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By

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2009

Dar a Luz Network:
A Working-Model Peer-to-Peer Education and Support Group
for Women in the Childbearing Years

A Thesis
Presented in Partial Fulfillment of the Requirements for the
Degree of Master of Science in Midwifery
in the
College of Graduate Studies
Midwifery College of Utah

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March 2009

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Authorization to Submit Master's Thesis

This thesis of April Annette Kline, submitted for the degree of Master of Science of Midwifery and titled "Dar a Luz Network: A Working-Model Peer-to-Peer Education and Support Group For Women in the Childbearing Years" has been reviewed in final form. Permission, as indicated by the signatures and dates given below, is now granted to submit final copies to the College of Graduate Studies for approval.

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Abstract

An abstract of the thesis of April Annette Kline for the Master of Science in Midwifery presented _____, 2009.

Title: Dar a Luz Network: A Working-Model Peer-to-Peer Education and Support Group For Women in The Childbearing Years

There are so many helpful organizations and classes available to pregnant women, birthing women, and new mothers, that it may seem there is no need for another. Yet the literature clearly shows that a number of women have needs that are not being met. They are under-supported and under-informed about pregnancy, birth and the postpartum experience, and are suffering physical, emotional and psychological difficulties as a result.

This paper explores the state of pregnancy, birthing and early parenting; the inter-relatedness of knowledge, support and empowerment; and the outstanding need women have for accurate information and unconditional support. It details the beginnings of and the rationale for creating the non-profit education and support group Dar a Luz Network, and suggests some possible explanations for why this organization has grown from one Chapter in Dayton, Ohio in 2005 to nine Chapters in the United States and one in Portugal as of this writing.

Acknowledgments

With deep appreciation for all the women and their families who have been part of Dar a Luz Network the last three years. You have all taught me so much.

To Devon without whom, none of this would be a reality.

Dedicated to Erin who helped me realize in a very personal way the need we all have for unconditional love and support.

Big thanks to Penny Simkin for her insightful comments and encouragement.

A tip of the hat to Jon, Grandma, and Bruce E. for digging through early versions.

And especially to my husband, my mom and dad, and Kayla and Hanalei for their infinite patience with, love of, and pride in me.

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Definition of Terms and Abbreviations

ACOG

American College of Obstetricians and Gynecologists

CS, C-Section, Section

Cesarean section

ICEA

International Childbirth Education Association

IV

Intravenous therapy

LLL

La Leche League

NIH

National Institute of Health

OB/GYN

Obstetrician/Gynecologist

Pit

Pitocin, an artificial form of the naturally-occurring hormone Oxytocin

PTSD

Post-Traumatic Stress Disorder

ROM

Rupture of membranes

SIDS

Sudden Infant Death Syndrome

Unconditional

Not conditional or limited: absolute, unqualified

VBAC

Vaginal Birth After Cesarean

Introduction

The childbearing year is a liminal period for a woman and her baby; the woman is transformed into a mother, and the fetus becomes a newborn. What happens at this time affects mother and baby not only in the moment, but well into the future. Many helpful groups, classes, and organizations exist with the stated purpose of providing information and support to pregnant women, birthing women, and new mothers. Yet the literature shows that there remains a population of women suffering physical, psychological and emotional complications directly related to their childbearing experiences.

Judith Lothian (2007), associate professor at Seton Hall University College of Nursing and member of Lamaze International's Board of Directors writes, "We can let go of the myth that women are making informed decisions about their care. Although women want the full information required to make informed decisions, they are not getting that information, even if they attend childbirth classes" (p. 66).

These women are under-informed about pregnancy and birth and are also under-informed about the postpartum experience and early parenting. A 2000 survey of 324 women from 2-9 months postpartum identified major themes "listed in order of frequency: (1) need for social support, (2) breastfeeding issues, (3) lack of education about newborn care after discharge, (4) need for help with postpartum depression" (Kanotra et al., Abstract). The conclusion of this study states, "The themes identified indicate that new mothers want more social support and education and that some of their concerns relate to policies regarding breastfeeding and medical care. These results can be used to inform programs and policies designed to address education and continuity of postpartum care for new mothers" (Kanotra et al., p.449).

According to one study (Westdahl et al., 2007), when women feel informed, when their

experiences are validated, and when they have a continuously supportive rather than confrontational social context within which to process their experiences, they are less likely to experience postpartum depression (para. 7-8).

Though the impetus for Dar a Luz Network was a personal experience, the need for such an organization was also clearly indicated by the available literature. Founded in 2005, Dar a Luz Network strives to provide a broad range of accurate, evidence-based information and unconditional support for women throughout their childbearing years. Attendees report that they want to belong to a well-facilitated community of peers who provide these services (Kline, 2008).

This paper explores the current state of childbirth education, support and care for pregnant women and new mothers. It also explains the need and rationale for creating Dar a Luz Network as well as the set-up and structure of the organization, the protocols for training leaders, and the state of the organization as of this writing.

Purpose

- 1) To demonstrate that need exists for an organization that provides a source of evidence-based and unbiased information about the childbearing year and unconditional support for all women.
- 2) To describe the impetus for and the set-up process of Dar a Luz Network.
- 3) To describe how Dar a Luz Network Leaders are trained so they:
 - a. demonstrate a core knowledge about pregnancy, birthing and parenting
 - b. demonstrate capacity to find evidence-based information, and
 - c. understand how to avoid the traps of providing biased information or conditional support.
- 4) To illustrate the circular nature of Dar a Luz Network and how this appears to create an ongoing, integrated system of knowledge, power and support.

Literature Review

Available Support Groups for Women During Pregnancy, Birth and Early Parenting

There are many education and support groups available to women during the childbearing years with the majority focusing on one aspect of this process (e.g., breastfeeding, hypnobirthing, attachment parenting). Appendix A lists website addresses for the support groups noted in this review.

BirthNetwork. An education and support group for women and their families established in 1999. “BirthNetwork National is leading a grassroots movement based on the belief that birth can profoundly affect our physical, mental and spiritual well-being. BirthNetwork National (2007a) advocates mother-friendly care, as defined by the Mother-Friendly Childbirth Initiative” (para. 2). They also see themselves as part of “a growing movement of birth activists” (2007b, para. 2). This group is the most like Dar a Luz Network, the major difference being that they are more focused on birth activism and on promoting the Mother-Friendly Childbirth Initiative which has the potential to lead to promoting a particular type of birth.

International Cesarean Awareness Network. The International Cesarean Awareness Network (ICAN) is a nonprofit organization founded in 1982 with local support groups throughout the country for women who have had previous Cesarean births or first-time mothers who may be concerned about their chances of having a primary c-section. Their mission is “to prevent unnecessary cesareans through education, to provide support for cesarean recovery, and to promote VBAC” (2008, para. 2). Their vision is to see “a healthy reduction of the cesarean rate driven by women making evidence-based, risk appropriate childbirth decisions” (para. 3). This organization obviously appeals to a certain portion of the pregnant population.

La Leche League. An education and support group founded in 1956 that is focused on breastfeeding. Their stated mission is “to help mothers worldwide to breastfeed through mother-to-mother support, encouragement, information, and education, and to promote a better understanding of breastfeeding as an important element in the healthy development of the baby and mother (1993, para. 1). Some mothers report that they have felt a lack of support or even judgment in certain LLL groups because their choices were not completely in-line with that group’s philosophies and tenets (Kline, 2008. p. 3).

Trust Birth. Trust Birth trains leaders and has local groups that meet regularly. In the document *What is Trust Birth?* founder Carla Hartley (2005) wrote, “Who are we to tell any woman that birth is dangerous? Is it? *If we tell her she has to have a birth attendant there then that is EXACTLY what we are telling her. Birth is dangerous unless you have a birth attendant.* Then WE are putting ourselves in the position of saying ANY birth attendant is better than NO birth attendant” (p. 9). This organization works to shift how women think about birth and where and with whom they birth and appeals to a certain population of women.

