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Virginia Commonwealth University Volunteer Doula Program Training Manual

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Virginia Commonwealth University
Volunteer Doula Program

Training Manual

“Empowerment, advocacy and support
for one of life’s greatest journeys.”

Reflection and Discussion

- ❖ *Why are you here?*
- ❖ *Why did you decide to do this doula training?*
- ❖ *What experiences do you have with birth, and how have they shaped your desire to participate in this program?*
- ❖ *What does it mean to be a doula with the VCU School of Nursing?*
- ❖ *What other reflections do you have?*



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This curriculum is dedicated to all of the determined, beautiful mothers who shared their most intimate and proud moments with us as doulas and nurses. We are forever grateful for this honor and hope that by continuing our work, we are giving other mothers and families the same opportunities to grow and thrive through positive birth experiences.

Chapter 1: An overview of birth: Statistics and trends

Who are we and what do we do?

A doula is a woman who cares for a pregnant and laboring woman. In serving, doulas help expectant women learn about their pregnancy, their changing body, and their impending birth. Topics of education often include non-pharmacologic management of pain in labor, achieving optimal emotional and spiritual health during pregnancy, breastfeeding education, and garnering postpartum support for the woman and her family.²³

As you research birth statistics for Virginia, what do organizations such as the Virginia Department of Health and the March of Dimes say about these statistics?

If you ask many women who have experienced childbirth, they will tell you that their experience ran a full gamut of emotions. People may describe their birth with positive language such as “joyful”, “amazing”, “empowering”, “magical” and “perfect.” Other women, however, have a different experience. Due to medical or psychosocial complications or deviation from their birth plan, some women use words such as “terrifying”, “upsetting”, “disappointing”, “painful”, and “horrible.” As women’s health care providers, we certainly don’t wish the later on our patients. We want them to emerge from their birth experience with feelings of accomplishment and empowerment, no matter the route of delivery, the type of anesthesia, or the feeding wishes of the mother for her newborn child.

A doula is in such a powerful and wonderful position to assist women and childbearing families during their labor and birth journey. As you read further, you will see why your participation in this program plays a significant role in the health of the mother and her newborn, but more importantly, how it will serve to enact change in the culture of birth in Richmond, Virginia.

Scope of the Problem

An analysis of data specific to the state of Virginia demonstrates a caesarean section (c-section) rate of 34.5% in 2010 as reported by the March of Dimes²⁰. The United States c-section rate was 32.8% in 2011.^{9,19} In addition to c-section data, only 15.8% of infants are exclusively breastfeeding at six months of age in Virginia.⁴ This breastfeeding data is not meeting benchmarks set forth by Healthy People 2020.²⁸

One answer to bettering birth data in our country and specifically in Virginia lies with doulas. Doula services can be expensive, however. Average support “just”

for a labor can range from \$300-\$1,000 depending on geographic location, and the experience level of the doula.²⁷ Another confounding variable is that lower socioeconomic status (SES) women are often disproportionately affected by high risk pregnancies.⁹ Additionally, low SES and women experiencing high risk pregnancy are at greater risk for postpartum depression, or PPD.¹⁶ With increasing risk, rates of cesarean section and intervention during labor and birth rise. High risk obstetric clients can thus benefit greatly from the services and education doulas provide.

The Answer

Virginia Commonwealth University School of Nursing (VCU SON) is fortunate to have a compassionate and motivated cohort of students and student volunteers who want to improve prenatal care and birth outcomes for low socioeconomic status women. The first clinical cohort of student doulas began with eight nursing students serving four mothers and their families in January, 2011. Through discussions with certified nurse midwives (CNM) at the Virginia Commonwealth University Health System (VCUHS), and other vested community partners, it was discovered that the need for doula support was greater. Nursing students throughout the school became excited and interested in the doula program. A volunteer group was formed and these nursing students enrolled in the same training as the nursing students in the clinical group. The students continue to support laboring mothers in the Richmond community. Many deliver at the VCUHS, but may also deliver at other Richmond area hospitals.

The program was modeled off of a “birth companions” program which was started at The Johns Hopkins University in 1999.²³ Volunteer students functioned as doulas to identified women in the Maryland community, and provided non-pharmacologic pain relief and psychosocial support during labor and childbirth. Final analysis of their data suggest that, “...as birth companions provide more interventions to their clients, the risk of epidural use and cesarean birth goes down, particularly when additional physical interventions are incorporated” (Paterno, Van Zandt, Murphy & Jordan, 2011, p. 33). What a fantastic impact! Students in the VCU group have also had similar experiences, and we are quite proud of their accomplishments thus far.

As a doula serving mothers on their labor journey, there are tenets surrounding women’s health care that should guide your practice and your decision making.

1. Promote *safety* and *maternal/child wellbeing* above all else.
2. Offer non-biased, truthful, evidence based information so that the mother and her partner may make an *informed decision*.
3. Meet the mother and her partner where *they are* on their birth journey.
4. Advocate for your *patient's* wishes and desires, not what *you* believe to be her best option or best birth.
5. If the mother is happy, it was a “good birth.”

It is our hope that at the conclusion of this training, you will have a framework with which to better enact these tenets of your practice as a volunteer doula. By empowering and educating women and their families, we can strive to eliminate disparities in birth among families in Richmond, Virginia. You are playing a tremendous role. Thank you for your enthusiasm and dedication.

Chapter 2: Birth Workers and Their Roles

In our society, there are many ways to enter into nursing, medicine and midwifery. Women may experience confusion when trying to decipher ones title, education and preparation. There are vast differences in the types of providers who work in birth and with childbearing families. This chapter will serve as an introduction to the types of people with whom you may interact during your time as a doula.

Medical Doctor (MD)

Medical doctors are individuals who have a doctoral degree; they attended four years of medical school and an additional four years of residency in obstetrics and gynecology. If you are attending a birth at the VCUHS, you will work with resident and attending physicians. Resident physicians are, in fact, licensed medical providers; it is a misnomer that they are “not real doctors.” They have not, however, passed board certification exams, and this is why they are in residency building up their body of knowledge prior to sitting for this examination. They will be responsible for admitting patients, managing antepartum, intrapartum and postpartum care, and delivering babies vaginally or by cesarean section (c-section). Other specialty services as they relate to obstetrics include the placement of a cerclage, diagnostic ultrasound, and in-utero testing such as amniocentesis.

