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Compassionately Communicating

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By Katie Olliffe

Early in my career as a trainee doula, one of the first births I attended turned out to be one of the hardest births I've ever supported for various reasons. The midwife seemed to have difficulties accepting my presence. I worked so hard to make a connection with her, however, after a few hours of trying, I eventually admitted defeat. There is only so long you can attempt to communicate with another person, receiving only one word answers! Instead I turned my efforts to attempting to keep the birth environment a positive space, which was sadly almost impossible. The labour and birth was faced with various challenges, and the strained relationship between the midwife and I was a huge and unnecessary hindrance. I was attempting to support my clients with the birth wishes we had researched extensively during our antenatal preparation. Some of my client's wishes were different to the advice of the midwife, health care professionals and hospital guidelines. It was an incredibly difficult situation with a theme of very defensive communication.

I left that experience with a heavy heart, feeling misunderstood, angry and frustrated. It was concluded by the midwife and some of the health care providers that they believed I had been 'strongly influencing' my clients. To be accused of something by assumption and partial observation by people that clearly were not interested in understanding my role in the birth space was not an easy situation to be in.

One of the first things we learn in our doula training is to actively listen: Listening intently for information that may help us to understand our clients. This can then effectively help us to signpost appropriately to

existing evidence and information and to provide individualised support and encouragement so our clients can make their own informed decisions. So not only was it hard to be accused of influencing or advising, but by default it felt incredibly patronising to the birthing couple. The birthing couple had spent a long time exploring their birth wishes, with the mother making decisions for herself, and after a very exhausting birth experience they were not in a position to dispute this belief. Part of the process of being mentored as a doula is the opportunity to thoroughly debrief experiences with a more experienced doula. My wise and experienced mentor listened, empathised and later asked me to consider why the midwife might have felt the way she did about my presence? I am a natural empath, I found it very easy to consider why she may have felt negativity towards me. I imagine some midwives find it incredibly challenging to form a relationship with someone who is in active labour, because most midwives in our current system will never have met the birthing person during the antenatal period. A birthing person in active labour can be very much focussing on the task at hand. To then observe the relationship between another birth support person that has had an opportunity to form a relationship and understanding of that family prior to the big day must be very challenging. Working out where you fit within that, particularly if you do not understand the role of a doula must be incredibly difficult. So for me finding empathy retrospectively was easy, however the much harder part was working out what exactly I could have done differently.

A big part of my role as a doula is to research evidence and to find useful information. I am also often in situations where the way that I communicate is the difference between a positive or negative appointment or birth environment. So, I started to research evidence-based ways of communicating in conflicting situation which led me to a book called Non-Violent Communication (NVC) by Marshall Rosenberg. Studying this way of communicating has been incredible and life changing and has supported me endlessly over the years, not only in personal relationships but especially in my work.

The fundamentals of NVC are this: Every person shares a similar set of needs. A need for honesty, feeling cared for, supported, feeling able to contribute and a desire to be included. NVC supports you to hear any judgements you might be making and to hear the judgements of others. It then supports you to focus on the underlying needs that may be influencing those feelings or judgements. NVC encourages us to actively listen to others, to enable us to identify differing needs and for the practitioner to listen to their own inner dialogue and chatter, and to meet it with self-compassion and kindness. This process can then support outward compassion and kindness to others. It can also support your ability to hear the unspoken dialogue of multiple people.