Available Childbirth Education Options for Women During Pregnancy, Birth and Early Parenting

There are many options for women looking for childbirth-specific education. This being said, the majority (87%) of women choose to attend hospital- or care provider-based childbirth education classes according to the *Listening to Mothers Survey and Report Part II* (2006, p. 23). Appendix B lists website addresses for the childbirth education options discussed in this review.

Hospital-based childbirth education classes. These classes are typically taught in a classroom within the hospital or in a doctor’s office and the teacher is paid by the hospital or by

the doctor. Connie Livingston, an RN and Lamaze International certified childbirth educator for 29 years says:

During the late 1970s and early 1980s... hospitals began offering childbirth education along with free car seats and steak dinners as part of a marketing strategy to increase the volume of expectant parents in their facilities for additional services. While hospitals advertised that childbirth education classes were taught by nurses, many of the hospital-based childbirth educators were not trained or certified in childbirth education. Unfortunately, this phenomenon continues today. It is important to note that hospital-based childbirth education class curriculum are approved by staff education committees, whose members include physicians. Curriculum may be crafted to reflect the philosophy and practices of the hospital. (Personal communication, March 12, 2009)

If the teacher is certified, it is most likely through Lamaze International or the International Childbirth Education Association (ICEA). ICEA (2008) says their goal is to train “educators and other health care providers who believe in freedom of choice based on knowledge of alternatives in family-centered maternity and newborn care” (para. 1). Lamaze cautions expectant parents to choose where they take their childbirth classes carefully noting, “if you attend hospital-based classes, be careful that they do not simply present the hospital’s rules” (Walsh, 2008, para. 5).

Charlotte and Raymond De Vries (2007) reported on an unpublished Lamaze International Zoomerang survey of Lamaze educators, stating that 73% of the participants “indicated that they felt their teaching was strongly or somewhat censured. Admittedly a Zoomerang survey is not a scientific study, but it clearly indicates the pressure that childbirth educators are under” (p. 42). They went on to report that childbirth educators said they have been forced to move their classes from homes to hospitals, have been required to add more medical

and pharmacological content to their courses, and have also had to shorten their courses to accommodate the wishes of attendees (p. 42).

Lamaze, Inc. Lamaze has changed substantially in the last few years. They no longer teach the old-style breathing method. Their current mission and vision according to their website is “to promote, support and protect normal birth through education and advocacy. We envision for the future a world of confident women choosing normal birth. Lamaze International believes that women who are fully informed, confident and supported will want normal birth” (2009, para. 1-2). This seems to be a very common-sense approach, but does not address those women who are “fully informed, confident and supported” but who, for whatever reason, do not want (or do not get) a “normal birth.”

The Bradley Method of natural childbirth. As the name suggests, this well-established childbirth education organization promotes natural birth. Their webpage titled *Why Take Bradley Classes?* says “Of over 200,000 Bradley®-trained couples nationwide, over 86% of them have had spontaneous, unmedicated vaginal births” (2008, para. 2). This organization offers a wealth of information and support for women who value a certain type of birth.

HypnoBirthing. HypnoBirthing is typically taught in small couples-oriented groups or privately with one woman and her chosen partner. Their website states, “The method teaches you that, in the absence of fear and tension, or special medical circumstances, severe pain does not have to be an accompaniment of labor” (2008, para. 1). HypnoBirthing is appealing to a certain population of women.

Pregnancy, Birthing and Early Parenting

There is a vast amount of written work on the process of becoming pregnant, carrying a child, birthing a child, and raising a child. It would be impossible to cover the entire range of

books, magazines, journals, scholarly articles, and studies on even one of these topics. This literature review explores the written work on these subjects to demonstrate that while an abundance of information exists for women in the childbearing years, there remains a population of women who still are not finding the information they need and who are suffering negative outcomes.

It also needs to be stated that there are women who choose their care providers and then follow what they are asked to do without question. These women often have inductions, augmentations, epidurals, episiotomies, etc. – and are completely fine with the way their births go. These women need information and support as well. They need to know about the potential side effects of interventions so that they are not surprised and confused postpartum and they most certainly need to know that they are not alone. Ironically, if a woman who makes these choices lives in a community where the majority is making different choices (e.g., less interventive care), she will need *more* support to come through her birth with the least chance of postpartum issues.

There are also women who will read all the available literature and will understand the importance of evidence-based information – and they will *still* make choices that may seem incongruous to an outside observer (e.g., a woman may elect to have a scheduled c-section or choose to go ahead with an unassisted birth even though her pregnancy has multiple risk factors). This is, perhaps, the most important area of impact for Dar a Luz Network. Dar a Luz Network will still support this woman *no matter what her choices*. Because each woman has her personal history, her own family input and pressures, her own emotional and psychological makeup, she will, with all the information made available, make her own decisions. And, if the goal is to encourage every chance of an empowering experience, she still needs the same high level of care and support.

The largest surveys of pregnant women and new mothers ever conducted in North America were the two-part *Listening to Mothers Surveys*. Part I was conducted in 2002 by Harris Interactive for The Maternity Center Association and Part II was conducted in 2006 by Harris Interactive for Childbirth Connection in partnership with Lamaze International. The surveys included 1,583 women who had given birth in the previous 24 months. The information contained in these two surveys is immense and covers everything from testing during pregnancy to types of interventions participants received during labor to their feelings about their experiences.

The participants from these comprehensive surveys were also interviewed for the 2008 *New Mothers Speak Out*. Conducted by Harris Interactive with Childbirth Connection in partnership with Lamaze International, this survey explores what the postpartum experience is like for new mothers, charting their course from immediate postpartum to six months after birth.

Childbirth Connection, in their website overview of the *New Mothers Speak Out Report*, states “that life is challenging for many women at this time. Participants in this survey cited that they:

- experienced new physical and emotional problems following technology-intensive births with high rates of surgery and other interventions
- struggled to get exercise and rest, eat a healthy diet and manage stress
- did not return to their pre-pregnancy weight
- got limited support from husbands/partners and others
- were unable to start or continue breastfeeding as they wanted
- wanted but did not have the maternity benefits that women in other affluent countries take for granted
- returned too quickly to employment due to financial pressure” (2009, para. 2)

What is clear from these three surveys is that what the mother and baby experience during the childbearing year has a life-changing impact on both of them, short- and long-term.

The mother and the infant are, in fact, so closely aligned that they are often referred to in research literature as a dyad; one entity with two parts. What happens to one part of the dyad, directly affects the other. Charles Alexander Nelson and Monica Luciana explore mother-infant pairing in their *Handbook of Developmental Cognitive Neuroscience* (2001). They explain that this bonded relationship is not only sociological; it is also a biologically-necessary synchronization for the healthy development of essential systems. This development includes such basic physiology as heart function, breathing, and blood pressure (p. 608). Nelson and Luciana found that the mother-infant dyad provides many “hidden regulators” including, but not limited to, cardiac rate, sleep-wake states, sucking pattern, vocalization and blood pressure (p. 610).

In their book, *A General Theory of Love* (2001), *Doctors* Thomas Lewis, Fari Amini and Richard Lannon explore the interdependent mother-baby dyad. They suggest that the newborn is actually incapable of regulating its own systems; it must have a more mature physical presence to help it maintain and develop its physical and emotional health (p. 85). “Prolonged separations even can be fatal to an immature nervous system, as vital rhythms of heart rate and respiration devolve into chaos. Sudden infant death (SIDS) is increased fourfold in the babies of mothers who are depressed – because without emotional shelter, infants die. Lengthy parental absence deprives a child of limbic regulation” (p. 157).

This intense bond begins, of course, before birth. Everything that happens during pregnancy and the birth itself, therefore, affects the mother-infant pairing as well. Some of the most pointed information on this subject comes from Dr. Michel Odent, a French obstetrician and strong advocate of mother-directed birth who has written dozens of books on the subject. He

is adamant that mothers must be allowed to birth without disturbance. According to Odent (1999), this accomplishes many important goals, one of which is the release of a highly specialized “soup” of hormones including adrenaline and noradrenaline (the hormones of fight or flight), endorphins (the hormones of pleasure), prolactin (the mothering hormone), and oxytocin (the love hormone). He proposes that one of the major purposes of this soup is to elicit our capacity to love, the foundation of which is laid in utero and the first few hours after birth (pp. 15-18).