Attending physicians, however, are board certified in obstetrics and gynecology. They are in charge of the labor and delivery unit at a hospital 24-7, and also supervise the residents. Some of the attending MDs with whom you will interact also went on to complete fellowship training in a specialty area; the most germane to labor and delivery is the fellowship in maternal fetal medicine, or MFM. They also have full admission and discharge privileges, and can manage care throughout the pregnancy, labor and birth. They can also deliver patients vaginally or by c-section.

Certified Nurse Midwife (CNM)

The CNM is a graduate prepared RN who holds a bachelor of science in nursing (BSN) degree. While completing their graduate studies, these nurses study under other CNMs and/or advanced practice RNs (such as nurse practitioners). Upon completion of their program, they are granted a masters degree. They may practice in all 50 states, DC and US territories.² As you will see in your doula work, midwives can also attend births in the hospital; however, they cannot perform a c-section. CNMs are also highly trained in antepartum and postpartum care, and will round on their own patients postpartum and arrange for their post-hospital care.² Midwives hold the view that birth is a non-pathologic, normal life event. As such,

they tend to advocate for non-interventional labor and birth, and the natural onset and progression of labor. The important thing to remember is that this does not make midwives “anti-intervention” or “anti-doctor.” When needed, midwives can and will employ interventions such as artificial rupture of membranes (AROM), pitocin augmentation and epidural anesthesia if it ensures the mother’s comfort and achieves the goal of a healthy mom and healthy baby.² Finally, it is important to distinguish that the CNM does not work *under* the physician, but rather, beside and autonomously. While MDs are available for consultation and collaboration, midwives will manage their patients independently and fully within scope of practice during their labor and birth.²

Certified Midwife and Certified Professional Midwives

While you will not be engaged with either of these types of midwives, it is prudent to offer a brief discussion of them and their roles, so that you can distinguish them from CNMs and MDs. The certified midwife, or CM differs from the CNM in that (as the name suggests), the CM does *not* hold a nursing degree or license. They have a bachelor’s degree, but it is not in nursing.² They train the same ways a CNM does, and also take a licensure examination to be able to practice upon graduation. Similar to the CNM, the CM is awarded a masters degree upon graduation, and they are licensed to practice in New Jersey, New York and Rhode Island.²

Certified Professional Midwives, or CPMs are regulated in a different way, and are similar to CNMs or CMs. Individuals seeking this pathway to midwifery can educate themselves via a portfolio evaluation process or an accredited, “formal education process.” (ACNM, 2011) CPMs have various methods of recognition in the states in which they practice; they are currently able to practice in 26 states in the US and are regulated by the Boards of Medicine in Virginia.²

Women's Health Nurse Practitioner

The women's health nurse practitioner or WHNP is an advanced practice RN who holds a BS in nursing and has obtained a master's degree through advanced study. Trained to care for women across the lifespan, the WHNP focuses on obstetric and gynecologic care.²² The WHNP may admit patients to labor and delivery and discharge them from the postpartum service. However, the WHNP does not attend deliveries. Many WHNPs function in an outpatient setting, but some do practice in the hospital, and you may see them during your work with patients.²² There are also graduate programs available which combine the WHNP and the CNM degrees to make these practitioners more versatile and marketable.

International Board Certified Lactation Consultant

The IBCLC is an individual trained to offer counseling and guidance to breastfeeding women. While it is the responsibility of the RN and the doula to help a mother first latch her baby, the IBCLC can be particularly helpful if there are problems with breastfeeding including, but not limited to:

- Poor/weak latch
- Problems of prematurity
- Insufficient supply
- Breastfeeding after breast augmentation/reduction
- Special needs in the breastfeeding infant (i.e., structural deformities of the tongue and palate.)

All IBCLCs at the VCUHS are RNs, and many hold a masters degree. They will make rounds on all mothers postpartum, but are also available for consultation.^{14,15}

More information on the IBCLC role may be found at their professional website, <http://www.iblce.org>.

The Doula

The doula plays such an integral and important role in the mother's labor and birth! Doulas function solely as a support and an advocate for the mother and her significant other. They are not medical professionals, nor are they acting in a "medical" role when they are in the hospital. It is not their job to provide medical assessment (i.e., determination of cervical dilation, pitocin titration, etc.), but rather, to act as an emotional and psychological support to the mother while she is

<http://bfconsortium.org>

*A free, breastfeeding education and advocacy CEUs! These modules are valuable and wonderful; take advantage!

<http://www.vabreastfeeding.org>

laboring.⁷ Through knowledge of non-pharmacologic and pharmacologic pain management techniques and therapeutic communication, the doula helps the mother and her partner advocate for *their* desired birth.⁸ Doulas work in conjunction with all birth providers in settings such as hospitals (where you will practice), birth centers and homebirth settings.

The types of families doulas assist vary greatly, too. You may see single mothers, married women, lesbian women, and women who are acting as gestational carriers or “surrogates” for a couple unable to carry their own child. Each family is different, and even within subgroups, there is great variability. Approach each family with the same respect, acceptance and enthusiasm you would any other. If you find that you have personal beliefs or intrapersonal conflicts which would preclude you from working with one of our families, please discuss those feelings and thoughts with a faculty member. We would much rather you communicate honestly, then be in a situation where you cannot give total dedication and support to a mother and her family or support system.

Many doulas chose to obtain specialty certification from a regulating body such as Doulas of North America, or DONA. In order to use the title “certified doula”, these persons must meet rigorous standards including required training, readings and analysis of findings, and attend a specific number of births and provide a specific number of hours of labor support.^{7,8}

More information on doulas and certification may be found at

<http://www.dona.org> and
<http://www.tolabor.com>.

It is important to note that this training does *not* meet national requirements for certification as a doula; therefore, you may *not* use the title “certified doula”, or CD in your communications.

Chapter 3: You are a doula! Your birth-bag and preparation

After you have taken the doula training, you will be able to sign up to assist a mother through her birth. How exciting!

Expectant mothers and their contact information are housed in the google drive document in the “VCU Student Doulas” website. You have to request access to this list by e-mailing the supervising faculty. Once you have access, you may pick a mother to doula! Please consider their due date, your schedule and other conflicting factors which could preclude your ability to really work with this mother and (hopefully!) attend her birth. While we can’t control all facets of life, please don’t pick a mother with a due date that has obvious conflicts for you (i.e., you will be out of town, etc.)

