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# On message - What can we learn from listening to our internal monologues?

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*By Sophie Martin*

We all have continuous internal monologues running day and night[1].

Much of what the voices in our heads say is a reflection of our subconscious, a constant behemoth of an undercurrent, processing thousands of pieces of information every day, whilst our conscious mind skitters along the surface. Our subconscious is often only dredged up in our dreams: weird mish-mashes of half-processed content from our day, matched onto experiences both past, present and possible. This subconscious monologue is a powerful tool, something that enables us all to make snap judgements that contain a myriad of personal biases. Bias gets a bad rap today as it is often associated with discrimination: biases linked to ethnicity and gender usually have negative or controversial connotations. But these snap judgements and pattern-matches are an endlessly useful strategy to inform our evaluations of one another: What does this person think of me? Can I trust them? Am I safe? Could just being aware of our own internal dialogue help us strip back our own and others' conscious judgements to address our deeper needs underneath? This subconscious storytelling, our sixth sense, our 'gut feeling' has been key

in our evolutionary history.

And it is also key to our health. Studies have shown that outcomes are influenced by the stories we are told, and we tell ourselves, overt and implied, about our well-being and care. Some pathologies are so ingrained in the inner conversation that we become the pathology itself: 'I AM depressed', 'I AM high risk'. It is well known that doctors who build a good rapport with patients promote their health and well-being,[2] and and that the side effects of drugs and placebos are strongly influenced by the assumptions of those who have been blinded to what the little pills they're prescribed actually contain[3]. So what narratives can be active in the perinatal period, and how are these shaped by interactions with our care providers? Are they effective in supporting our emotional, and therefore physical well-being? Most women and families take their cues from medical professionals when developing their inner discourse around pregnancy, even mirroring doctors' and midwives' language closely. It could be argued that rather than a medical event, childbirth is first and foremost a rite of passage but differs from other life changes because it often takes place in a medical setting. Spiritual and other celebratory aspects are often overlooked, and the meaning-making can take on a risk-based approach. It'd be strange to book a wedding and alongside making all the plans for the beautiful touches – favours, signage, chair-covers, flowers – picturing your perfect day in your mind's eye, to be told ***'it's only going to get worse'*** or ***'you should think about your safety'*** or feel like you have ***'carried the weight of words'*** while carrying your baby[4]. If that were the case maybe folks would think twice about getting hitched in the first place. Phrases like this can pervade the subconscious of the mother, and be deeply unhelpful.

Pregnancy and childbirth also differ in that, despite much care taking place in a medical environment, no innate pathology is involved: in the majority of pregnancies under midwife led care, no disease is being cured, no malfunctioning part removed. The trickle-down effect of consultant led care, quantifying risk rather than qualifying it, and a move away from case-loading, means the relationship between a woman and her healthcare providers might be a distant one, with decisions based upon protocols rather than her personal informed choices. It is also often the case that mothers invest much time and emotional energy in communicating with medical professionals, in an environment where supportive and informative interactions can degenerate into a risk-minimising, box-ticking exercise. Far from the midwife or obstetrician listening as a friendly and helpful ear on an equal footing, they can appear dictatorial, patronising, even hostile. There must be some contributing factors to the tribalism that can arise between women and families and their caregivers, some influence that is responsible for corrupting erstwhile questioning, courageous and confident mothers into litigious and fearful patients, under the risk-mongering care of practitioners urging birth partners to ***'talk some sense'*** into their nearest and dearest.

It can take courage and a certain amount of space and time (and legal backbone) to speak honestly and openly about some negative experiences in the NHS, and to examine the internal dialogue of those operating within the system, free from the burden of future reprisals. An example of this is former obstetrician Adam Kay, who in his frank, funny and horrifying account of working in the NHS, shines a light onto the struggles of caring for birthing people and families in a climate of unacceptable staffing

pressures[5]. In contrast to midwifery-led care there can be a higher level of perinatal pathologies for women under obstetric care, as they can comprise mothers with complex needs and co-morbidities, mothers and babies who, in the doctors' view, could potentially die on their watch. Trapped in a narrative of death lurking behind every cubicle curtain, the precious and vulnerable lives in their care, and without the time or emotional space to connect with birthing people, is it any wonder that 'you can't pay any attention to the (wo)man behind the curtain, your own sanity relies on it'[6] whilst at the same time '...couldn't think about anything bad ever happening again... women were having unnecessary caesareans... but if it meant everyone got out of there alive it was worth it'[7]. Surely, this is a strategy for self-preservation and risk control, to neither acknowledge the mother as a person nor allow her to assume responsibility for her choices, for fear of the worst becoming a reality. Given the climate of fear, we can appreciate that the subtext to many medical conversations – and even consultants' self-talk – is laced with implications for safety, heavy with inference on parental responsibility, heavy with risk, fear and just bloody wretched for all concerned.

So how to use this tool of subconscious messaging, of instant judgement, to help support not only our well-being, but change the conversation entirely around perinatal healthcare? Is this too monumental a task? Firstly it's okay not to burden ourselves with this, at times, herculean undertaking. To go as far as bringing our own monologue into the bright light of day, scrutinising it, augmenting unhelpful aspects, letting it go, that in itself is work enough. But as Kay says, 'why would any sane person do that job for anything other than the right reasons?'[8]. The lack of appreciation by the system, the demands on personal time and the arguably pitiful salary mean that the medical staff we have left could possibly be our greatest gift. Are there strategies that already exist to uncover the unmet needs beneath the self-talk, align diverse points of view, and promote empathy, understanding and health of both mother and doctor?

