agreed that most careproviders minimized or omitted information that might be considered crucial by most mothers. The careproviders that tended to offer more details were midwives. Knowing that the amniotomy "might or might not speed up your labor", "you might not be able to walk the halls", and "twenty four hours after rupture you are going into the operating room", was considered critical information for a mother to have.

Additionally, by giving a more detailed description of the intervention and its implications for the mother and her labor, the doula implied that there might be other alternatives. (Lydia did this in the previous example.) These alternatives ranged from doing

nothing to other interventions. Encouraging parents to ask about alternatives implied the possibility of refusal. Most often, the doula implied the possibility by outlining several possible choices or encouraging parents to ask their careprovider about alternatives. Sometimes the doula explained outright that refusing an intervention was a possibility. For example, Georgia was at home with her waters broken and no contractions. She had been told by her midwife that she needed to come into the hospital to receive interventions. In discussing her options with her doula, she recalled, "I guess I didn't even realize that you can argue. I mean that was something Peggy [doula] pointed out. She's like, 'You know you can just refuse Pitocin. They can't make you take Pitocin.' Which for some reason, it had never really occurred to me that I had that option."

Another function of informational support was to communicate to the mother and her labor partner the perspective of the "medical model" of childbirth. Doulas used this term quite frequently to refer to a model where medical management and information obtained from tests are more important than trusting the natural processes of birth. Another mother, Jessie, shared the point of view explained by her doula:

> "You're in a hospital and that's their job'…these are the interventions that you are supposed to do in a hospital environment, and to make me really aware of those things, and what can I do to tell them if I didn't want them. And, yeah, so that was exciting, it's very empowering; it's really scary at the same time because people don't say like "No" to a hospital! Or whatever, because they're supposed to know best."

A last function of informational support was to empower the mother to look to her own embodied experience of labor as a source of information. As Jessie put it, "I know my pregnancy, like my pregnancy tells me something that the hospital does not, despite their good intentions." By giving the mother and her labor partner information rather than advice, and encouraging them to pay attention to the mother's own experience, she empowered them to be

leaders in their own labor experience rather than following the dictates of their medical careproviders. Empowerment was a very robust concept that emerged from the analysis. It was integral to the doula's philosophy of informational support, which provided the background for its functions and processes, and is discussed in a future section.

Processes Involved in Providing Informational Support

The processes of effective informational support explain how it was administered by the doula during labor. The analysis revealed that in order to be effective, the doula needed to possess competent communication skills and familiarity with medical information and procedures. Many doulas mentioned the importance of continuing to grow their knowledge base and learning as much as possible from each birth. Sonia, a New York City area doula, elaborated on the point of view shared by many doulas:

> "I also think you do need to know the informational piece of it. If you're going to be doing hospital births, you need to know your meds, you need to know the clinical names for everything, you need to know what the instruments look like. You need to be able to know different procedures and what's going to happen, because you're there as their guide. And if you don't know what's going on, you can't guide them through it. You're trying to make them feel better through maybe a really complicated thing. And I'm not saying you're going to know everything about everything, but you should have an idea about, if Mum says she has Type I diabetes, what that means, what her possible risk factors are, and then you should really—I think if you're a good doula—go back home and find out something about that. You should have enough books that you can look that up at home, or go online."

Being a guide was an accurate description given by many doulas in their interviews about their role. Doulas said they helped parents to understand the physical and emotional progress of labor, the medical atmosphere of labor and delivery, and different protocols and procedures in different hospitals. Besides understanding that different facilities have differing protocols, doulas in this study described needing to be aware of physician and midwife preferences and comfort zones for labor events. Some had very strict time limits for length of first or second

stage of labor, or how long waters may be broken until birth. Doulas explained that sometimes physician and nurse preferences change according to events that happened recently with another patient. Overall, doulas felt that the atmosphere for what was allowed for an individual client's labor was more fluid rather than concrete. This was especially true when the doula was familiar to the medical staff. As Sonia states, "I find part of being an experienced doula is that I know a good deal of the docs I work with…the nurses are like, "Hey! I haven't seen you in a while!" It makes the couple instantly relax. And I think it gets the doc. If it's a doc you haven't worked with before, and the nurse is saying, "Oh, Sonia's great!" Phew! You can really just, it's really nice."