Regarding the use of synthetic oxytocin (Pitocin), Odent (2007) writes, “Today, in many countries, most women give birth without relying on the release of the natural hormone. But the synthetic does not reach the brain and cannot stimulate maternal love” (p. 16). In fact, “epidural anesthesia interferes with the release of the natural endorphins” (p. 16), nature’s own pain reliever. “*The long-term effects of this unprecedented situation must be considered in terms of civilization*” (p. 16, emphasis in original).

Pitocin, the most-used synthetic oxytocin, is often prescribed to stimulate or speed up labor. It has many documented effects for the mother including harder, shorter contractions, or even tetanic contractions. These artificial contractions increase the possibility of “premature separation of the placenta, rupture of the uterus, laceration of the cervix or post-birth hemorrhage” (Weiss, 1998, para. 5).

Naturally occurring oxytocin is transported from producing nuclei to either the posterior pituitary (and from there to the circulatory system) or directly out to other parts of the brain. But oxytocin (synthetic or natural) in the bloodstream cannot cross over the blood-brain barrier into the brain (Moberg, 2003, p. 56). Therefore Pitocin, which is delivered directly into the blood stream, does not affect the brain and “endorphins are not released in response to the increasingly

strong and painful uterine contractions. Laboring women do not experience the benefits of endorphins as they try to manage their contractions” (Lothian, 2006, para. 9).

According to Dr. Sarah J. Buckley (2002), “we do not know the psychological effects of giving birth without the peak levels of oxytocin that nature prescribes for all mammalian species” (para. 22). It is clear that Pitocin does not create the same physiological and psycho-emotional effects as does natural oxytocin.

The literature also reveals that Pitocin has a negative impact on the baby. Pitocin-induced contractions do not allow the baby sufficient time to re-oxygenate as do the rolling contractions of natural labor. This lack of time has the potential to cause neonatal asphyxia or hypoxia which explains the requirement for external fetal monitoring with Pitocin administration (Buckley, 2002; Lothian, 2006; Block, 2007).

Even seemingly innocuous interventions such as laboring in an unfamiliar place, birthing in the presence of one or more observers, laying horizontally, or not being allowed to eat or drink at will can negatively impact the birth and postpartum experience (Wagner & Gunning, 2006, p. 110). Penny Simkin (1986) specifically studied stressors during childbirth and reported that 27% of women who were not able to eat in labor found the experience stressful, and 57% who were on restricted fluids found the experience stressful (p. 239).

The reason most often given to laboring women for limitation or complete restriction of food and/or fluids is that if an emergency c-section that required general anesthesia were performed, there would be concern about anesthesia-related aspiration. But even in the extremely rare case that this would happen, anesthesiologists are taught to treat *every woman as if she had recently ingested food or liquid*. The Key Concepts for the chapter on *Obstetric Anesthesia, Clinical Anesthesiology* states, "regardless of the time of last oral intake, all obstetric patients are

considered to have a full stomach and to be at risk for pulmonary aspiration" (Morgan, Mikhail & Murray, 2005, p. 819).

Listening to Mothers II cites medical interventions to be the norm in American labor and delivery. The most common interventions include:

- 63% induction (17% of those induced cited pressure to induce from care provider)
- 93% electronic fetal monitoring at some time during labor
- 85% intravenous drip
- 63% epidural or spinal analgesia
- 75% one or more vaginal exams
- 41% urinary catheter
- 67% rupture of membranes
- 47% Pitocin (to speed up labor)
- 12% allowed to eat during labor (Declercq, Sakala, Corry & Applebaum, 2006, p. 66)

At 85%, the use of IV fluids in labor is arguably over-prescribed. A 500-1000 mL bolus of IV fluids is required before administering a spinal block and a 1000-1500 mL bolus is required before placing an epidural (Morgan et al, 2005, p. 825-826). If we look at the numbers from *Listening to Mothers II* (2006), that means that of the 85% of women who received IV fluids, 63% of them also received epidurals or spinals. That still leaves the other 22% of women who were given IV fluids without receiving spinal anesthesia. A safe assumption would be that care providers have gotten into the practice of starting fluids "just in case."

A study conducted in Toronto, Ontario (Tourangeau, Carter, Tansil, McLean, & Downer, 2001) evaluated the changes in a birth center's intravenous therapy practice. After a new, case-by-case IV protocol was implemented, 74% of the 219 women in the study received intravenous

therapy as compared with 100% under the old protocol. The authors conclude, “The change in the intravenous therapy protocol was supported by the study findings. Nurses should increase patient education about drinking and eating adequately throughout labor if appropriate, and resuming adequate fluid and food intake as quickly as possible after childbirth” (p. 36).

According to Drugs.com (2009), the FDA rates Lactated Ringer’s – the most common IV fluid – a Category C, meaning there is a medium level of risk based on animal studies, or no animal studies have been conducted. The full cautionary statement reads:

Animal reproduction studies have not been conducted with Ringer’s Injection, USP, Ringer’s and Dextrose Injection, USP, Lactated Ringer’s Injection, USP or Lactated Ringer’s and Dextrose Injection, USP. It is also not known whether these injections can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. These injections should be given to a pregnant woman only if clearly needed. (para. 27)

Administration of IV fluid is not a benign intervention. It can, according to Michelle Murray and Gayle Huelsmann (2008), “dilute the blood and may worsen tissue oxygenation and perfusion (p. 65). They go on to write, “excess intravenous fluid causes dilutional coagulopathy. Crystalloids [lactated Ringer’s] dilute clotting factors and contribute to platelet dysfunction, thus decreasing their ability to create a clot, which results in increased bleeding” (p. 65).

In fact, intravenous fluids may:

- cause hyperglycemia with accompanying rebound hypoglycemia in the newborn (Tourangeau et al, 2001)

- potentially cause hemodilution of maternal blood and thereby a reduction of maternal oxygen transfer to the baby and clotting issues (Sommer, Norr, & Roberts, 2000; Murray & Huelsmann, 2008)
- potentially lead to neonatal complications and a cascade of interventions for mother and newborn (Kroeger & Smith, 2004)
- cause unnecessary edema/fluid overload (Murray & Huelsmann, 2008) which may impair or inhibit breastfeeding (Cotterman, 2005)

It is difficult to call this commonly prescribed intervention “doing no harm.” It is even more difficult to believe that pregnant women are not always aware of this information when their chances of receiving IV fluids, as we have seen, fall somewhere between 85 and 100 percent (if birthing in hospital).

Still, in multiple studies (Declerq et al, 2002; Declerq et al, 2006; Childbirth Connection, 2008), women report that they did not feel fully informed and, in some cases, did not even give informed consent before certain procedures were performed. This lack of prior knowledge and consent has the potential to leave women with short- and/or long-term physical, psychological and/or emotional effects.

Episiotomy is a prime example of this phenomenon. According to the *Listening to Mothers* survey of 2002 (Childbirth Connection, 2008a, para. 25), episiotomies are performed on 35% of mothers who birthed in hospital.

Patrice Wendling reported in *Ob.Gyn. News*, “The routine use of episiotomy has been standard for years with apparently limited research to support it” (2005, para 6). In fact, episiotomy, according to many studies, does not help with the majority of the issues for which it is performed including:

- intracranial hemorrhage
- intrapartum asphyxia
- fetal distress
- shoulder dystocia
- prevention of third- and fourth-degree lacerations
- dyspareunia
- urinary incontinence
- cystoceles
- rectoceles or pelvic floor muscle strength
- Episiotomy may actually increase the risk of anal sphincter damage, postpartum blood loss, poor wound healing, infection, pain, and dyspareunia (Woolley, 1995; Feldman & Hurst, 1987)

Even the American College of Obstetricians and Gynecologists in its 2006 Practice Guidelines for use of episiotomy states, “The best available data do not support the liberal or routine use of episiotomy” (p. 962).