Once you have selected a mother, make contact with her. There is a place for you to note in the google drive spreadsheet that you have done this. You can try to make contact 2-3 times. If after that you still don’t have a response, then we will mark that on the spreadsheet and we will assume that this mother doesn’t wish to have doula support anymore.

Many of you may be nervous about establishing this initial contact. It’s okay to feel this way! Ways that you can alleviate that nervousness are to suggest a mutual meeting place (i.e., at MCV after an appointment), and a convenient time for both of you. **Remember: for safety and security reasons, we cannot have you meet the mother in her home.**

You will have two meetings with your mother. At the first meeting, it is a good idea to discuss

- The birth plan
- The service agreement
- Expectations and initial thoughts about labor and birth
- The pre-birth survey

At the second visit, you can continue to make sure that mom is on track to achieve her goals as specified in the birth plan. You can also begin to discuss how the labor and birth process will unfold. Ideas of topics to discuss include:

- Who will be with her at the birth
- Any updates from her provider (i.e., induction, planned c-section)

After the birth, you will be helping the mother fill out the post-birth survey. This is a survey which talks about her thoughts/feelings about her birth and the amazing doula support she had during the pregnancy and birth.

Research at the School of Nursing

It is important to understand that the doula project was funded through the incredibly generous support of the Clinical Nurse Scholars program. This is a \$15,000 grant donated by alumni. The grant has the potential to renew annually for three cycles, and as such, we are conducting research to evaluate the impact this program has on expectant mothers and their families.

Your expectant mother has the option to consent to participate in this research.

The research consists of filling out the pre- and post-birth survey, and the Edinburgh Postnatal Depression Scale.

If the mother decides to consent to participate in our research, she will need to sign an informed consent form. This is included in the service agreement that the mother must fill out when you agree to be her doula and she agrees to participate in the program. More details about this will be delivered during the training. Key points to remember include:

1. There is NO change to her plan of care or who she sees for prenatal care based on her decision to participate or not.
2. There is NO financial compensation for participating.
3. All mothers who have a VCU doula receive a “gift bag” this is not only an incentive for mothers who participate.
4. If they decide later (after consenting to participate) that they do not wish to participate any longer, they may withdraw their consent without penalty; we will still doula them!

Your Birth Bag

It is so important to have a well-stocked birth bag when you go to attend a labor and birth. You may be there for 30 minutes, you may be there for hours, and you may be there for 24 hours! Being well prepared helps keep you focused and refreshed, and shows the mom that you thought about her comfort *before* coming to the hospital. Some ideas for things you can put in your birth bag are:

Administrative

- ❖ Copies of mom's birth plan
- ❖ Pens and notepaper so you can jot down key events and a birth timeline
- ❖ Business cards

Food and energy for **you**

- ❖ Granola/cliff/Luna bars
- ❖ Chocolate
- ❖ Massagers (for example, tennis balls)
- ❖ Bottled water or vitamin water

Helpful supplies for **you**

- ❖ Wallet and change purse (vending machines!)
- ❖ ATM card
- ❖ Water bottle
- ❖ Caffeinated beverages (good for you and tiring support people!)
 - Starbucks "to go" or some sodas
- ❖ Cell phone and charger
- ❖ Chapstick
- ❖ Hand lotion
- ❖ Hand sanitizer
- ❖ Mini first aid kit
- ❖ Toothbrush/toothpaste
- ❖ Contact lens fluid/eye glasses
- ❖ Deodorant
- ❖ Feminine hygiene products
- ❖ Camera (good to have a backup in case the family's doesn't work)
- ❖ Change of clothes

Helpful supplies

- ❖ Ziplock bags in all sizes (good for clothes that get wet, instant ice packs, etc.)
- ❖ Flashlight (small one on your keychain)
- ❖ Small trinkets for mom and baby (i.e., little toys for baby, gold medals for mom) 😊

Helpful energy boosts for mom

- ❖ Peppermints
- ❖ Lollipops (The "Yummy Earth" brand has no HFCS)
- ❖ Chewing gum

- ❖ Spray bottle to mist mom if she's very hot and tired
- ❖ Hand held fans

Toiletries/ADLs

- ❖ Colgate "wisps" or "Brush on the go" (very helpful if mom is nauseated and can't actually brush or teeth or get up to the bathroom)
- ❖ Hairbands/elastics/barrettes for mom
- ❖ Chapstick for mom (lips get dried out with all that paced breathing!)
- ❖ Hand held mirror

Natural Labor Support

- ❖ Rebozo
- ❖ Rice sock
- ❖ iPod and headphones (most moms will bring this on their own)

"Thank yous" for the staff

- ❖ Cookies
- ❖ Lotion
- ❖ *Anything you can think of!*

Chapter 4: Anatomy and Physiology of Birth

The healthy, functional female body is meticulously designed to support healthy pregnancy and birth. An intricate system of bony structures, muscles, ligaments and aid from hormonal mediation (discussed in the next chapter) all help support the pregnancy and initiate labor. While not intended to be all inclusive, nor a review of gross anatomy, the following chapter will review key structures and their function in the normal labor process.

Recall from anatomy courses that the pelvis is comprised of “...four bones: two innominate bones, the sacrum, and the coccyx” (Hughes, Steele and Leclaire, 2006). These bones give rise to the shape and structure of the pelvis; this is the most important determinate of the feasibility of vaginal delivery.²⁴ When women remark that their babies “didn’t fit” or “got stuck” during any stage of labor, they are referring to cephalopelvic disproportion (CPD), or the inability of the pelvis to allow vaginal birth. This may be to structural deformity (from birth defect or trauma), or the size of the fetus. When a provider preforms a vaginal exam, they will note the station of the fetal head. This is the relation of the fetal head to the ischial spines.¹⁸

The four types of pelvises are noted in the following chart, taken from the text *Women’s Gynecologic Health*.²⁵ The gynecoid pelvis is the most commonly seen; approximately 50% of women have a pelvis of this type.^{18,25} Provided as a reference only, it is important to note that pelvic measurements are no longer routinely obtained on pregnant women because of the risk to the fetus from exposure to radiologic imaging.¹⁸

Women may fret that their pelvis isn’t “big enough”; rumors and inaccuracies about CPD abound. Women may cite their race, family history, or wives’ tales as to why they feel they won’t be able to birth their baby vaginally. It is important to reassure the woman that there are many types of pelvises, and chances are she has made a baby which her body can birth. Additionally as noted by authors Battista and Wing, “***CPD cannot be accurately predicted***” (as cited in Lowdermilk, Perry, Cashion & Alden, 2012, p. 794). Therefore, help the mother to focus on positive affirmations of her abilities to birth, and not on subjective measurements.^{18,24}

While bony structures are certainly important, there are many other structures which work together to achieve a vaginal birth. Powerful pelvic muscles help to coordinate the fetus’ descent through the pelvis with its final expulsion via the vagina. While a detailed review of perineal musculature is beyond the scope of

doula practice and this training, it is worth discussing two main groups of muscles instrumental in childbirth.