Besides understanding medical procedures and interventions, and the preferences of different caregivers and facilities, analysis revealed that doulas needed to be skilled at assessing their clients. Not all mothers and their labor partners wanted the same amount of information, nor do they want it from the same source. This was another primary process of giving information appropriately. It was important for the doula to assess the client's overall desire for information, what kind they would want to hear, what they would not want to hear, and who they would like to receive it from. In a later excerpt, one of Sonia's clients objected to hearing information about her upcoming induction from the doula. She wanted to get medical information from her doctor. The labor events also dictated how much information to give and when. The doula needed to be a keen observer of parents in order to moderate effectively. Sonia explained what finding this balance is like:

> "For one couple, five centimeters can be time to leave, and for another couple, its two days from leaving [home]. And helping them really to--sharing with them as much as they need to know, want to know, or seems appropriate, about why I'm thinking what I'm thinking, about where we are or why I'm doing what I'm doing. And at the same time, if they don't want to, we can all just sit in silence and just really be in the moment."

In the study, mothers also felt that they were active participants in soliciting information from their doula, and that they wanted a doula for that specific purpose. Gail had a very long and difficult labor with many undesired interventions. She described what the information support role of her doula, Beverly, meant to her:

> "I was afraid that the hospital would make me do something. And I was really glad that Beverly—she said she would if she needed to—would speak as a translator and an advocate. But we didn't run into that. What was more was that I knew that we wouldn't have to worry about that because she was there. But that's sort of too cognitive. What it felt like more was, she was going to be a conduit of more connection of things that we could do.
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> I guess that's two separate things. The conduit is just like the, the information of the knowledge of birth, like the wise woman person; that kind of archetype, she was like that. But the protective force was like, not I guess an invasion but just more like the magic circle kind of thing, like we were in the circle and Beverly had helped us make that circle. And whatever we were going to do, it was really going to be okay, and we were going to be able to make the decision.
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> And I remember later I thought, you know in our birth class we talked about women who, whatever their birth was, tend to feel good about their birth if they felt that they made the decision. And that's true, I don't like some of the things but I do feel that I made the decisions, and that is the protective force. It's that she gave us that space to do that. And the information flowed into this base so that we could make the decision we wanted to."

Another mother, Jeanne, who birthed twice with the same doula, explained the level of trust she had in her doula to ascertain what she needed to know and to communicate it appropriately:

> "Because I think, I think that for most—at least for me, I guess I should just say that for me—having someone else there who is aware of what's going on around you when you're – you can only see so much when you're in labor, and you can only consume so much information. And I think that even for my husband, he's so concerned about me and the pain that I'm going through, that there's only so much that he can consume at a given time. And to have someone else there who remembers, you take these classes that are supposed to make you wise in the ways of giving birth...when you do it through the hospital it's so, 'This is how it's going to happen.' You know, what you want to have happen is kind of the last priority. It's what their doctor and what our hospital's policies are that are going to dictate how things go. And for me, having someone behind me who has credibility to say, 'No, I don't think that's the best way to do it. We want to talk about it,' who can help us weed through the facts, and some of it fiction, and saying,

> 'Okay, these are your options at this point. If you can, if you do this, this is where things could go. If you don't do it, this is where things could go."

Both Gail and Jeanne trusted their doulas to dole out information in the amount and at the time she felt it was needed. She did this by interpreting their signals, the atmosphere in the hospital, and the priorities of the careproviders, and then proceeding to fulfill the functions of informational support appropriately. Balancing these tasks well while providing emotional and physical support required skill and attention to detail.

In their interviews, doulas acknowledged that effective informational support required acute attention to communication processes. In the first excerpt where Lydia was elaborating on the procedures and consequences of an amniotomy, she purposefully used neutral vocabulary and nonverbal communication to convey her message. Being clear and credible was very important to the success of a doula's informational support. If parents did not believe the doula's information they could easily ask a nurse or other medical careprovider. Some doulas preferred that medical information come from staff and not themselves. They saw their role as getting that information from nurses, midwives and doctors, not providing it themselves. Their medical knowledge allowed them to know when their clients were getting both the pros and cons of interventions, and to remind them what to ask questions about. Both Gail and Jeanne intimated in their excerpts that their doula served as a guide to them during labor. As Gail saw it, her doula had "knowledge" but also provides a "protective force". Jeanne saw her doula as having "credibility" and "being aware of what was going on". However in her role as guide, the doula was an interpreter not a decision maker.

