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Women's experiences with doula support during first-trimester surgical abortion: A qualitative study

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Abstract

Objective—To explore how doula support influences women's experiences with first-trimester surgical abortion.

Study Design—We conducted semi-structured interviews with women given the option to receive doula support during first-trimester surgical abortion in a clinic that uses local anesthesia and does not routinely allow support people to be present during procedures. Dimensions explored included: (1) reasons women did or did not choose doula support; (2) key aspects of the doula interaction; (3) future directions for doula support in abortion care. Interviews were transcribed and computer-assisted content analysis was performed; salient themes are presented.

Results—Thirty women were interviewed: 19 received and 11 did not receive doula support. Reasons to accept doula support included: (1) wanting companionship during the procedure; (2) being concerned about the procedure. Reasons to decline doula support included (1) a sense of stoicism and desiring privacy; or (2) not wanting to add emotion to this event. Women who received doula support universally reported positive experiences with the verbal and physical techniques used by doulas during the procedure and most women who declined doula support subsequently regretted not having a doula. Many women endorsed additional roles for doulas in abortion care, including addressing informational and emotional needs before and after the procedure.

Conclusion—Women receiving first-trimester surgical abortion in this setting value doula support at the time of the procedure. This intervention has the potential to be further developed to help women address pre- and post-abortion informational and emotional needs.

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Implications—In a setting that does not allow family or friends to be present during the abortion procedure, women highly valued the presence of trained abortion doulas. This study speaks to the importance of providing support to women during abortion care. Developing a volunteer doula service is one approach to addressing this need, especially in clinics that otherwise do not permit support people in the procedure room or for women who do not have a support person and desire one.

Keywords

Abortion; Doula; Full-spectrum doula; support

Introduction

Doulas are lay health workers traditionally trained to support women in labor [1]. During labor and delivery, doulas provide both verbal support (e.g., verbal guidance, relaxation techniques) and physical support (e.g., hand-holding, massage). Doula support is used in 3% of U.S. deliveries and is associated with improved pain management, shorter labor, and decreased cesarean delivery rates [1, 2]. More recently, doula support has expanded to other reproductive contexts, including miscarriage, adoption, and abortion. The use of doulas in abortion care has only recently been studied [3].

During surgical abortion, doulas adapt techniques used in labor and delivery [3, 4]. Doula support may be especially relevant to women presenting for first trimester surgical abortion, as many receive local anesthesia and are awake during the procedure [5]. A randomized controlled trial conducted in a clinic that uses local anesthesia and that does not routinely allow support people to be present during procedures found that, though doula support did not improve pain or satisfaction with first-trimester surgical abortion, 96% of women who received doula support recommended that it be routinely offered and 72% of women who did not receive doula support would have liked to have it [3]. Despite negative findings, therefore, women did value doula support. This qualitative study explores why women in this clinic endorsed doula support, despite not experiencing measurable improvements in pain or satisfaction.

Materials and Methods

This study took place in a high-volume, urban, first-trimester surgical abortion clinic between May and July 2014. The clinic has incorporated doulas into first-trimester abortion care. Doulas in this setting have completed a two-day training session, undergone proctoring, and have been deemed ready to function independently in the clinic [3]. Doula training consisted of a two-day course conducted by a family planning fellowship-trained obstetrician-gynecologist (JC) and two doula trainers with 5 years of combined doula experience. Trainees participated in lectures, group discussions, and role-playing on topics including: medical and psychosocial aspects of abortion, values clarification, pregnancy options counseling, team building, and doula techniques. Prior to functioning independently, one of two doula trainers observed trainees to assess their competency in: providing verbal support, using physical techniques, and working well with other clinic staff members. Five

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doulas provided support in the clinic during the study period, with a range of three months to five years of practice in providing abortion doula support. Their role includes: meeting women immediately prior to the procedure, providing support during the procedure, and escorting women to recovery after the procedure. During the procedure, doulas engage in verbal coaching, handholding, massage, breathing guidance, and relaxation techniques.

The clinic typically performs 15 to 30 first trimester surgical abortions per daily clinic session. Standard clinic procedures include providing women with 400 mcg of buccal misoprostol and 800 mg of ibuprofen 30 minutes prior to first trimester surgical procedures. Providers routinely perform procedures with a paracervical block consisting of 1% lidocaine, though the use of a paracervical block is left to the discretion of the individual provider. At least one physician, one surgical assistant, and one ultrasound technician are present during procedures. Family members or support persons other than doulas are generally not allowed to be present during procedures. Doulas in the clinic are volunteers and are present as their individual schedules permit. On days when doulas are available, women have the opportunity to accept or decline a doula. On days that doulas are not available, additional staff members are available to come to the room to provide additional support when needed. These staff members have not undergone formal doula training.