As mentioned before, the lasting effects of episiotomy are not always solely physical; there may also be related psychological and emotional issues. One maternal risk of episiotomy is “extreme fear of subsequent delivery,” according to Woolley (1995, para. 197). Wendling (2005) writes that one reason for this fear may be that “Although episiotomy is among the most common surgical procedures performed on women, it is the only one in which neither informed consent nor patient assent is obtained before performing the procedure” (para. 15).

And episiotomy is just one of many interventions associated with long-term effects. Declerq et al (2006) reports that new mothers cite a wide range of difficult physical changes

months after giving birth. At six months or more, many women continued to experience problems, including:

- stress (43% of all mothers)
- weight control (40%)
- sleep loss (34%)
- lack of sexual desire (26%)
- physical exhaustion (25%)
- backache (24%)
- pain at incision site (18% of cesarean mothers) (p. 2-3)

Compounding these issues, is the fact that many women are suffering alone. Childbirth Connection (2008) reports that more than 7 in 10 mothers “never consulted a health professional to get help for the specific early or continuing problems they experienced” (p. 1). Declerq et al (2006) reports that about three in four mothers cite notable symptoms of depression, and three in five of those with “notable symptoms of post-traumatic stress, had not consulted a professional about mental health challenges since giving birth” (p. 22).

Cynthia Good Mojab (2009) points out that care providers often underestimate postpartum issues resulting from traumatic birth because they are unlikely to routinely evaluate new mothers for iatrogenic trauma (p. 70). She also suggests that women often “conceal their depression due to feelings of shame, embarrassment, failure, fear of judgment, and fear that they might jeopardize their custody of the baby” (p. 71). Several studies have found that up to 88% of new mothers suffering from postpartum depression are not diagnosed and do not receive care because they are not reporting their symptoms (MacLennan, Wilson & Taylor, 1996; Whitton, Warner & Appleby, 1996).

Even if we only look at those who are reporting their postpartum issues and/or are receiving treatment, the numbers are still alarming. The National Institute of Mental Health (2008) for instance, finds the number of new mothers suffering postpartum depression as high as 15% (para. 8).

Postpartum depression is one long-term psychological issue that care providers and most of the general population are at least aware of. Increasingly, health care providers are seeing that the number of obstetric procedures used in labor and delivery could be playing a role in increased numbers of postpartum women suffering from the less-understood diagnosis of post-traumatic stress disorder (PTSD).

Cheryl Beck, a professor at the University of Connecticut School of Nursing and Sue Watson, chairperson of the Trauma and Birth Stress charitable trust published results of their study on the effects of birth trauma on breastfeeding in the July/August 2008 issue of *Nursing Research*. They reported that as high as 34% of women experience some sort of trauma during childbirth. “Birth trauma is an event that occurs during any phase of the childbearing process that involves actual or threatened serious injury or death to the mother or her infant. The trauma can be classified as a negative outcome, such as a postpartum hemorrhage, or psychological distress. Experiencing this extremely traumatic stressor, a woman’s response can be intense fear, helplessness, loss of control, and horror (p. 229). They go on to say that the mothers reporting signs of PTSD (up to 9%) experienced a higher rate of medical intervention and were more likely to describe feeling helpless in a threatening environment (p. 230). The authors concluded that “...intensive one-on-one support for traumatized mothers may be necessary to help them establish breastfeeding. Sensitivity and awareness by medical professionals of the traumatized mother’s needs may also be helpful” (p. 236).

This short review demonstrates that a population of women is consistently not accessing evidence-based information. It is also clear that even those women who may be able to gather reliable information are not always able to put what they have learned into practice in the management of their own childbearing experiences. This is evidenced in the large number of women and babies suffering immediate and long-term physical, psychological, and emotional morbidity. There remains a need for women to have consistent and reliable access to evidence-based information. Dar a Luz Network is striving to fill this need.

A Brief Overview of the Literature Regarding Knowledge and Power

Beyond providing information, Dar a Luz Network also strives to help women take what they have learned and put it into action, thereby creating the opportunity for a powerful and transformative experience.

Many authors, philosophers and sociologists have concluded that knowledge is power. One of the most influential of these is Michel Foucault who developed an entire philosophy on the relationships between knowledge, power and discourse. The classic text on Foucault's philosophies is the collection *Power/Knowledge: Selected Interviews and Other Writings 1972-1977* (1980). Foucault writes that whoever holds the knowledge in a society also holds the power. "The exercise of power perpetually creates knowledge and, conversely, knowledge constantly induces effects of power. Knowledge and power are integrated with one another" (p. 52).

Ellis, Gates & Kenworthy (2003) write, "People with power have the ability to select the content and form of what is being communicated. In particular, Foucault examined how medical knowledge has been constructed to produce an apparently legitimate, and consequently prominent, way of viewing the world" (p. 41). They go on to say:

But Foucault's argument is that there is not one 'factual' way of viewing the world... Diabetes, obesity, anorexia, nervosa, hyperactivity, heart disease and dementia are arbitrary categories whose existence, boundaries and importance to both individuals and society have changed in the past and will change in the future. The medical discourse is a reflection of what those with power in society have deemed to be of significance at that point in time. (p. 41-42)

This is a key concept in the founding and development of Dar a Luz Network. If the "keys to the castle" can be distributed to individual women rather than being held by a powerful elite, then the basis of power has the opportunity to shift from the few to the many. For instance, often, the more research a woman does about "gestational diabetes," the more empowered she feels to determine the best protocol for her own prenatal care (T. Adoff, personal interview, February 18, 2009; A. Kline, personal observation of Dar a Luz Network attendees, March 2005 through March 2009).

Melissa J. Cheney (2008), Certified Professional Midwife and Assistant Professor of Anthropology at Oregon State University, took Foucault's philosophy of knowledge/power a step further in her study of pregnant women and their homebirth midwives. Cheney concurred that narrative is an important element in the interplay between knowledge and power, and she also identified a subtler, perhaps even more crucial element in this continuum: support.

Another key in the process of turning knowledge into power according to Perkins and Zimmerman (1995) is that "Empowerment-oriented interventions enhance wellness while they also aim to ameliorate problems, provide opportunities for participants to develop knowledge and skills, and *engage professionals as collaborators instead of authoritative experts*" (pp. 569-570). Zimmerman (1995) also suggests one more key: to create opportunities for individuals to

...control their own destiny and influence the decisions that affect their lives. They are a series of experiences in which individuals learn to see a closer correspondence between their goals and a sense of how to achieve them, gain greater access to and control over resources, and where people, organizations, and communities gain mastery over their lives.” (p. 585)

April Kline (2008) found that a combined 68% of Dar a Luz Network leaders and participants cited feeling more in control of their lives in general because of their pregnancy and birth experiences (p. 14). Cheney (2008) found that feeling powerful in pregnancy and birth affects how a new mother feels about early parenting. “Many of the women who discussed power or empowerment in some form also made an explicit connection to parenting” (p. 262).

The Coalition for Improving Maternity Services works to promote and spread the influence of mother-friendly care. Some of the highlights of this initiative include:

- Receive accurate and up-to-date information about the benefits and risks of all procedures, drugs, and tests suggested for use during pregnancy, birth, and the postpartum period, with the rights to informed consent and informed refusal.
- Receive support for making informed choices about what is best for her and her baby based on her individual values and beliefs. (para. 3)

Dar a Luz Network (2008) believes that optimal care with the goal of providing women every opportunity for gaining knowledge and empowerment (and, therefore, lessening their chances of suffering a traumatic birth with its many negative associated issues) must also include the following:

- Each woman’s individual needs are addressed and she is fully aware of what her individual needs require including tests and treatments only as needed, appropriate

care provider, appropriate place of birth, and complete support during pregnancy, birth and postpartum.

- Information is provided across the spectrum with teaching points about what constitutes evidence-based information.
- Information is not provided in a way to persuade or influence.
- And, most importantly, support is offered no matter what choices the woman makes.

(pp. 1-3)

Methods and Procedures

Dar a Luz Network Conception and Growth

The impetus for Dar a Luz Network was a fifty-two hour homebirth with a vaginal-birth-after-Cesarean (VBAC) mother. The outcome was a healthy baby and a joyously transformed mother.