During a family's birth journey there are often four different dialogues going on:-

- That of the birthing parent or couple
- The midwife/health care practitioner and hospital guidelines
- The silent dialogue of the baby
- The doula or birth support partner

For example:

Birthing Family: Planning a vaginal birth at home, this is a second baby, the couple experienced a positive first birth experience which has led to a very positive approach in the preparation for the second birth. The pregnant woman is aware that the hospital protocol suggests induction between 39 and 40 weeks gestation as she is over 40 years old. The birthing family has spent more than six months getting to know their doula, together exploring her birth wishes. The doula has shared loads of books and evidence based articles. The doula has spent lots of time listening to her talk about her hopes and wishes, really listening out for things that may be triggering or worrying. They spend lots of time imagining and visualising together and of course have talked intently and imagined what it might be like when they finally scoop their baby into their arms. They have finalised two sets of birth wishes or care plans that cover spontaneous labour, induction and birth with medicalised support. This birthing mother's preference is to avoid induction because their first baby was born in a birth pool in the birth centre. From that experience the birthing family have learned that finding a setting that feels safe and private for her to birth their baby in is really helpful to the birthing hormones she will experience. Additionally, Mum wants to birth at home because her 2 year old needs Dad around at bedtime and she feels she will feel safer knowing that her 2 year old has support. She feels confident that she will have support from her doula and midwives and she has decided she doesn't want to have routine vaginal examinations unless she requests them. She is aware that the induction process is likely to involve more vaginal procedures than spontaneous labour might. Approaching 39 weeks of pregnancy she feels well and baby's movements are normal and if this were to change she would of course adapt her wishes. Together the family and doula have read the guidelines from the Royal College of Obstetricians and Gynaecologists around maternal age and recommendations.

Consultant Obstetrician: Has various families this week that have been recommended induction for various reasons. She undertakes approximately three planned caesarean births a day plus whatever emergency procedures may come up. She has performed two caesareans and supported three induction conversations already this morning. She has a younger trainee consultant working with her this afternoon. She is running to a tight schedule. She has five families in her care this afternoon for conversations about inductions and elective caesarean and needs to run through recommendations and procedures with each of those families, what to expect and their expectations. She speaks very fast, she is assertive, she is efficient, but she appears abrupt and practical and at times insensitive. One of the families is coming in to be monitored and to make a decision about homebirth or induction and has very specific birth wishes, preferring to decline induction. The consultant feels that induction is the safest option given that there are risks associated with age and gestation and she finds this family's decision to be frustrating, and inconvenient. She doesn't really understand their choice, particularly as she has recently supported a family that resulted in a poor outcome for baby and mother. The mother's choices and wishes are going against hospital protocol and the protocol or guidelines exist for a reason. If the consultant supports their requests and there were to be complications later on with either mum or baby, questions might be asked of her. Why had she supported not following hospital guidelines? How could

she justify this? Her perception is that her practicing license could be compromised if she hasn't followed protocol and doesn't have a good explanation for doing so. It seems evident that there is a need for this doctor to feel in control of both the situation and of the potential consequences to herself.

The Baby: Hasn't started the birthing process but is getting ready to. All baby's needs are being met in mum's womb. Recently the womb space has been contracting gently. Baby is gradually getting used to the tightenings. The mother's cervix is softening. Baby is head down, sometimes applying pressure to the cervix and sometimes not as this is mum's second baby. There is a complex physiological puzzle going on in order to prepare baby for its journey in the world. The baby feels safe. The physiological hormones support the baby to prepare for birth and for baby's entrance into the world. A gentle entrance into the world will support baby in adapting from the familiar womb environment that he experienced over the last 9 months to its new world outside of the womb. Once baby has entered the outside world his new favourite place will be on his mother's chest. Ideally for this transition to take place smoothly he needs uninterrupted skin to skin so he can follow the scent and crawl to his mother's breast, his next safe space.

The Doula: Is very much thinking about the birthing family's hopes for a home birth, is thinking about the last induction she supported that had been long and challenging for the family and her. Tries to keep an open mind and argues internally that she has also attended very positive inductions. Is wondering if the evidence that supports the guideline is really that black and white? This mother literally turned 40 three weeks ago and has otherwise experienced a healthy pregnancy. She cannot stop thinking about the physiological process that prepares the baby for birth and the information that she researched that told her that a substance called surfactant, and the protein within that, in migrating to the uterine walls may be involved in causing labour to start. She knows that this substance is critical in lung development and for baby to breath outside the uterus. This all makes so much sense and she marvels at how wonderful our bodies are and finds it hard to push the intrinsic puzzle to one side. She reminds herself that she must keep the birthing family's wishes and the safety of the family as a whole in the forefront of the dialogue.