There is precedence for creating a framework in which potentially conflicting interests can communicate effectively to mutual benefit. AIMS is not alone in its longstanding work for the rights of birthing people[9]. Birthrights, for instance, has applied the lens of human rights to perinatal care to allow mothers to stand on the shoulders of legal giants, and discuss their pregnancy choices as equals with even the most exhausted and risk-averse of consultants[10]. We can also delve deeper into the underlying needs of both pregnant women and healthcare providers by assuming every interaction is at its most basic either a 'please' or a 'thank you' exchange. This changes an induction booking from a ***'kick start a car'*** into a 'PLEASE, let me try to explain this with a simple metaphor', ***'incompetent contractions'*** and ***'don't endanger the life of your baby'*** to 'PLEASE, don't either of you die'. If these requests were acknowledged more openly, it could become easier to empathise with one another.

This lack of trust and respect that can occur between women and their care providers can foster an atmosphere of doom and gloom, and overlooks the productive and trusting relationships that do develop, in spite of the strain on time and resources. What a gift for the health of the mother, unborn baby and her healthcare professionals, when they are supported to enhance one another's internal dialogue! What change in subconscious narrative might take place, and thus augment nuance and inflection during

discussions? What wonderful trickle-down effects might we expect for families and maternity services as a result?

This work originates within us, and begins with interrogating the voices we all hear from within. Unwrapping the layers of the metaphorical onion (rotten now from overuse) we can choose to use our discoveries of underlying needs beneath our internal discourse to re-frame our own narratives, and thus conversations with others. Joe Griffin and Ivan Tyrell in their thesis on the human condition postulate on nine 'givens' that we need to live a fulfilled life: security, attention, autonomy, intimacy, community, privacy, status, competence, and purpose[11]. With our eyes opened to this knowledge about which needs might be unmet in our perinatal circumstance, we might seek to prod our care-givers, partners, and families into action, and open their minds to diverse outcomes other than the binary of “life and death”.

We might seek other tools that exist to promote understanding to benefit the health of both parties, and put any conflict into perspective. Marshall Rosenberg's ability to reconcile two apparently black and white points of view was honed during 1960s race riots in America, using a model he developed called 'non-violent communication' (NVC)[12]. He reasoned that needs of different parties are never in conflict, with relationship breakdown ensuing only when the possible strategies for meeting needs clash. According to his model, individuals are encouraged to cultivate self-compassion, to honestly express how they feel, and to listen empathetically within four criteria: observe, note feelings, discover deeper needs, and finally make requests of the other person[13]. Rosenberg noted successes even when one party is neither motivated by compassion, nor aware of NVC: if we ourselves are able to 'stay motivated solely to give and receive compassionately, and do everything we can to let others know this is our only motive, they (the other party) will join us in the process'[14]. There are also clear benefits from NVC in medical settings, one doctor commented 'NVC helps me understand what patients' needs are and what they need to hear at a given moment... I feel more energy and joy in my work as I become increasingly engaged in NVC'[15].

It is noticeable then that, in sharp contrast to what at times can seem to be an all-pervasive climate of fear and pathology around the perinatal period, there can also be a myriad of ripple effects from outstanding, or even just 'caring' care. This is witnessed by women in very clear terms: when ***'language used made me feel strong and capable'***, ***'how great I was and that I could do it'***, and ***'they (the midwives) were just there to help and support'***. This is what can be achieved when we have gained a better understanding of the deeper meaning-making in what we say. Mothers and care-givers can grasp the opportunity to support one another to not only endure pregnancy and the perinatal period, but to re-phrase their internal monologues to marvel at the amazing work the mother's body is doing, and as a result be more easeful, safe and well.

The rewards for us all when we cultivate healthful internal monologues are great, and their positive powers far-reaching. Listen up.

**Quick-fix guide to re-framing your self-talk**

1. Helpful or unhelpful: Are your internal narratives bringing positive changes and feelings that are helpful? Or are there unhelpful themes that can be harmful to ourselves or others?
2. Pick out three 'feeling' words, adjectives that sum up unhelpful themes in your internal story, for example 'tense, anxious, fearful'
3. Interrogate these adjectives to find opposites that ring true to us. It's important that these are free from negatives or quantifiers ('less anxious' or 'more relaxed' do not count) or time phrases ('relaxed later' and 'brave next week' don't count either). Following the examples above, the three opposite words might be 'relaxed, calm, courageous'.
4. Deeper needs: how do these tie in with the nine human givens? It could be that feeling anxious might reflect a lack of emotional security, for example. This can help us to communicate our needs clearly to ourselves and others, e.g. 'I want to know that I can choose to relax, and feel secure'.
5. Reflecting on others' language: Can we pick out adjectives that hint at others' self-talk themes? Can we work opposite adjectives into our responses to show we understand their subconscious needs?

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4 All quotes in ***bold italic*** type are anonymous excerpts from a discussion on Facebook on 13 January 2021 in response to a request made by me with respect to language use in maternity care and its impact on women.

5 Kay A. *This is Going to Hurt: Secret Diaries of a Junior Doctor*. 1st ed. London: Picador; 2018.

6 Kay, *This is Going to Hurt*, p. 258.

7 Kay, *This is Going to Hurt*, p. 258.

8 Kay, *This is Going to Hurt*, p. 261.

9 Ashworth, E., 2020. *AIMS Guide to Your Rights in Pregnancy and Birth.* 1st ed. Association for the Improvement of Maternity Services.

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