The founders were in attendance for all fifty-two hours and left that birth with a renewed respect for the birth process when it is allowed to work on its own terms and in its own time. It was clear to them that the birth would have unfolded very differently if it had occurred in a hospital with even the most open-minded of care providers.

The mother had done extensive research before the birth, as had those attending the birth. Some of the research was complicated and not easy to assimilate, some was difficult to make sense of with conflicting data, and some was just extremely difficult to find.

All of those present at that birth were completely supportive of the mother's decisions. Each person in attendance might not have made the same choices, but they were supportive of this mother in making her own decisions. It is important to note that a large part of the mother's comfort was due to the fact that her care providers were knowledgeable and experienced enough to recognize complications that might arise which would necessitate a change of plans, but were supportive enough and comfortable enough with the natural rhythms of birth not to intervene in ways that might have been more typical in an institutional setting.

Because the transformation for this mother was so profound, the founders wanted to understand the reasons behind the transformation and determine if it would be possible to replicate this woman's experience. This contemplation led them to the formula for Dar a Luz Network: provide all women with a broad range of evidence-based and unbiased information as

well as unconditional support in their pregnancies, births and new parenting processes. The founders were clear that the goal of the organization would be to provide opportunity for an empowering experience for women via the inherently and uniquely powerful experience of pregnancy and birth, not to promote a particular type of pregnancy or birth experience.

The founders began researching existing groups and organizations that provide information and support during the childbearing years (Appendices A and B) and also reading the literature on the importance of pregnancy and postpartum support, the prevalence of birth interventions, the amount of misunderstanding and misinformation regarding pregnancy, birth and new parenting, and the incidence of postpartum depression. They quickly realized that though their desire to create an organization had grown out of a personal experience, the need for such an organization was also clearly indicated by the available literature.

They chose the name Dar a Luz because it is the phrase for giving birth in Spanish and because the literal translation into English is “to give to the light” or “to bring to the light.” This double meaning summed up what they envisioned for the organization.

Once the name was chosen, they put together a lending library which developed into the Dar a Luz Media List (Appendix C), built an article library of relevant articles, procured a space, selected a guest speaker, printed and posted hundreds of flyers, and hosted over forty women at that first meeting in March of 2005.

After that first meeting, the founders formalized the organization by writing corporate the By Laws (Appendix D) and the Philosophies and Purposes (Appendix E), registered Dar a Luz Network, Inc. as a 501c3, non-profit organization, and set up the Board, which was initially made up of the founders.

When several regular attendees wanted to become Leaders, the Board realized that there was a need for Leader Training protocols (Appendix F). When one of the newly accredited leaders wanted to open a Chapter out-of-state, the Board wrote the Leader Handbook (Appendix G) in order to record and preserve the proper ways to build a Chapter and conduct monthly support meetings.

Dar a Luz Network Leader Intake and Training

The majority (85%) of Dar a Luz Leaders are also certified Doulas. In the first screening telephone call, each potential leader is assessed for level of knowledge and training regarding the childbearing years, her purposes and goals in joining the organization, her ability to balance existing commitments along with Dar a Luz Network commitments, and (perhaps most difficult to ascertain, but most importantly) whether she has a fundamental belief in the basic Dar a Luz philosophy. Does the potential leader believe that a woman is most likely to grow into her own power when she is encouraged and supported to gather information and make the decisions that work best for herself and her family, or does she believe that there is a “right way” to do things?

Once the potential leader has been accepted into the training process, she goes through a process similar to Doula training to ensure that she has a broad knowledge about the childbearing years including pregnancy, childbirth, postpartum, breastfeeding, complications, testing and treatment options, newborn care, vaccinations, parenting skills, etc. Leaders are also taught how and where to find valid, evidence-based information when they need it. The Board is one resource for this information with working members and advisors who are Doulas, Midwives, Psychologists, Lactation Consultants, Herbalists, Licensed Massage Therapists, Neonatal Nurses and published authors. There are many other sources including books, websites, articles and

studies and Dar a Luz Network trains leaders to know which sources are reliable and how to recognize biased or inaccurate information.

The core of Dar a Luz Network training is a series of one-on-one telephone conversations with a trainer or a one-day workshop which encompasses the following:

- how to set appropriate personal goals within the organization
- empowerment: what is it and how do we provide opportunity for others?
- definition of personal success
- the Dar a Luz Network definition of “unconditional support”
- how to maintain role as facilitator while remaining part of the circle
- respect for each individual
- how to facilitate someone’s search for their own truth
- how to encourage peer-to-peer relationships (strengthening the circle of support)
- how to understand what an individual is looking for when they come for help
- burnout and how to avoid it
- how to create a welcoming meeting
- overview of how adults learn, esp. different learning types
- how to moderate a meeting
- tools for managing difficult personalities or someone who attempts to control a meeting
- how to be sure everyone feels heard and respected
- how to balance the demands of running a Dar a Luz Network Chapter (from Leader Training Sessions, Appendix F)

Leaders are taught how to help women feel informed, heard and respected so they have an opportunity to learn, question, debate, explore and exercise their power in a safe and supportive environment.

Where the Organization is and Where it is Going

Dar a Luz Network has grown in four years from one meeting in Kettering, Ohio to nine Chapters in the United States and one in Portugal with six new leaders-in-training who will be joining existing Chapters or opening new Chapters. Dar a Luz Network is a working model of how to provide women every opportunity for an empowering experience in their pregnancy, birth and early parenting experiences.

The organization plans to continue helping women gather knowledge and put that knowledge into action. To that end it is developing several new initiatives including:

- Developing a continuing education program for existing leaders. The purpose of this program will be twofold: 1) to increase and update leaders' core knowledge and leadership skills and 2) to nurture a leader culture of support and care.
- Seeking out grants to help the organization develop and grow.
- Utilizing technology more effectively. This initiative will include updating the website to include streaming video of appropriate content, and podcasts and/or webinars featuring guest speakers on a broad range of relevant topics.
- Updating and adding to the website including more evidence-based information and links to appropriate websites.
- Developing an outreach program with the goal of educating students at the high school and college level about evidence-based information and unconditional support.

- Offering a course on evidence-based care and unconditional support to nursing school students.
- Presenting at conferences, seminars, etc. about the import and impact of the Dar a Luz Network model.

Dar a Luz Network Leader and Participant Survey

Two questionnaires were developed for this survey (Appendices H and I). This qualitative study utilized grounded theory, therefore both questionnaires were created with the goal of gathering a broad range of information without a specific foregone thesis.

All existing leaders at the time of the survey were contacted by email, and all nine agreed to be interviewed. The leader questionnaire was an online, written interview. SurveyMonkey.com was the hosting site for this questionnaire. Private information was not attached to any of the data. Data was compiled using surveyMonkey.com's software.

The interviewees for the participant section were chosen as follows: an email inviting people to be interviewed was sent to each Chapter's current email list, totaling approximately 300 people. There was a time limit for responding. Anyone who responded to the email within that time frame was interviewed. No one that offered to be interviewed was turned down or chose not to participate. Anyone who responded after the deadline was not included in the survey.

This portion of the survey was conducted as a live interview with a consistent set of questions. Approximately one-third of the interviews were in-person and were audio-taped. The other two-thirds were telephone interviews that were taped using a digital in-line recording machine. Each interviewee was assigned a random number. The interviews were transcribed

verbatim using only the assigned random number for identification after which the tapes were destroyed.

Findings/Results

The *Dar a Luz Network Leader and Participant* survey (2008) points to at least two areas that may be of interest for further study.

- 1) Is there a direct correlation between unconditional support and empowerment?
- 2) Does this organization have greater retention and higher numbers of returning participants than other support groups and, if so, for what reason?

This survey interviewed 28 women. Nine were leaders and 19 were participants.

Additional interviews would offer depth and breadth to this study.

The data collected for the leader portion was in the form of an online written survey. This may have limited the length of the responses due to the fact that the information was gathered by way of typing rather than by speaking.