Three out of four of the above dialogues are obviously my perception of the different stories.

As a doula, my role is to hear and understand all of the dialogues, and to listen compassionately to my own inner dialogue and ensure the support and guidance that I give is not being influenced by my own fears or unprocessed experiences. From that, I have to somehow ensure the voice of the birthing family is heard and, as much as possible, that they can work towards their goals and birth wishes in an environment where they feel respected, heard and included in the decision making. I need to do so without my own personal agenda, sometimes outside of the advice of the hospital or medical teams and their guidelines, if this is the parents' wishes. Often, the parents' decisions are different to the choices I might personally make if I were to be in the same position.

Using NVC means I am able to hear the family's needs and acknowledge that the family are entitled to make their own, researched and informed choices. Using NVC means I am able to decipher the needs of the consultant, the midwife, the protocol or guideline of the hospital and which also means I can introduce their perspective to the parents and support them to understand why a consultant may be

appearing to be insensitive, hurried and uncaring and how we might navigate that. NVC gives me the ability to hear any judgements that come up in my own mind when I'm listening to others speak and to use language that acknowledges everyone's needs. To empathise with my clients, to have empathy for the needs driving the behaviour of the health care providers that enter my clients' antenatal or birth space. This does not necessarily mean I agree with or condone the behaviour of others, but that I will seek to understand and try to explain what may be driving their behaviour which can sometimes make life easier for the birthing family to understand.

So when approaching the above situation, this is an example of how that might look with our ordinary human reactions and thought process:

The birthing family have an appointment with the consultant obstetrician. They are approaching 39 weeks and have read lots of information including guidelines to support them to make an informed choice. They have decided that they would like to wait until labour happens and birth at home and are hopeful that because of the healthy pregnancy to date, and the very recent 40th birthday, that the obstetrician will be objective and will support their wishes. However they are also concerned that she might not. The obstetrician arrives a few minutes late, looking flustered and introduces herself. The couple introduce themselves and their doula. The consultant eyes the doula and then smiles and says "I've never met a doula before but I've heard all about you". The couple feel uncomfortable. The doula is used to it. The doula sits quietly making notes of the conversation at the couple's request. The consultant opens the discussion by saying "so I understand you are over 40 years of age, and we would recommend booking you in for induction if you're labour hasn't started by around 39 weeks, which looks like we are approaching fairly soon".

The expectant family begin to ask a few questions. They start with, "Can you explain why this is the recommendation?" The consultant interrupts them to say "The risks associated with stillbirth double for mothers over 40 and of course we want to minimise the risk of any harm to your baby and to you."

At this point the heavily pregnant mother starts to feel deflated and to become tearful. Her partner comforts her and feels angry. He senses that they might have a battle to achieve support for the mother's decisions, and he isn't sure that this conversation will be conducive to continuing to feel safe with their wishes. The doula, hearing this explanation and seeing the mother's response, immediately feels protective and defensive. She thinks that this language is not acceptable, that it sounds coercive and not informative enough. Angry thoughts are running through her head.

The father says, “At the moment my wife feels well and is very keen to have a homebirth for multiple reasons.” the consultant looks sympathetic, but she is thinking, “Why would you even consider taking ANY risk?” She says, “Yes, I understand, however I am sure you would not want to expose your unborn baby to elevated risks of stillbirth.” She begins to tell a story of a birth she attended recently that ended with a poor outcome. The doula wants her to shut up and is thinking this is not relevant or an individualised approach. The doula sees that the doctor is not even listening to her clients or trying to understand the mother’s birth wishes. This is fear-based scare mongering.