1. The transverse perineal muscles
2. The “pelvic floor” muscles

The table below discusses the composition and function of these groups.

Female Pelvic Floor Musculature²⁵

Group	Composition	Function
Bulbocavernosus muscles	-- (single group)	Allow for constriction of the introitus
Transverse perineal muscles	Transverse perineal Bulbospongiosus Ischiocavernosus	Support anal canal Support pelvic viscera Support lower vagina during birth
Pelvic Floor	Levator ani Coccygeus muscle	Support the pelvic contents via a “sling” mechanism Structure off of which the fetus will rebound during descent and pushing.

Previous trauma to or weakening of any of these structures either by surgery, multiple childbirths, abuse or female circumcision may hamper the body’s ability to coordinate descent and expulsion of the fetus.^{3,18,25} This type of problem will probably be identified by the provider prior to the onset of labor, however, there is no guarantee that this will occur.

Perhaps the most commonly associated organ with childbirth is the uterus (or womb), and with good reason. Responsible for housing the growing fetus, the uterus is an incredibly muscular, vascularized organ which becomes abdominal in location with a term pregnancy, though it is normally a pelvic organ in its non-pregnant, non-pathologic state.^{3,18,25} Comprised of fundus (the superior, rounded portion), body and cervix, the uterus contracts rhythmically to a) dilate the cervix and b) expel the fetus. You may recall from anatomy, that the uterus is comprised of many layers. Outside the scope of this training, we will only focus on the myometrium. This is the muscular layer; the longitudinal fibers of this layer are

predominately in the fundus and are responsible for the contractile forces which occur during labor. These are the contractions palpated by the woman and her providers during labor and birth and typically range from mild to strong in their palpable intensity.^{18,25}

The cervix is the opening to the uterus, and must dilate to 10 centimeters to allow for safe passage of the fetus through the vagina. It is highly elastic, and this makes sense when its function is considered. Additionally, it is composed of connective tissue and is quite fibrous. It is important to remember that the cervix is three dimensional, and it helps patients to visualize this by likening the cervix to a doughnut. There is the “internal os” (inner hole) and the “external os” (outer hole.) The dilation and effacement (thinning) of the *internal* os is the critical measurement during labor and delivery. Certainly, previous cervical complications can hamper proper and adequate cervical dilation. Previous surgeries (such as surgical management of an abnormal Papanicolaou or “Pap” smear), trauma from childbirth or abuse, or structural abnormality may preclude proper dilation of the cervix.^{3,18,24}

An Appreciation for Fetal Development:

Obtain a few balloons. Blow them up to the various sizes of gestation. This really gives you an appreciation of the hypertrophy and distention that occurs during pregnancy.

When working with your expectant mothers, *teach* them about their anatomy. This is such a powerful way to empower mothers. Teach them about their uterus, vagina and cervix. Remember to use anatomically correct terms and teach them if the mother doesn't know!

Commonly mistaken as part of the uterus, the vagina is its own structure. It is a three layered, hollow tube-like structure which is the passage way for the fetus. Because of its highly elasticized and collagenous fabrication, the vagina is capable of significant distention; an important function for vaginal birth!

By understanding basic reproductive anatomy, you are able to better understand your patients' concerns, and the assessment findings and care plan relayed by the provider. Additionally, you will have a better working knowledge of the intricate system which must be healthy and functional to allow for vaginal birth.

As we end this chapter, it is also important to remind all doulas that while patients may use slang or colloquial terms for their reproductive anatomy, it is inappropriate and unprofessional for the doula to use these terms. Friendly and

gentle redirection and education is called for in this situation. An example of such a statement would be, “I notice that you used the word ____ for your vagina. Your (midwife/doctor) will be using the word ‘vagina’, so that is the word I’ll use when talking with you. This way, we all know that we’re on the same page when talking about your labor and birth.” This statement deflects potential embarrassment and uncomfortable feelings on behalf of the mother, and brings the rationale for your statement back to promoting patient participation in her care and birth.

Chapter 5: Hormonal Regulation of Labor and Birth

Just as anatomic structures play a significant role in the birth of a baby, hormonal regulation of labor is also important. An understanding of basic physiology as it surrounds pregnancy and birth is crucial to understanding how and why labor starts, and how you can best assist the mother at key moments in the labor. Breast anatomy and physiology will be covered in the breastfeeding chapter of this text.

Not meant to be an exhaustive physiology course, this text will focus on the following hormones:

1. Human chorionic gonadotropin (hCG)
2. Human chorionic somatomammotropin (hCS)
3. Progesterone
4. Estrogen
5. Oxytocin
6. Follicle stimulating hormone (FSH)
7. Luteinizing hormone (LH)

Many of your patients will present to care shortly after having a positive result on a home pregnancy test. This type of test measures hCG levels. Serum levels are typically detected shortly after implantation (8-10 days after conception), and will continue to increase in an exponential fashion. Eventually, these levels plateau. The exact value of hCG is typically not measured via serum measurements unless the provider suspects pathology (i.e., molar or ectopic pregnancy), spontaneous abortion (or SAB), or multiple gestation. Any of these conditions and many more affect hCG levels.¹⁸ hCG has a very critical function in the early stages of pregnancy. It is responsible for maintaining the function of the corpus luteum. The corpus luteum secretes progesterone and estrogen in levels compatible with sustaining the pregnancy until the placenta is developed.¹⁸

hCG used to be called human placental lactogen. This hormone is responsible for fetal growth in that it stimulates maternal metabolism. Glucose readily diffuses across the placenta with the aid of this hormone, and maternal resistance to insulin *increases*. As its name would suggest, this hormone also plays a role in lactation in that it stimulates breast development.¹⁸

Why do we call pitocin the “love hormone?”