The data collected for the participant portion was in the form of live, taped interviews. The data may have been influenced to some degree for those who personally knew the interviewer. Although the interviewer made clear at the outset of each interview that all identifying features would be removed from the transcription and all names would be kept strictly confidential, a small number of those interviewed may still have felt some concern about giving certain answers since they knew the interviewer.

The sample for the leader portion of the survey was self-limiting. All of the accredited leaders at that time opted into the survey. The sample for the participant portion of the survey was a random sampling of any person who had attended any Dar a Luz meeting over the last four years and self-selected by replying to an email within the designated time. Available time and person-power were the only limiting factors for the number of interviews conducted in the participant portion of the survey.

All interviews for this survey were conducted with women. Although men do attend meetings, none of them opted to be interviewed for this survey. The survey did not take into account socio-cultural or socio-economic information such as income, race, age, marital status, etc. The only context taken into account in the leader section was level of education and any childbirth-related education/certifications. The only context taken into account in the participant section was attendance at a Dar a Luz meeting, number of pregnancies/children, and location of residence.

Since the survey was conducted utilizing grounded theory, the questionnaires were written with the goal of gathering a broad range of information without a predetermined thesis. Responses were consistent along several lines, revealing the following emerging theories:

- 1) the importance of the childbearing year in a woman's life
- 2) the need for and appreciation of unconditional support
- 3) the desire to continue attending Dar a Luz Network meetings beyond the timeframe of the participant's pregnancy and birth

The growth of this working model peer-to-peer information and support group demonstrates that it is filling a gap in the available offerings.

Discussion

There are so many helpful organizations and classes available to pregnant women, birthing women, and new mothers, that it may seem there is no need for another. Yet the literature clearly shows that a number of women have needs that are not being met.

Experienced mothers reported in *Listening to Mothers II* that they found information in the following places:

- 48% relied on their own past experience
- 13% looked to their doctor or midwife
- 13% turned to the internet
- 12% looked to books (Declerq et al, 2006, p. 23)

Of note in this portion of the study is the deep impact a woman's first birth has on her subsequent pregnancies and the fact that experienced mothers gathered information almost equally from their care providers, the internet and books.

First-time mothers reported that they found information in these places:

- 33% relied on books
- 19% went to friends and relatives
- 18% looked to their care provider
- 16% turned to the internet (Declerq et al, 2006, p. 23)

Again, it is interesting to note that first-time mothers gathered information almost equally from their care providers, friends and relatives, and the internet.

What is clear from this survey is that women are seeking information from every resource they can think of and they are finding information from a wide variety of sources - and certainly with widely varying levels of reliability. Take for instance the 33% of first-time mothers who

rely upon books for information: are they reading *What to Expect When You're Expecting* or *Ina May's Guide to Childbirth*? There is no literature on what impact a woman's reading choices have on her pregnancy and birth experiences, but it is obvious that what a woman reads will have some level of impact.

Even when women turn to their care providers, they may not be getting reliable, evidence-based information. In fact, the data indicates that many of these women are getting incomplete, biased, or even misinformation. Let's take cesarean section as an example. Jennifer Block (2008) writes,

Prominent physicians continue to present cesarean delivery as nearly risk-free. In spite of the evidence to the contrary, Gary Hankins, MD, chair of ACOG's obstetric practice committee, told me that "a scheduled cesarean section absent labor, in a controlled environment, actually has lower mortality for mom than an anticipated vaginal birth." (p. 121)

Block goes on to refute Hankin's statement saying "the most recent study [on c-section] looked at 65 deaths in mothers with no risk factors and found that mortality was 3.6 times as likely for those who had cesareans, even those who had surgery before labor" (p. 119). And this does not even take into account maternal morbidity.

The authors of a retrospective, population-based cohort study of all Canadian women who delivered between 1991 and 2005 summarized,

Although the absolute difference is small, the risks of severe maternal morbidity associated with planned cesarean delivery are higher than those associated with planned vaginal delivery. These risks should be considered by women contemplating an elective cesarean delivery and by their physicians. (Liu, Liston, Joseph, Heaman, Sauve &

Kramer, 2007, para. 4)

Why are some care providers choosing to disseminate information that is so blatantly out-of-line with the literature? One explanation is that the pressures most care providers work under are extreme. For example, Rita Rubin (2008) quotes Douglas Laube, a former president of ACOG as saying he blames “very significant external forces” for the overuse of expensive technologies in maternity care. “I don't like to admit it, but there are economic incentives for doctors and hospitals to use the procedures” (para. 8). “In fact, some doctors might get bonuses for performing more labor inductions, which adds costs and increases the risk of c-sections, which, in turn, increase hospital profits because they require longer stays” (para. 10) Rubin quotes Laube again: “In addition, some doctors order unnecessary tests and procedures to protect against malpractice suits” (para. 11).

A Harris Interactive poll (2002) found that hospitals and hospital-based care providers are dealing with multi-layered pressures.

- Hospital administrators feel that... unnecessary rules of protocol are often created out of a concern about liability protection.
- 43% of all nurses also feel prohibited or discouraged from doing what they think is right for the patient because of rules or protocols set up for liability protection.
- 51% of all physicians think that their ability to provide quality medical care to patients has gotten worse in the past five years.
- 76% of physicians feel that concern about malpractice litigation has hurt their ability to provide quality care in recent years.
- All respondent groups report increased levels of concern or awareness about the risks of malpractice liability over their career. (p. 8-9)

Anecdotal evidence from my own work in hospital and out-of-hospital settings with a wide variety of care providers has suggested two other points to me:

- 1) The majority of hospital-based care providers have not seen a great number of low- or no-intervention pregnancies and births (in fact, in my experience, some have *never* seen one). This seems to deeply influence their practices and their views of what is “normal” and “to be expected.”
- 2) In a hospital setting, all the backup one could ever need is a pager away. This seems to influence the decision-making of hospital care providers, e.g., the “hands-off” approach (which is typically time-consuming and labor-intensive) is usually more costly than the riskier, interventive approach. Therefore, the interventive approach is usually the norm which seems to cause many more iatrogenic issues. But these issues can be managed quickly and (usually) effectively in the hospital setting, so there is little disincentive to change the approach.

Where does this misinformation (or lack of information) and interventive care leave women postpartum? One three-week postpartum Dar a Luz attendee said,

I just can't let go of the feeling that everything was just being done to me. I went into this thinking that everyone had my best interests at heart and that I should just put myself in the hands of the professionals and everything would be OK. But I don't feel OK. I know I should be happy with my baby who is healthy and everything... but I'm just kind of not. (Kline, 2008)

This is surely not the outcome women are looking for. With all of the information and resources available to women during their pregnancies and births and early parenting, why are such large numbers still receiving misinformation, non-evidence-based care, and a high

incidence of postpartum morbidity? What do they need to claim their pregnancies and births as powerful, transformative experiences?

They need:

- A “one stop shop” of accurate, evidence-based information from a broad range of credible sources.
- Encouragement to explore their own truths and build their *own* best pregnancy, birth and early parenting experiences.
- Time and space to test their shifting beliefs by listening, reading, arguing, etc.
- Unconditional support (e.g., support that is not dependent upon a specific “right” decision).

Dar a Luz Network appears to be filling that need for a certain population of women. A mother of three who attended Dar a Luz Network throughout her third pregnancy said:

I think that’s what all women who go to Dar a Luz meetings - those who are homebirthers or those who chose a planned cesarean - are looking for: information and support so they can make their own best decisions. *And they don’t feel they are getting that information and support from other places in their lives.* (Kline, 2008, p. 8, emphasis added)

Therefore, the first thing these women need is access to a wide range of reliable, evidence-based information. Then, they need time and space to incorporate that information into their existing knowledge-base, weighing it and testing it with their own value systems and life experiences. If they feel supported in this process, they are more likely to access a door into “knowledge makeovers” wherein entire belief systems are challenged and partially or wholly

replaced with new beliefs. Melissa Cheney (2008) calls this a process of “unlearning and relearning” and suggests that it is a crucial element of empowerment (p. 256).