Women were recruited for study participation after completing clinic intake procedures and abortion consent. Inclusion criteria included: age ≥ 18 years; gestational age ≤ 13 6/7 weeks; desiring pregnancy termination, and; able to provide informed consent. Research staff asked eligible women to provide consent to be contacted by phone for participation in a telephone interview. Research staff employed purposive sampling to invite eligible women to participate in interviews based on: age, level of education, marital status, gestational age, termination history, and having requested or declined doula support. Research staff contacted women within two weeks post-procedure to explain the nature of the study and obtained oral consent. While we determined an *a priori* sample size of thirty participants, the study team determined the final sample size based on thematic saturation, at which point further data was not expected to reveal additional themes.

Women completed a short background survey prior to participating in a semi-structured interview exploring a range of themes related to how the presence or absence of doula support shaped their abortion experience. Interviews were digitally recorded, transcribed, and de-identified prior to analysis. Research participants received $25 gift cards in compensation for their time. All study procedures were approved by the Institutional Review Boards at the John H. Stroger Jr. Hospital and the University of Chicago.

Analysis used a modified template approach [6]. The lead investigator developed a preliminary code directory, using themes derived from the interview guide and from interview transcripts. Research team members modified the code directory in an iterative process with continued readings of the data. Two researchers (JC and PL) then independently coded five transcripts, achieving inter-rater reliability of 84.5%. All transcripts were subsequently coded using Atlas.ti® Version 7 (Berlin) qualitative analysis software. Two researchers independently reviewed code queries and met to discuss and interpret key findings. Disagreement regarding data analysis was resolved through

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discussion. This analysis presents salient themes regarding: reasons for requesting or declining doula support; key aspects of the doula interaction; and ideas for additional roles for doulas in abortion care.

Results

Study recruitment and demographics

During the study period, 1144 women aged 18 years or older obtained a first trimester surgical abortion. Anticipating potential challenges in reaching participants by phone, we approached 191 women over ten clinic sessions to obtain consent to be contact for phone interviews. A total of 144 women provided consent to be contacted by phone: 36 declined to provide consent and 11 did not meet eligibility criteria. We completed interviews with thirty women, at which point the interviews reached thematic saturation: 19 participants received doula support and 11 participants did not. Table 1 presents demographic data for both study participants and clinic patients during the study period. The clinic does not routinely collect data regarding whether or not a doula is present during abortion procedures. However, 95 (66%) of the women who consented to be contacted indicated that they desired a doula present during their procedure.

Reasons women chose or declined doula support

Women discussed a number of factors that informed their decision whether to accept doula support. Salient themes concerning reasons to accept doula support included wanting companionship during the procedure and being concerned about the procedure. Prominent themes regarding women's choice to decline doula support included a sense of stoicism, desiring privacy, and not wanting to add emotion to this event. Among the few women that knew of doula support, those who opted for doula support did so due to a positive perception of doula care; those who declined doula support did so due to a belief that doulas did not belong in abortion care.

Many women were motivated to request doula support for companionship. For some women, doula support complemented the presence of social support for the abortion decision. Women who had support from family or friends for their abortion decision requested doula support as family and friends could not be present during the abortion. "I was excited . . . because they told me parents couldn't go in the room with me . . . I'm used to doing stuff like this . . . shots, surgeries, with my parents." For other women, doula support compensated for the absence of social support for the abortion decision. One woman whose partner did not support her decision stated, " . . . you feel more comfortable if you have someone there, especially when the man that did all this to you, you know it takes two, and he . . . has no support." In several cases, the choice to request a doula reflected women's concerns about the procedure itself. Some chose doula support to allay fears about pain and perceived risks of abortion. "To feel comfortable, to feel safe, to feel protected in some way, because . . . I felt scared."

Women who declined doula support largely felt it to be unnecessary, out of a sense of stoicism or due to privacy concerns. These women reflected such stoicism through

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statements of resignation that the abortion would be a difficult experience. “I just knew it was going to be hard regardless, even if like I had someone there, or if I didn’t.” Women also projected a sense of stoicism through their expressed desire for emotional distance. “I just didn’t want anybody to be there to pamper me or to hold my hand. . . I just wanted to get it over with . . . I needed to be strong and I needed to not be so emotionally attached, maybe because I was detaching myself from a baby.” Other women felt an additional person would impinge on their privacy. “I guess because of privacy questions . . . I was like, ‘A total stranger?’ . . . I just wanted to do it on my own . . .” Though many were satisfied with their clinic experience, some who declined doula support expressed regret about not having a doula.