What makes us go into labor?



Progesterone is a commonly known hormone, and your patient may have some knowledge of this hormone and its role in her endocrine function. Progesterone can be thought of as “calming, relaxing” hormone. It also helps the uterus maintain a highly vascularized, lush environment for the growing fetus. The endometrium, or inner most layer of the uterus maintains itself via progesterone, and progesterone is also responsible for *decreasing* uterine contractility. Because of this critical function of progesterone, current evidence based research supports the use of supplemental progesterone therapy in helping to prevent preterm birth in women who have already experienced a spontaneous, preterm birth. The treatment algorithms will not be covered in this text, but progesterone may be supplemented in the form of IM injections, or vaginal suppositories and help to support the endometrium as the pregnancy progresses.²¹

Estrogen is another commonly known hormone, and your patient may have a working knowledge of this hormone, as well. If we think of progesterone as a “calming” hormone, estrogen can be thought of as its counterpart being the “excitable” hormone. Estrogen is responsible for stimulating uteroplacental blood flow, uterine growth, breast tissue development, and uterine contractility.¹⁸ In fact, one hypothesis suggests that it is elevated levels of estrogen and decreased levels of progesterone at term which bring on labor.¹⁸

Most all patients have heard of oxytocin. They have heard of it because its synthetic counterpart, pitocin, is often used to induce or augment labor. Oxytocin is released by the posterior pituitary, and is responsible for causing uterine contractions.¹⁸ After the birth, oxytocin will also be released as the baby breastfeeds and sucks, which in turn stimulate the let-down reflex!¹⁸ More about this hormonal relationship will be discussed in the breastfeeding section of this text. As labor progresses, many women who are laboring without pharmacologic intervention will report an unavoidable urge to “bear down” and push. This is called “Ferguson’s reflex”, and is directly related to oxytocin. As the vagina’s stretch receptors are activated during the descent of the fetus’ head, oxytocin boluses are released which cause more contractions to aid in expulsion of the fetus.¹⁸

FSH and LH are mentioned here only as they relate to estrogen and progesterone. If we are to study the normal menstrual cycle, we see that LH is responsible for ovulation. A “surge” of this hormone triggers ovulation, and when women are taking home fertility predictor tests, they are measuring urine concentrations of LH. Working synergistically with LH, FSH is responsible for growth of a follicle, which contains an ovum.¹⁸ If ovulation occurs and the ovum is fertilized,

conception has occurred, and the woman is then pregnant. These functions are suppressed during pregnancy by higher levels of estrogen and progesterone which allow for the pregnancy to continue to develop and grow.¹⁸

As you can see, hormones play an instrumental role in fertility, maintenance of pregnancy, and in labor and birth. By having this rudimentary understanding of these hormones and the roles they play, you can better understand how labor starts and is maintained.

Chapter 6: Pharmacologic Management of Labor

The decision to use pharmacologic or non-pharmacologic pain relief during labor is the topic of much debate, research and criticism in the United States. A woman's decision to utilize pain relief techniques is deeply personal and is driven by a host of factors including personal history, culture, personal preference, attitudes of providers, and attitudes/opinions of her partner, family and friends.¹⁴

As a doula, it is extremely important to remember that the mother's perception of her pain and her birth experience is just that-hers. It is not your job, nor your responsibility to determine the level of her pain, nor is it your job to advocate for a non-medicated birth at all costs. **By advocating that a mother finds her voice and asks for intervention she feels necessary to control her pain (be it pharmacologic or non-pharmacologic), you will help empower her to view her birth as positive!**

Many women who chose to have medication to alleviate the pain of childbirth will chose either intravenous medication (IV) or regional anesthesia in the form of an epidural. This text will cover the more commonly seen methods of intrapartum pain management. This includes:

1. IV medications
2. Spinal
3. Epidural
4. Combined spinal-epidural
5. Pudendal nerve block
6. Local perineal anesthesia
7. General anesthesia
8. Nitrous oxide (inhalation agent)

When examining this list, it is clear that there are many options available to laboring women, and their use varies considerably depending on location, available providers skilled in the administration of the technique, and maternal/fetal indications that the usage of such a technique would not jeopardize maternal/fetal status or safety. Some women are not candidates for various methods of anesthesia. For example, some women with pre-eclampsia experience thrombocytopenia. If the thrombocytopenia is particularly severe, they are *not* candidates for epidural or spinal anesthesia because of the risk of hematoma and bleeding at the injection site. Some of these women find themselves having an

How do we really make these connections with our clients?

How do you have this crucial conversation and present options?

How do you do it without sounding judgmental?

unmedicated birth or only the relief of IV medications! Each situation and each labor is very different. By examining these techniques in detail, you can begin to understand why and how these methods are used by laboring women, and how you may best provide non-biased information on them.

IV medications are used by women who desire to “take the edge off” their labor, but without the level of intervention brought about by an epidural or a spinal. Medications which can be given IV to achieve this effect include sedatives, opioid agonists and opioid agonist-antagonists.¹⁸ They are administered by the registered nurse (RN) during labor, and are generally tolerated well. These medications decrease anxiety, and increase sedation.¹⁸ The RN administering them will monitor for common side effects of respiratory depression, nausea, vomiting, and fetal intolerance of administration (typically marked by minimal heart rate variability.) These drugs work particularly well in the earlier stages of labor when cervical dilation is slower and contractions are occurring in a fairly regular pattern, but are not particularly strong.¹⁸ These drugs cannot be used in the second stage of labor (or far along in the active phase of labor) because of their risk for neonatal drug depression and respiratory depression in the neonate. Mothers should be aware of this if they are planning to use IV medications as a pain relief technique for labor.¹⁸

The following table lists drugs which are included in each of the aforementioned categories. Again, when in the doula role, you are not functioning as a medical professional. Therefore, it is not your responsibility to suggest a particular agent, nor know your patient’s indications or contraindications for receiving it. It is simply provided for your information only.