Women also need to be validated for their own innate knowledge. This internal or intuitive knowledge is typically the most overlooked or undervalued by women and by society. During pregnancy, birth and postpartum, women are often more attuned to this type of embodied knowledge than at other times in their lives (Northrup, 2002). There are many ways to refer to this type of knowing. Cheney (2008) reports that “Mothers mentioned multiple forms of, or terms for, concepts like instinct, intuition, and embodied knowledge as a means of describing knowing that was not intellectual, rational, or logical, but more bodily and experiential” (p. 258).

Dr. Sarah Buckley (2002) writes that this

awakening of maternal capabilities is well known among animal researchers, who link it to the action of pregnancy and birth hormones on the brain of newly delivered mothers. Such intuitive capacities are sorely needed in our human culture, where we rely so heavily on outside advice from books and experts to tell us how to care for our babies. (para. 64)

Once a woman has gathered information and internalized it, the next step in the process of empowerment is to put that information into practice: to utilize it by putting it into action. This can be a challenging and even frightening experience for many people. Looking to Cheney again, it is clear that the essential element in turning knowledge into action is support.

Steven Lukes (2005) explores what it means to hold the power in any given situation and outlines three important dimensions of gaining and controlling power. Dar a Luz Network has borrowed from these dimensions in developing their Leader Training protocol and their monthly meetings.

- 1) Decision Making – the power to make and implement decisions.
- 2) Non-Decision Making – the power to set agendas and therefore limit what is even being discussed – certain issues are stopped by the powerful before ever reaching the point where decisions are made (e.g., the powerful can ignore the demands of the weak by delay, avoidance, or masses of bureaucracy or inconclusive inquiries. Issues are avoided that the powerful anticipate will cause opposition).
- 3) Shaping Desires – the power to manipulate what people think they want – powerful groups can make people think they want or consent to something which is actually harmful to their interests (e.g., women accepting patriarchal power). Ideological power is exerted through ideological institutions like the media or religion. (p. 29)

Dar a Luz Network strives to provide every opportunity for women to exercise their own decision-making abilities as per Lukes' first dimension of power. The full opportunity for empowerment intrinsic in this exercise cannot be understood until it has been experienced. Take, for example, a mother of one who attended Dar a Luz Network meetings throughout her pregnancy: "Before I came to DaL, I didn't know that when you're in the hospital, you can refuse things. Now I feel like I have the power! Things won't just be done to me – it's my choice" (Kline, 2008, p. 8).

Dar a Luz Network also strives to minimize the impact of Lukes' second two dimensions of power in two ways:

- 1) By ensuring that leaders and, as much as possible, other attendees, do not either limit discussions (dimension two) or attempt to shape anyone's exploration and truth-defining processes (dimension three).

- 2) By bringing to peoples' consciousness specific areas where the metanarrative is limited or it appears that ideological forces are trying to shape knowledge and desire (dimension three).

This approach appears to be creating opportunities for growth and empowerment within support meetings. A mother of two who attends her local Dar a Luz Network meetings says:

Dar a Luz was supportive of my decisions. I remember specifically there was a vaccination discussion one night. Some people were on one side and others on the other and they got very passionate about their points. I felt like I really saw both sides because both sides were so passionate about it and had done a lot of research, too. But at the end, we were all still talking together over snacks and... it was wonderful. (Kline, 2008, p. 9)

As previously discussed, there are many support groups and childbirth education classes available. Dar a Luz Network differentiates from these groups in three fundamental tenants:

- 1) By setting an organizational goal of facilitating the process of empowerment (rather than the goal of impacting a woman's childbearing experience in a particular way).
- 2) By providing unconditional support to all attendees. *Whatever* choices a woman makes with the information she gathers, she will be completely supported.
- 3) By offering a circle of information, support and social context for all women throughout their childbearing years and beyond.

Unconditional is defined by the Merriam-Webster Online dictionary as "not conditional or limited: absolute, unqualified" (2009). 23 of the 28 women interviewed for the survey (82%) directly cited unconditional support as a determining factor for their interest in and continued involvement with Dar a Luz Network (Kline, 2008, p. 14).

The *Dar a Luz Leader and Participant* survey quotes a mother of one:

Even though there tends to be a similar philosophy with a lot of the women [who attend meetings], which is great and fine, the best thing is that that type of voice is not really heard much in the mainstream. So it allows those women to have a place where they feel heard and understood. But it is just as important to integrate all the voices and have them *all* feel heard and understood. I'm not sure how this organization accomplishes that, but it really does. (Kline, 2008, p. 12)

Another mother of one from the same study says:

I've been to lots of other support groups like LLL, and there's just a vibe about Dar a Luz: less judgment, a little less rigid. And it's ironic, because a lot of the choices people make [within the group] are kind of homogenous, but it still feels totally ok if you are making different choices. An outsider might stereotype a lot of the attendees as sort of crunchy-granola, but it's not a creed you have to follow. It's not exclusionary. And there's a definite sense of that. (p. 12)

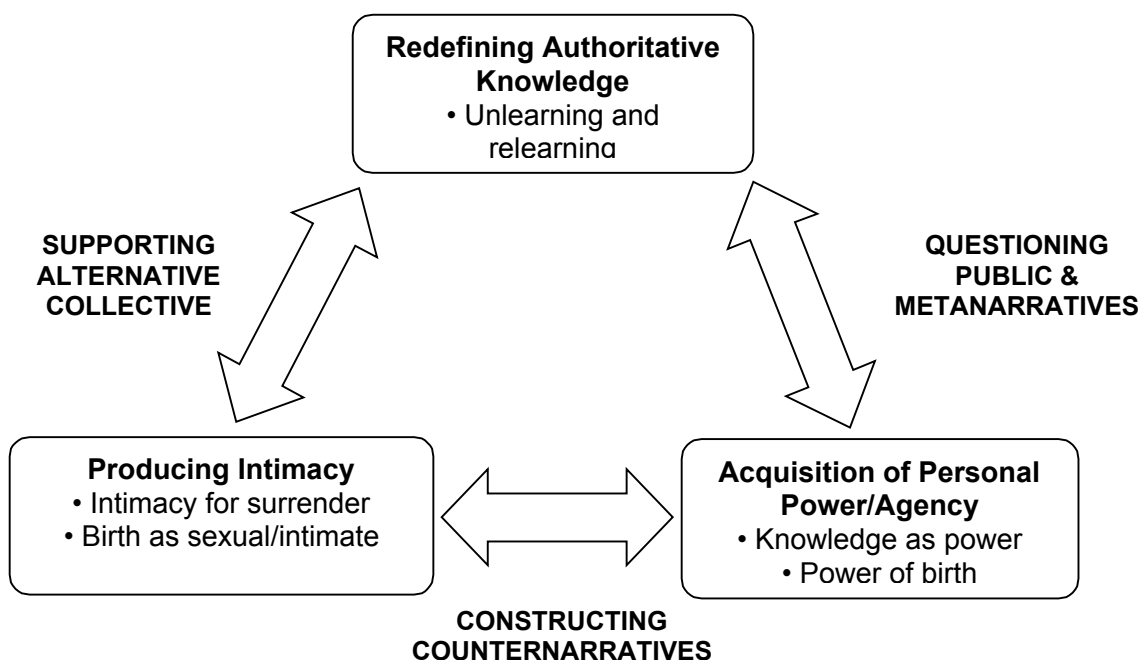
The power intrinsic in gathering knowledge and making that knowledge active may be one reason women stay involved in Dar a Luz Network past the point one might think they should "need" it (e.g., beyond their own childbearing years). Some other possible explanations drawn from the *Dar a Luz Leader and Participant* survey (2008) could include:

- 1) Women are looking for a place where they don't feel judged and continue to seek it out.
- 2) Women are attracted to the wholistic approach of Dar a Luz meetings, e.g., the organization provides information and support for the entire process of pregnancy, postpartum and parenting (rather than an individual needing a separate group for pregnancy, for breastfeeding, for parenting, etc.).