Timing of informational support was also revealed as being an important element. Timing was first mentioned as significant in giving clients information about interventions that might be suggested. In this way, doulas previewed the possible paths that the labor might take if

a particular recommendation was followed or not followed. Another way timing was important was when the medical staff was giving information the doula knew was incorrect. In her story, Lani shared an incident from her early career as a doula:

> "I learned very early also that you don't really contradict a nurse. I learned that the hard way. Because a nurse told one of my clients directly that the epidural does not pass through to the baby. And I said, out loud, because it was an automatic thing, 'Oh, yes, it does.' I said, 'It does pass through to the baby.' And I didn't do it privately. Because she was telling this woman that the epidural didn't pass through to the baby. And I said, 'But it does pass through.' And the nurse got really pissed, and I made an enemy that morning. And I learned—that was a lesson, I mean, you learn something at every birth—that you don't talk in front of the nurses. Because, first of all, that's stupid, you're contradicting the nurse. Why would you, you know? She was taught that it didn't. So as far as she's concerned, it doesn't. She doesn't know any different. So to respect what she learned and to say, okay, you know, it doesn't pay – I'm not going to do that anymore. So I don't do that anymore and I wait, and I say, 'But it does, and we know that it does.' And you know, so, a lot of it is timing, knowing when to say what to whom."

This story exemplified several of the processes involved in informational support. Lani learned that waiting to speak was important, and having a relationship of trust with a client was needed when the doula's information contradicted that of the nurse. Doulas as well as mothers mentioned this situation several times when describing interactions with nursing staff. For example, one mother, Jeanne, mentioned it earlier when she described information given from hospital staff during labor as "weed through the facts, and some of it fiction". Jeanne trusted her doula to help her remember what she learned in her birth class and her own reading. However the motives ascribed to giving misinformation were not devious, rather nurses were seen as having outdated information, or desiring mothers to comply with the physician's wishes. As Lani rationalized, the nurse was taught a particular fact and "she doesn't know any different".

Summary. The functions of informational support explain the behaviors of doulas, what they actually do when giving informational support. To summarize, doulas gave explanations of medical terms, events of labor, and medical careprovider behaviors. They also previewed

possible interventions that may be presented, offered other perspectives on interventions, and additional information about their implications. Doulas outlined other options including refusal. Informational support also entailed sharing the different perspectives of the medical model of birth employed by most hospitals and caregivers; and a respect for the mother's embodied experience of pregnancy and labor.

The processes of informational support outline the internal mechanisms that were present in order for doulas to perform the informational support effectively. First, their perception of their role was as a guide and supporter of what the laboring mother wanted, not as a leader or spokesperson. Understanding that, doulas reminded clients to ask their own questions. They needed to assess their client's needs for information: how much, from whom, and when they wanted to know it. Doulas needed to be savvy enough in their communication skills to phrase things neutrally and understand the most appropriate timing for certain conversations. Different facilities and caregivers had different protocols and options available to a laboring mother. These options varied depending on factors unrelated to the mother's labor and were outside of her control. The doula's effectiveness in providing informational support rested in understanding this fluid environment for options and choices in decision making.

The result of receiving informational support fall into two categories for parents: emotional and strategic. Parents reported feeling less anxiety about the events of labor; relieved they had more options; and reassured about their situation. Mothers stated they felt confident because they could trust their doula to give them information that was in alignment with their agenda, not the hospital's agenda. Several also reported that their trust in their doula increased over time. Strategically, parents either indirectly or directly asked for more time to make a decision; discussed their options with their caregivers; and ultimately chose or did not choose the

option recommended by their careprovider. Conflict between the careprovider and patient sometimes occurred if the option favored by medical staff was not chosen.

In their interviews, doulas repeatedly emphasized that the decision about what to do did not belong to them and was up to the parents. By effectively performing the informational support function, doulas expressed that they have helped parents, empowered them, and have fulfilled the parent's expectations of them as a doula. Lastly, doulas acknowledged that giving effective informational support was also about finding an appropriate client-doula match. For some doulas that meant the mother's philosophy of birth must be close to her own. Other doulas were comfortable supporting clients who had different perspectives on health care decision making.

