Pregnant women are some of the most sensitive people you will ever meet. They are highly vulnerable and very suggestive, at a time when they are actively seeking information and support from a wide range of contacts. They listen to everyone and everything, read copiously, ask myriads of questions and are the recipients of mountains of advice.

Central to this communication is the language of birth. The words that are used and the manner in which they are spoken can be uplifting and inspiring or devastating and undermining. As caregivers, we often fail to appreciate the impact our words are having. When we talk about topics that are familiar and comfortable to us, we need to be very aware that they may seem threatening and scary to others. Sometimes it is not the words themselves that create the problem, but the connotations and impression these words create that does the damage, perhaps leaving the woman feeling anxious and even afraid when reassurance and comfort was intended.
In working with pregnant women, our main aim must surely be to help her feel competent, capable and powerful as she journeys through the most creative work she will ever do. All our actions and words must support the realisation of this outcome, even when we have to convey bad news. Developing a sensitivity to the impact of what we are saying is an important skill that every midwife, educator and doctor must develop as part of their professionalism. Remember that what you say will have a profound impact on the pregnant woman—she will be hanging on every word you say. This is a very powerful position to be in and we must be careful not to accidentally use it to coerce her, undermine her rights or sap her confidence.

Developing the skill of “watching what you are saying” is essential. This can be done directly by tape recording your consultation or teaching session for self-appraisal later, having a colleague sit in as an observer to offer feedback or even videotaping a session. Watch for the pregnant woman’s reactions as you are speaking—note her body language, facial expression and verbal feedback. This is often a very brutal way seeing yourself as others see you yet it can be highly instructive and a beneficial learning experience for you!

Whenever you are talking to a pregnant woman, try to develop the ability to “split yourself up” into three parts: the person speaking, the person you are talking to and an observer noticing the interaction between both of you. Putting yourself in another person’s shoes is an important first step in developing effective communication skills and is integral to the processes of negotiation and conflict resolution. Analyse what you observe from these three standpoints and use this to formulate changes to your approach. Notice, for example, what you were saying when she narrowed her eyes—this probably indicated she didn’t understand what you were saying.

You may need to repeat the information and either paraphrase it or use different terminology.

People are very sensitive to the congruence between what is being said and the accompanying body language of the speaker. Just raising an eyebrow as you are taking a blood pressure can create alarm in a client, even if you are saying “this seems to be just fine”. Be wary of creating bias through the use of emotionally laden expressions and personal opinion. “If I were you I would...” and “in my professional opinion you should...” are messages designed to influence rather than empower, for example.
Think carefully about your vocabulary. Most of the terminology used in maternity care is masculine, negative and medical, probably the result of the early textbooks being written by the doctors of the time rather than midwives. One of the worst examples is the word “delivery”. This has become so commonplace that we hardly notice we are saying it, yet in the wider sense it describes a service that is performed for you, rather than something you do for yourself. This is hardly the impression we want to be giving pregnant women, is it? There is not one occasion when you use the word “delivery” that you could not neatly excise it and replace it with the word “birth”. Try saying “I was at a wonderful birth last night” rather than “I had a wonderful delivery last night” and see how it alters your perceptions of the whole event while maintaining the woman in her central role.

In prenatal education, as in all interactions you have with pregnant women, pay careful attention to avoiding the use of jargon. Abbreviations (e.g. V.E.) and acronyms (e.g. APGAR) are appropriate for quick communications with colleagues but unsuitable for facilitating understanding amongst pregnant women. You may need to find whole new ways of describing certain conditions to avoid creating negative impressions with women: think of the impact of being told you are “failing to progress”, have an “incompetent cervix”, or are being given a “trial of scar”. Even apparently safe words such as “coping”, “adequate” and being “in control” need to be reassessed for the impressions they are conveying. It has also been popular to talk about uterine contractions as “pains” e.g. “How often are the pains coming now?”. What messages are being embedded in this false description? Yes, some contractions are painful, but to call all contractions “pains” is inaccurate and potentially damaging to women’s perceptions.

Sometimes even apparently innocuous words can have profound effects. “Still” and “only” are two examples. How would you feel about being told, after hours of dealing with contractions “you’re only in early labour”, or some hours later “you’ve still got a long way to go” or for the full double whammy, “You’re still only 5 cms”?

Many caregivers tend to blame women when communication fails: it is the woman’s fault if she doesn’t understand. In any educational setting (and these are many and varied in maternity care) if the message is not received then it is the responsibility of the message sender to make amends and find better mode of communication. A completely different approach may be needed, such as drawing a picture, acting out a situation or using a prop for clarification. Selecting different words will also be important and using vernacular or slang words may work well. Ask yourself, “how would this woman describe the situation herself?”.
During labour, women are particularly alert to what is being said by caregivers. Even though she may look as though she is lost in concentration during contractions, the labouring woman will hear, often acutely, what is being said around her. She looks to the midwife for confirmation that she is doing well, particularly with handling the pain. A few well-chosen words of encouragement and support can be far more effective than pethidine in achieving relaxation and confidence in the labouring woman. The midwife at a birth has great influence on the woman’s reactions and impressions, so be careful not to introduce your own feelings and biases into the room. This woman is not a “poor thing” who won’t cope without you—she is a strong, innately capable woman uniquely designed for giving birth easily, safely and enjoyably. If you truly believe this then you won’t need to watch your language, you will already be consciously feeding this information back through your language and responses.

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