Medications Used for Pain Relief in Labor¹⁸

Sedatives	Opioid (Narcotic) Agonists	Opioid (Narcotic) Agonist-Antagonists	Opioid (Narcotic) Antagonists
Barbiturates - anything ending in “-barbital”	Dilaudid Demerol Fentanyl Sufenta	Stadol Nubain	Narcan **This is not a pain relieving medication, but rather, is given when the effects of a previously given opioid need to be <i>rapidly reversed</i>
Phenothiazines - Phenergan - Vistaril			
Benzodiazepines - Valium - Ativan			

The use of spinal anesthesia is a popular choice among women and providers for whom rapid, dense pain relief is needed. Consider the various situations in which this could be particularly useful. Emergent c-sections, operative vaginal deliveries, or precipitous (incredibly fast) labors are all reasons to utilize this method of anesthesia. Anesthetic is injected via sterile procedure into the woman’s subarachnoid space; it then mixes with cerebrospinal fluid, or CSF.¹⁸

The epidural is administered via the same sterile technique, and is placed by a trained anesthesia provider. The American Congress of OB-GYNs and the American Academy of Pediatrics estimate that approximately “...two thirds of American women in labor choose epidural analgesia (as cited in Lowdermilk, et al., 2012, p. 404). A catheter is placed in the epidural space and through it, medications are administered which manage pain, but preserve motor function. This is a particular benefit of epidural anesthesia for the woman who is attempting vaginal birth; she will still have control over her lower extremities.

With both spinal and epidural anesthesia, the RN and other members of the healthcare team will be responsible for monitoring maternal and fetal responses to the anesthesia. Since one of the most common side effects of these aforementioned anesthesia methods is hypotension, the RN will monitor the patient closely, administer PRN fluid boluses, and watch for signs of fetal compromise including minimal variability and fetal heart rate (FHR) decelerations.¹⁸

The combined spinal-epidural (CSE) is just as its name implies; a combined method of anesthesia. This technique involves introducing a catheter into the epidural space for the purposes of pain relief as described above in the epidural portion of the text. However, just before the catheter is placed, a smaller needle is used to inject medication into the spinal space as also described above.¹⁸ This is a wonderful option for women who need immediate pain relief, but will also need more long term pain relief after the effects of the spinal wear off. Many of you may be wondering what type of a clinical scenario would warrant such an intervention. Once such scenario is a grand-multiparous woman who is laboring quite quickly. Let us say that there is a mother who is having her 5th baby. She presents to labor and delivery in great pain and is found to be 4 centimeters dilated. We may hypothesize that her labor will move rapidly since this is her fifth baby, but we do not know that absolutely. Therefore, a CSE is a wonderful option for this woman. She will receive immediate relief from her pain at 4 cm, but will have an epidural for continued pain relief should the remainder of her labor last longer than the effects of the spinal.

Safety Tip:
When a client is having an epidural placed, you may be asked by the anesthesia personnel to leave the room. Please be polite and understanding; you can rejoin your patient as soon as the epidural is placed.

The **pudendal nerve** block is a type of anesthesia which is used rarely, but is still available. Its usage depends entirely on the skill and comfort level of the provider administering it; it is administered by the OB-GYN or CNM attending the patient's birth. Unlike the previously discussed methods of anesthesia, pudendal blocks do *not* relieve pain from contractions, but rather, alleviate pain in the perineum, vulva and vagina.¹⁸ The nerve is anesthetized via the transvaginal administration of anesthetic. As you may imagine, its success is dependent on the skill of the provider, maternal cooperation and maternal position/movement at time of administration. The feeling of "fullness" which encourages bearing down will be obliterated with this method of anesthesia.

Local perineal anesthesia is typically used after the vaginal birth of the child, and is used to repair perineal lacerations or episiotomies which were cut. This is again, administered by the CNM or MD attending the patient, is short acting, and does not affect maternal vital signs or neonatal status since the baby is already delivered.¹⁸

General anesthesia (GA) is discussed here only in the context of being able to fully understand and comprehend your patient's plan of care should this become the method by which they are anesthetized for their delivery. GA is used for c-section deliveries, especially those which are emergent, and for mothers who could not

have spinal or epidural anesthesia placed, such as those with morbid obesity or structural deformity such as scoliosis.¹⁸ Once the general anesthetics are administered, it is imperative that delivery occur rapidly. This is because these drugs quickly diffuse across the placenta and can cause marked drug depression of the neonate.¹⁸

If you find that your patient is undergoing this type of delivery, you will be asked to leave the operating room as per protocol. This is because the anesthesia provider needs all space at the head of the bed to intubate and further monitor the patient. The neonatal intensive care team (NICU) will be called for the baby. In this case, your best location is with the patient's partner or family outside the operating room. You may rejoin the mother at the conclusion of her c-section and remain with her as you normally would in recovery.

Nitrous oxide

This is mentioned here only because patients are starting to ask for this method of pain relief for their labor. It is used quite frequently in Europe, and many midwives have experience with this form of pain relief. It is currently offered at the VCU Health System, and at other community hospitals in the greater Richmond area. Nitrous oxide is an inhaled agent, and it acts to reduce pain during labor. The woman inhales the nitrous via a mask as a contraction begins, and continues to inhale throughout it. As the contraction diminishes, she is to remove the mask and breathe normally.¹⁸

Through discussion of the most common anesthesia options for laboring women, you are able to fully participate in her care and her pain management plan. Remember that it is your job as a doula to help the mother achieve her *best desired birth*. If this includes the use of pharmacologic pain management, that is okay! It is her body, her baby and her birth. Help her to understand which methods are used and why. Help her to understand which methods are available to her. If you are ever in doubt as to whether or not a method would be an acceptable option, check with the patient's provider during a prenatal visit or during the labor. It is not your job to recommend specific drugs or therapies, but rather, to give unbiased, informed information to the patient and her partner on *all* options so that she may make a decision.

Chapter 7: Non-Pharmacologic Management of Labor

The joy of assisting and empowering a woman through an un-medicated childbirth is intangible. Many individuals are called to be doulas, labor and delivery nurses, midwives and OB-GYNs because they enjoy this aspect of their job so very much, and they are passionate about non-interventional birth. Some of your clients may desire this type of birth, and it requires a very special, highly individualized and “high touch” rather than “high tech” approach. While your heart may be in the right place when you declare an enthusiasm and desire to help women through unmedicated childbirth, you may be saying to yourself,

“I have *no idea* how to help this woman!”

“What if she doesn’t want to be touched?”