The Doula Philosophy of Informational Support

Understanding why doulas provided informational support was integral to understanding their actions. The analysis revealed that doulas believed strongly in individual empowerment and mothers as primary decision makers in their labor management. Sonia, an experienced doula in New York City, stated that, "The one thing you have to understand about hiring me is…I like information, I like it, it makes me feel better." Many doulas mentioned the importance of information to their own wellbeing in their personal lives as well in their professional ones. Thus, they brought this bias towards information giving and empowered decision making to their client interactions. Some doulas felt uncomfortable supporting mothers who did not want to be empowered decision makers. In the large suburban area of New Jersey where Lani and her partner Tierney practice, there were many obstetrical options. Certain hospitals or physician practices did not allow for choices during labor or a cooperative decision making model. Lani stated that, "I won't take a client that is delivering at such-and-so hospital. Because I tell them

ahead of time that we can't do our job... And then I'll refer her to somebody who will go to that hospital. But, other than that, there's not much that I do. I try and let go of things."

Other doulas felt that all women deserved support even if they didn't want to have a participatory decision making role in their labor. As Gladys, also from New Jersey, phrased it, "That's a real key, learning not to criticize even when it's against your sort of philosophical beliefs; to not criticize, to give the woman the space. You can provide her with all the evidence, all the information, and then it's her information to do with as she sees, and then you provide her with the support." Sonia recalled a learning experience she had when she was surprised by a mother's response to the information she offered her as a doula:

> "[I] took a mom who wanted me to fluff her pillows, really wanted me there almost as a private nurse. Didn't, found childbirth education classes very scary. Didn't want to know anything about what was going to happen. Wanted to live through this, was basically all she wanted. Didn't want her husband to be there because, as a girl from the South, didn't want her husband to see her in such a compromising position, it just wasn't proper.
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> And I thought, 'Well, I can—everybody deserves to have someone with them. I can do this. It will be relatively easy. I could use the extra income.' And what a mistake! And I've never done it since. Because it turned out that she was getting an induction, for no particular reason. And so I just sort of said, you know, 'I just wanted you to know.' Just thinking, well, I'll prepare her a little bit for the induction.
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> Get a call [from the husband], the mid-day, September 11th [2001], saying—because it was scheduled for like that night or the next day—saying how dare I question what the doctor was going to do. His wife had construed it that way, that I was questioning the doctor somehow in saying that it could happen a variety of ways. And that—and I sort of said at the time, all I could think of was like, 'Well, I'm not really sure that your elective induction is going to be happening today, since there, there really was a major event.' I just got off the phone going, 'Never again am I going to do that.' Because some piece of information is going to slide out of my mouth. I mean I guess I just shouldn't have said anything and just have said, 'Well just let me know if I need to be there in the evening or in the morning.' While I'm a really flexible doula and while I feel like I'm a different, you know, a different doula with each couple, I'm not a doula who doesn't know anything and I can't pretend to not know anything."

As Sonia shared, clients who did not want much information are more challenging for most doulas in this study to work with. It was more difficult to keep silent when one would normally explain alternatives, or help parents to solicit more information. They went against the doula's personal preference or belief that "more information makes someone feel better". It also went against the usual practice of giving information in service of empowerment. However, empowerment of the mother still occurred as long as respect for mother as decision maker was felt and acted upon by the doula. Even if the mother had handed her decision making power over to doctor or husband.

This was not true of all doulas, especially those who worked with women who were coming from cultural or disadvantaged backgrounds where empowerment was not the norm. Tracy was a hospital-based doula employed by a large hospital in Minneapolis, Minnesota. She worked with a variety of women and families. She explained that just asking them if they want more information and letting them know they can make choices was a huge step for many of them. "I know sometimes I just say, "Do you feel comfortable, do you have enough information?" Because I don't feel I'm doing anything wrong by saying that. And if they don't, either we'll find a way to reword it or rephrase it or you know. It's challenging because you've got the cultural barrier and the language barriers..."

In summary, doulas found that a period of self examination about their philosophy and what type of client they can best support was important in continuing their career. Some doulas, like Lani and her partner Tierney, did not take clients who did not want to be involved in the decision making of their birth or did not wish to avoid interventions. Other doulas, like Sonia and Gladys, did not care what decisions their clients made as long as they were based on having correct information. And then there were doulas like Tracy, who were used to working with

women who do not expect to fully understand what was happening to them or to be making informed choices.