3) Women have experienced a transformation in their own lives, attribute some part of that to Dar a Luz Network, and want to be part of offering that experience to others.

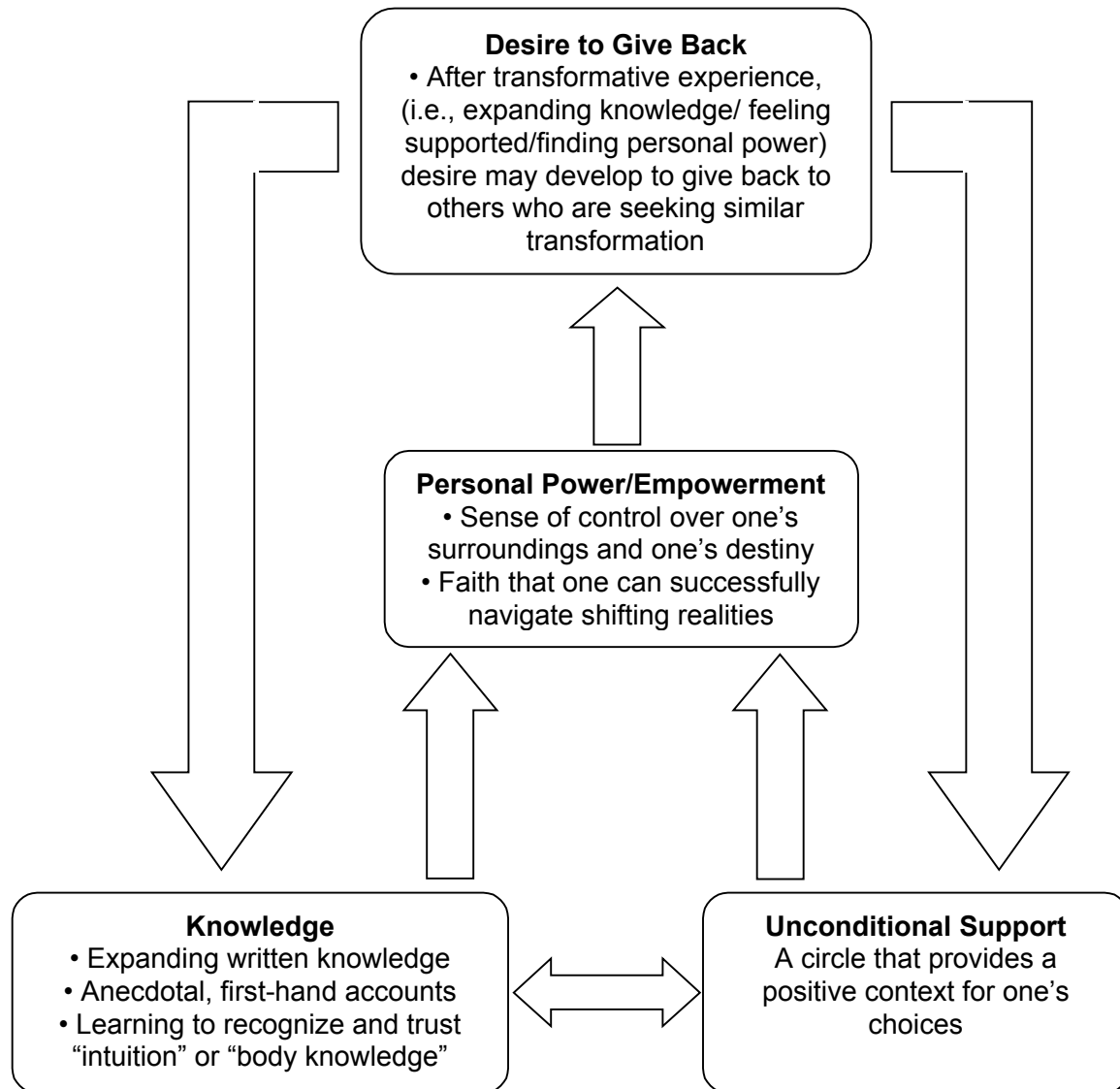
In Figure 1, Cheney (2008) illustrates the structure of knowledge, power and intimacy.

Figure 1
 The Cultivation of Knowledge, Power, and Intimacy in Homebirth
 as Systems-Challenging Praxis (p. 257)
 (Used with permission)



In Figure 2, Cheney’s chart has been modified to reflect what appear to be defining characteristics of Dar a Luz Network including the top tier, “Desire to Give Back.”

Figure 2
The Circular Nature of a Peer-to-Peer Group Offering Knowledge and Unconditional Support



Dar a Luz Network was founded on the life-changing experience of one VBAC mother who found her power through the process of her pregnancy and birth. The organization has been developed with a conscious decision to keep the focus on creating opportunities for empowerment through the process of pregnancy, birth and early parenting. The high level of

information gathering and unconditional support offered at Dar a Luz Network meetings have the potential to powerfully affect women's pregnancies, births and early parenting experiences and fundamentally change the way they live the rest of their lives.

A mother of one who started attending Dar a Luz Network support meetings during her first pregnancy says:

I can't believe how much I have learned and what a direct impact it has had on my whole life, not just my pregnancy and labor. I feel now like I can ask questions about pretty much anything. Because I did it in my pregnancy and labor and it turned out so much better than it would have if I hadn't. So now I'm not afraid to ask questions about *anything* I have questions about. (Kline, 2008, p. 3)

The Dar a Luz Network tenets and philosophies appear to be filling a gap in providing knowledge and support to a certain population of women. At this writing, Dar a Luz Network has grown from its original education and support group in Kettering, Ohio to nine Chapters around the United States and one in Portugal and also has six new Leaders-in-Training who will be joining existing Chapters or opening new Chapters.

Conclusions

There is a strong belief in this country that pain and its management is the single most important factor in determining whether a birth is positive. In reality, a meta-analysis of 49 studies spanning over thirty years and including more than 45,000 women found that “Pain and pain relief do not generally play major roles in satisfaction with the childbirth experience” (Hodnett, 2002, p. 68). What *does* affect a woman’s sense of satisfaction with her birth according to Hodnett (2002) includes: the amount of support she receives, open communication and empathy with caregivers, how involved she feels in making decisions about her own care, and having high expectations for the experience (p. 72).

“The experience of pain during childbirth, together with the experience of strength during childbirth, gives meaning to the transition to motherhood” according to a 1995 Swedish study (Lundgren & Dahlberg, p. 110). Therefore, it is not pain or lack thereof, but a feeling of being *powerful* that determines how women feel about their birthing experiences (and therefore, how positively or negatively their lives are impacted by their birth experience).

Foucault suggested that power is a direct outgrowth of knowledge. That is true as far as it goes. What he does not address, however, is the chasm that lies between acquisition of knowledge and implementation of knowledge (turning knowledge into action). As Cheney suggested, that essential element is support. This support may come from many different sources: another person, an online chat room, a simpatico relationship with an author or, in the case of Dar a Luz Network, from a well-facilitated circle of women.

Two happy side effects often come out of the process of gathering evidence-based information, internalizing that information, and feeling fully supported in putting that information into practice: 1) a feeling of power that affects every aspect of one’s life from

thenceforward, and 2) the desire to help other women experience that same transformative power in their own lives (Kline, 2008).

For a woman to find her own power through her pregnancy and birth, to come into her own as a new mother, she *must* make her own decisions. Nothing is, ultimately, more disempowering than looking back and feeling that one was persuaded or “railroaded” into making a decision – even if the decision was the “right” decision.

With that understanding, Dar a Luz Network was developed with the goal of providing every opportunity for empowerment, rather than the goal of specifically influencing how women navigate their childbearing year. The underlying philosophy is that there is not one right decision for everyone and that a “positive birth experience” does not mean the same thing for every woman: what may be the perfect birth for one woman might be complete anathema for another.

When the negative metanarrative is deeply rooted and powerful figures are successful at spreading fear and confusion about pregnancy, birthing, and early parenting, the process of gathering knowledge, finding unconditional support, and ultimately claiming ones own power is crucial - not only for each individual woman’s health, but for our collective health.

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