“What if she is hysterical, screaming and crying?”

“How do I help her?”

“How do I ground her?”

“How do I involve her partner, family, friends or others who may be present?”

You’re not alone in your thoughts, feelings and concerns. These are all very common and normal concerns as you begin your work as a doula; rest assured that they are felt by your colleagues and fellow birth workers. This chapter will discuss numerous ways to help a woman achieve her goal of an unmedicated childbirth. Not every technique will be a good fit for every patient, and some women may want to use a wide range of techniques, while others only wish to use one or two. Let the patient be your guide. Every labor is completely different and unique (even all labors of one mother are different), and has to be approached that way.

Before our discussion of non-pharmacologic techniques, it is important to discuss the concept of the birth plan. Birth plans are documents drafted by the mother, her partner and other important persons who will be at her birth, and sometimes the doula. The birth plan highlights the mothers’ wishes for her labor, birth and postpartum periods.¹⁸ Many birth plans cover topics such as use of pharmacologic vs. non-pharmacologic pain management techniques, infant feeding preferences, and visitation preferences. When assisting the mother in writing her birth plan, it is important to reinforce and remind that this is a *plan*, not a dictation of how the birth will unfold.¹⁸ As is the case with many life events, we cannot plan with

Did you know that we have our own birth plan for VCU doulas? Check out blackboard for a copy to fill out with your expectant mom!

How can you bring up the conversation of drafting a birth plan?

100% certainty how they will unfold, and a sense of flexibility is key.¹⁸ However, the birth plan can help the woman articulate her concerns, and gives her providers and her doula a template so that she doesn't have to keep voicing her concerns and wishes throughout the labor.

Touch & Massage

While some may write this off as a rather plain intervention for labor pain, it can be a wonderful way to connect with your patient and make her feel supported. Think of all the ways that we convey care and concern to our family and friends: We hug, hold hands, pat children on the head; the scenarios are endless when we think about how a simple touch says, "I am here for you; I care about you."¹⁸ If the mother is amenable, touch can be used at all parts of the labor and delivery to help achieve relaxation and calm. Things to ask the mother before using touch or massage

1. Would you like to be touched during your labor?
2. Do you have any cultural beliefs that would make this an inappropriate intervention? Do you have any personal history that would make this an inappropriate intervention?
3. Where are you holding your tension right now? (*to be used in the labor to ascertain where best to touch/massage)
4. Does massage or calming touch usually help you relax in stressful situations?

Some women do not want to be touched during labor. This may just be a personal preference, or there may be more deep seeded reasons for this including a past history of abuse or violence. Make sure to ascertain this before using this intervention. Some women hold tension and pain in their shoulders, neck, lower back and legs during labor. Massage helps relieve that tension, but also helps the mother gain a conscious awareness of where she is holding that tension so that she may attempt a fuller state of relaxation. Another benefit to this technique is that her partner may also be taught how to perform the massage so that they have a way to meaningfully contribute to their partner's comfort.

Music

It is such an “easy” intervention, but it is often overlooked! Women typically have play lists they have created on an IPod, phone, CD or computer. Many hospitals have docking stations for these types of media in the operating room, or in the labor rooms. Patients may bring their own equipment to facilitate the usage of their own media devices. Music can be a wonderful way to relax a patient, as it typically evokes strong emotion. If you are discussing this option with a woman prenatally, you may ask the following questions:

1. What are some of your favorite songs/types of music?
2. Are there any songs that conjure up wonderful memories for you? (i.e., your first dance at your wedding reception, a song that reminds you of your baby, a song you were sung as a child)
3. Are there songs/genres that are *not* a good fit for you?
4. Do you want to try and make play lists based on how your labor will progress?

Some women will try and “plan” their play list to coincide with their labor. For example, they will play slower, calmer, classical selections in the early parts of labor, and more upbeat, staccato tracks towards the harder/transition part of labor to keep them energized and focused.¹⁸ When considering music as an intervention, researchers Smith, Collins, Cyna and Crowther assert that “...Although promising, there is insufficient evidence at the present time to support the effectiveness of music as a method of pain relief during labor. Further research is recommended” (as cited in Lowdermilk, et al., 2012, p. 393-394).

Distraction

Many of you may be wondering what this means. Patients in pain may not be easily distracted, but others may be. Often helpful in the earlier stages of labor (such as latent), women might be able to still carry on conversations with you or their partner/family/friends. They may be able to watch TV in between contractions, or snack on light foods/drink. Let the patient be your guide when utilizing this technique, and know that it will probably not be as effective when the patient begins the more active, rhythmic portion of labor.

Q: What kind of music?

A: Whatever works for your mom and her significant other! We’ve seen it all...classical, opera, heavy metal, rap, country, etc.

As long as it’s kept at a respectable volume, it’s good to go!

****What would you put on your playlist?**

Visualization/guided imagery

Utilizing the same principles as distraction, guided imagery or visualization allows the mother to “escape” the moment temporarily and travel to a place of calm and peace within her mind. This may be a particular location (i.e., the beach or the mountains), or she may be visualizing the birth of her baby and the opening of her cervix.^{1,18,24} Some women will be very open and receptive to this method; others will not be interested and will want calm and quiet during their labor. It would behoove you to discuss these types of interventions with your patient *prior* to the onset of labor. Oftentimes a mother will have preferences based on previous labor and her individual personality. If a mother expresses an interest in using this technique, questions to consider include:

1. Where are places you like to go to relax?
2. Are there places that are *not* relaxing, or places that represent bad memories for you?
3. What are some of the things you say to keep yourself energized or “pumped” during times of stress/pain?

Paced breathing

Many of you have probably seen paced breathing mimicked or portrayed in movies or on TV. Often nicknamed “Lamaze breathing”, paced breathing is altering the speed and type of breath during labor to help cope with contraction pain; it also forms as a means of distraction.¹⁸ Some women will cope better with this technique than others; for some it is “too much to remember”, and they focus more on the pattern of breathing and getting it “right.” No matter the pattern, all paced breathing consists of “pants” and “blows”. Oftentimes, mothers using this technique have been taught by their provider, or in childbirth class. The breathing will become more staccato during the second stage and pushing stages, and is often more flowing, deep and steady in latent labor.¹⁸

When utilizing this technique, make sure that your mother doesn't enter a state of respiratory alkalosis! If breathing becomes too quick and frequent, the mother will rapidly exhale most all of her CO₂ stores. If the mother reports paresthesia, lightheadedness, or dizziness, she should stop using this technique. If the patient's nurse isn't already in the room, call them at that time so that appropriate management may ensue.