So, in the scenario above, where NVC is not used, you can see lots of judgements and thought processes that are angry, defensive, and blaming. If we entered this space and said our judgemental thoughts out loud such as, “The language that you are using is coercive. It is entirely irrelevant to this individual family that you attended a birth with a poor outcome,” you can imagine how the dialogue might continue. It is likely the consultant would feel angry for being spoken to in this way and defensive in her response. Now, as a doula using NVC, I meet those value feelings or judgements that arise with compassion. I hear the consultant’s dialogue and whilst feeling the feelings above I also try to consider “why?” Her disclosure that she recently attended a birth with a poor outcome, which could be considered irrelevant, incomparable or coercive and fear inducing also indicates to me that her intention to protect others from any negative experience is coming from a place of fear, a desire to protect others and informed by her previous experiences which she may not always have the opportunity to unpick and offload. In this moment I am able to silently acknowledge her fear, to perhaps share with this family later.

My thought process begins to focus on the family’s goals and to how I may be able to guide the consultant back to a place of individualised care, and from there to her hearing why homebirth feels safe to this birthing family. I am also keen to hear her explain the statistics so that the perceived risk that informs this guideline can be absorbed and explored together. I am hopeful that this might reassure the consultant that the birthing family are making an informed choice. I also hope that she may repeat from the guideline that the perceived risks of stillbirth starts low at 1 in 1000 in aged under 35 to 2 in 1000 in aged over 40 so whilst the words “risk doubles” is accurate, it is a risk that starts very low and doubles to another very small number. I think about how I can word a sentence that ensures that the consultant feels that her words have been heard, but that also achieves the goal of getting the conversation onto useful information that will support the birthing family and for the consultant to hear that it is the birthing family’s wishes - that the mother is making informed choices rather than being influenced by me.

So using NVC I would say "I'm so sorry to hear you recently supported such a challenging situation. These experiences must be a very difficult part of your work. Thank you for explaining the hospital guidelines and your recommendations" (so I am acknowledging her experience, not dismissing it and acknowledging the guidelines). Then, addressing the birthing family, I would say "Perhaps moving forward you would find it useful if we could talk about the statistics that inform the guideline so that you can more easily put the information into context?" The birthing family respond to say, "Oh yes, we have read them but it would be useful to look at them together."

The Consultant replies, "Of course, let me pull up the RCOG guidelines." I continue to address the birthing family and ask whether they would also find it useful to talk about their preferences of how they would like to move forward. I would continue throughout the dialogue to keep the conversation on track towards the goals of the birthing family and with the birthing family expressing their wishes for themselves with my mediation.

If everyone feels heard, and each individual hears someone acknowledging their feelings, we can often approach the sometimes conflicting needs of parents and the maternity unit and work together towards a mutually acceptable resolution with positivity. Rarely is someone being 'difficult' or 'challenging' for the sake of it or with the sole intention to cause us personal pain. There will always be a feeling or a need which is driving their behaviour and communication. If we can identify, validate and listen we can often move on to finding a resolution. Sometimes it can take some time, and in some scenarios giving that time doesn't feel possible to explore out loud. However, by understanding the process of NVC you will often find that the way you navigate information in your own mind will often support you to feel less anger and frustration towards others, particularly in situations where you do not necessarily agree.

Non Violent Communication can conjure up images of people communicating violently by default! I have always preferred to explain NVC as Compassionate Communication. The word compassion helps me to take responsibility and ownership for my own feelings and acknowledge which feelings belong to others. I wholeheartedly encourage everyone in the birth world to check it out as a way of communicating or interpreting situations.

I am a big advocate for the Hearts in Healthcare movement,[1] a community of health professionals, trainees and patient advocates who are champions for compassionate care with some amazing goals, such as encouraging health workers to reconnect with the heart of their practise and allowing compassionate caring to rise above institutional rules and limitations. There are also some great books and introductory videos for NVC on You Tube which enable you to self-study this method of communicating.[2]

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1. https://heartsinhealthcare.com/

2. Giraffe and Jackall l anguage explained by Marshall Rosenberghttps://www.youtube.com/watch?v=A-6zkwqjDVI