Although most (n=20) were unfamiliar with doulas and none of the participants had ever had doula support during a previous pregnancy, women who had heard of doulas in the birth setting differed in their opinions regarding doula’s place in abortion care. Some women responded enthusiastically to doula support based on prior personal experiences or media exposure to birth doulas. One participant explained, “when I was pregnant that’s how I heard about it . . . they rub your back if you need it, they help you breath and help you . . .” Others felt that doulas were incompatible with the abortion setting. One woman explained, “ I think that a doula is the person that would be there during like a labor . . . But in a procedure that I had, it was ending a life. And I don’t think I needed a doula there to support me through that.”

Key aspects of doula interaction

Women who received doula support universally reported positive experiences with the verbal and physical techniques used by doulas. Women likened doulas to nurturers, mentors, and family members. “It made me feel like someone . . . cared, like they not just . . .here just to do the job . . . I felt like [I] had support from my mother.” While several women compared doulas to loved ones, a few women explained that the anonymity of doula support created a welcomed safe space in which to experience the abortion. One woman described, “ . . . someone there that I do know is worse than someone that I don’t know . . . people that knows you or think they have the right opinion of you, they want to judge you . . . the lady in the room . . . she wasn’t there to judge.”

Many women valued the use of verbal support to distract and ease the burden of the procedure. Verbal support consisted of guiding women through breathing exercises, providing continuous reassurance, and engaging in conversation about a myriad of topics. One woman explained, “ . . . listening to her talk, took my mind off of the pain. . . when she [was] sitting there talking to me . . . I wasn’t thinking about the pain, I was just listening to what she was telling me to do and I was doing it.”

Women praised doulas’ provision of physical support, such as handholding and massage, which provided women with a greater sense of comfort and safety during their procedures. One woman explained, “ . . . she grabbed both of my hands . . . she rubbed my hands . . . she was like really close to me, like pretty much side to side. . . she was really like, just soothing. . .” Small physical gestures made women feel cared for during the procedure.

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"She . . . petted my hair with . . . cold towels, cause I was sweating and throwing up. . . she did something special for me."

Opinions of expanding doula support in abortion care

The vast majority of women responded positively when asked whether doulas might play additional roles during the abortion visit. Women regarded potential pre-procedure interactions with doulas as an opportunity to address emotional needs, further clarify the procedure, and connect prior to the procedure. One woman remarked, "I started getting a bunch of encouragement during the procedure, and I would like that before the procedure." Several women indicated that they would have appreciated speaking to doulas about what to expect during the procedure, as they perceived doulas to be trustworthy, relatable, and knowledgeable about abortion. "I feel like she would probably know about . . . what would go on during an abortion. I would probably talk to her over my doctor, more about you know abortions since that's like their specialty." Some stated that meeting the doula in advance would have enhanced the support provided during the abortion. "I probably would have felt more comfortable because we experienced . . . a conversation, and she had took the time out to meet me before the procedure . . ."

Women perceived the possibility of having post-abortion discussions with doulas as an opportunity to explore specific health-related topics and receive additional emotional support. Some women recognized a potential role for doulas as health educators and were interested in speaking with them about reproductive health topics, ". . . I think a doula . . . could like have a class about teaching young women how to go about getting all health insurance, and teaching them about condoms." Other women would have liked to build on the connection formed during the abortion to discuss persistent psychosocial concerns. " . . . the doula seems like an emotional being, and it seems like somebody who is very comforting. . . if I needed to talk with someone, then a doula would probably be my first choice than a counselor. . . they're more emotionally attached than a counselor would be." A few women were not interested in post-abortion doula support, feeling that doulas lacked medical expertise or that they wanted to "move on".

Discussion

Doula support at the time of abortion is a relatively new concept. Whereas a large body of evidence demonstrates benefits of doula support during labor and delivery, research is lacking on the impact of doula support during abortion. This paper elucidates some of the ways doulas support women during abortions. Doulas provided company for women, who felt cared for, pleasantly distracted, and soothed. While women did not perceive doula support as a solution to physical discomfort during abortion, they consistently described ways in which doulas helped them cope with their discomfort through the use of verbal reassurance and physical contact.

Perhaps because of the personal connection between women and doulas, many women favored an expanded role for doulas to address informational and emotional needs before and after the procedure. Based on their interactions during the abortion, women attributed to doulas varying degrees of reproductive health expertise. In addition, some women also

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perceived that doulas have personal qualities that make them more accessible than physicians. Women also had notable reasons for not wanting doula support or for not appreciating an expanded role for doulas. Some women wanted privacy or felt they did not merit support given that it was an abortion and not a birth. These women had pre-existing connotations with doulas and felt that they were antithetical to the abortion setting. Similarly, while many women enthusiastically suggested that doulas provide additional abortion counseling or offer further health education, some women were not interested in greater interactions with doulas, trusting a trained provider instead.

This study has several limitations. As we used purposeful sampling to invite women to participate in interviews, we were unable to determine the prevalence of interest in receiving doula support among women presenting for surgical abortion. The allowance of a two-week window of time to reach study participants by phone also allows for the possibility of recall bias during the interviews. While most women in this clinic receive a paracervical block for pain management, the decision to use a block is left to the discretion of the provider. As we did not collect data regarding whether or not participants received a paracervical block, we are not able to determine how the use of a local anesthesia may have influenced women's experiences during the abortion. Additionally, as study participants were primarily low-income women of color, findings may not be generalizable to all women. This study took place in a high-volume clinic in which different staff members perform each of the preoperative steps. In this setting, women are awake during procedures and have a limited opportunity to build patient-provider rapport. Importantly, women are not routinely allowed to have a support person other than a doula present during the procedure. Therefore, we were unable to elucidate the benefits afforded by trained abortion doulas compared to other support people during surgical abortion. While women valued doula support in this model of care, findings might differ in other settings where women are permitted to have family or friends present during their procedure.

Despite these limitations, this study underscores the importance of providing women support during their abortion experience. Developing a volunteer doula service is one approach to providing this needed support, especially for women who lack a support person, in low-resources settings with limited staffing, and in settings that otherwise do not permit family or friends to be present during the procedure. This study has important implications for abortion providers and clinics that may be considering introducing doula support into their practice. Although many women were receptive to the term "doula", a minority of women rejected this term due to associations with childbirth. These responses highlight the importance of further vetting the term doula, clarifying the role that doulas play during abortion, and distinguishing doulas from other staff members. By adapting skills and practices from the labor and delivery setting, doulas addressed certain emotional and physical needs that, for some women, may not be fully addressed in fast-paced, high-volume abortion settings.

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Table 1

Socio-demographic and obsteric history factors for interview participants and all first-trimester surgical abortion patients ≥18 years of age during the study period.

	Interview participants n=30	Surgical abortion patients ≥18 years of age May-July 2014 n=1144
Age (years)		
18–25	18 (60)	668 (58.4)
26–35	10 (33.3)	406 (35.5)
≥36	2(6.7)	70 (6.1)
Education		
≤High School	15 (50)	644 (59.3)
≥Some College	15 (50)	500 (43.7)
Gestational age		
≤9 0/7 weeks	17 (56.7)	626 (54.7)
9 1/7 weeks to 13 6/7 weeks	13 (43.3)	518 (45.3)
Prior surgical abortion*		
Yes	20 (66.7)	556 (49.3)
No	10 (33.2)	572 (50.7)
Race Ethnicity		
African American	29 (96.7)	994 (86.9)
Hispanic/Latina	1 (3.3)	118 (10.3)
White	0(0)	19 (1.7)
Other**	0(0)	13 (1.1)
Gravidity (median, range)*	2(1–10)	3 (1–13)
Parity (median, range)*	1(0–7)	1 (0–12)
Prior vaginal deliveries (median, range)*	1(0–6)	1 (0–12)
Number of prior cesarean deliveries (median, range)*	0 (0–3)	0 (0–4)
Number of prior induced abortion (median, range)*	2 (0–5)	1 (0–9)
Number of prior spontaneous abortion (median, range)*	0 (0–2)	0 (0–7)
Prior epidural***		
Yes	16 (53.3)	- -
No	14 (46.7)	
Ever heard of doula ***		
Yes	10 (33.3)	- -
No	20 (66.7)	
Requested doula***		
Yes	21 (70.0)	- -
No	9 (30.0)	
Received doula***		
Yes	19 (63.3)	- -
No	11 (36.7)	

Data, are n (column%) unless otherwise specified.

* Data missing for following: 16 for history of prior surgical abortion; 23 for gravidity; 1 for parity; 20 for number of prior vaginal deliveries, cesarean deliveries, and spontaneous abortions; 2 for prior induced abortions.

** Other includes Asian, Native Hawaiian/Pacific Islander, American Indian/Alaskan Native, and Other.

*** Data not routinely collected for clinic patients.

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