**You can ask the mom,
“Would you like to try and go
to your place now?”
“What does it look like” (sound
like, feel, taste, etc.)**

****Have you ever tried guided
imagery for yourself? Was it
successful?**

Bradley® (husband coached childbirth)

The Bradley® method of childbirth preparation is only one of many interactive classes available to expectant parents. Women may choose to avail themselves of childbirth preparation classes either in home (private instructors are available), or in a group format. If the expectant mother desires childbirth preparation, these are some of the factors she should consider:

1. Location and time of the class
2. How much does the class cost? Is their assistance available?
3. How many classes are included? Is attendance at all classes required?
4. Are there out of class activities or “homework?”
5. What method of pain relief does the class advocate?
6. Do you have to have a partner to attend the class?
7. Is the class open and accepting of all family types? (i.e., single mothers, lesbian couples, couples wishing to be present for the birth of their child via a surrogate, etc.)
8. Does this course cater to mothers delivering in a hospital or at home?

Alternative positions

Consider the anatomy of the pelvis; consider how a baby must engage and utilize every bone and muscle of the mother’s pelvis to be born! Is it any surprise that lying completely still and flat on one’s back is not a position conducive to birth? Researchers Roberts and Hanson explain, “Supine, semi recumbent, or lithotomy positions are still widely used in Western societies despite evidence that women prefer upright positions for their bearing-down efforts and birth” (as cited in Lowdermilk, et al., 2012, p. 460). Mothers should be encouraged to assume whatever position is comfortable for them during labor and birth. These alternative positions may include standing, squatting, sitting, sitting on a birthing ball, squatting using a birthing bar, or side lying.^{18,24} It is important to use a wide variety of positions/techniques so as not to fatigue the mother unnecessarily. Frequent movement and changing also helps to continue to move the fetus’ head into alignment for easier engagement and descent.^{18,24}

Make sure, however, that the patient’s providers are also amenable to these position changes. Certain positions may not be conducive to continuous fetal monitoring (if required for the patient), or the fetal heart rate may have been found

Before moving a laboring mother who has an epidural, you must notify her nurse!



to be more reassuring if the mother assumes certain positions, (i.e., lying on one side rather than the other.)

Safety should guide our interventions first and foremost; before changing a laboring mother's position (particularly if the mother has epidural or spinal anesthesia), engage the help and guidance of her care provider.

Counterpressure

Counterpressure is, just as its name implies, the application of *firm, steady* pressure against the sacrum, hips or knees. Oftentimes, a support person will use the heel of their hand, a fist, or other firm object.¹⁸ The purpose of this technique is to counter the marked sensations of pressure and pain felt in the lower back and sacrum during labor. Because of the way the fetal head is positioned when it is in an occiput posterior position, these techniques can be especially helpful if the mother is experiencing difficult “back labor”, or it is known that the baby’s head is in such a position.¹⁸ If pressure is to be applied to the lower back, it is typically done in the hollow of the lumbar spine; if pressure is to be applied to the hips, it is applied by squeezing both hips together. Again, let the laboring mother be your guide. Some women will require a heavier pressure; others will prefer lighter touch.

Hydrotherapy

Hydrotherapy receives very positive attention from women desiring unmedicated childbirth, and it only takes a few seconds to search the term “water birth” in a search engine and be flooded by serene birth videos, and images of women floating gently in undulating waves of water. Water therapy for pain relief has been shown through studies to be a very effective method for pain relief; in fact, research by certified nurse midwife Leah Albers cites, “Women in labor often report that pain and discomfort subside while in the water” (as cited in Lowdermilk, et al., 2012, p. 394). While certainly a very pleasant sensation, hydrotherapy doesn’t have to be confined to full emersion in a tub. Mothers may use the shower, or may use a detachable shower head to aim the stream of water at their back, abdomen, legs, thighs, etc.¹⁸

Hydrotherapy is used after the patient is in established active labor (usually 6+ cm or more.) This is so the water doesn’t dampen a contraction pattern, which can sometimes happen if the mother gets into the water in latent labor.

What are some conditions you can think of which would preclude laboring in the water?



As with any pain relief technique (pharmacologic or non-pharmacologic) there are contraindications for tub immersion including but not limited to, non-reassuring fetal heart tones, chorioamnionitis (or infection of the amniotic fluid), or epidural anesthesia. There may be other unique risk factors which preclude the laboring mother from using hydrotherapy. Before suggesting this or advocating for its usage, make sure you dialogue your concerns with the provider.

It is important to note that local hospitals in the Richmond area do not offer water birth. Your laboring mother will be asked to leave the tub and return to her bed to birth unless delivery is imminent and moving her would pose a risk to her safety or the safety of the fetus. Additionally, some women are not candidates for getting in the shower or tub. See the text box to the side.

Hypnosis

A somewhat controversial method for pain control during labor, those who wish to utilize hypnosis during their labor often receive training through the Hypnobirthing curriculum; more information may be found at <http://www.hypnobirthing.com>. Hypnosis allows the mother to enter a trance like state through self-discipline or the guidance of a support person. The purpose of hypnosis during birth, however, is not to eradicate pain, but rather, to enhance control and relaxation in the laboring mother so that she may better cope with the contractions.¹⁸ Mothers wishing to use this technique need prolonged, specific antepartum training and “practice”, and it is not a technique which can or should be utilized randomly or hastily during the labor.

Hot/Cold Therapy

One of the first lines in first aid is the application of heat or cold for tired, fatigued or injured muscles. The uterus is also quite fatigued and strained during a labor! All of the other major muscles are stressed and utilized to their maximum during a labor, particularly the muscles of the lower back, legs, and even arms as the mother supports herself in various positions.¹⁸ Heat packs can be wonderful tools on the lower back, uterus or legs if the mother is agreeable. Cold is also a wonderful tool as labor is an incredible metabolic demand; mothers will frequently become hot and flushed. Cool/cold compresses to the neck, face, pulse points, etc., may help to stabilize body temperature and enhance maternal comfort.¹⁸

Have you ever heard of a rice sock? These are tube socks with rice and essential oils. The sock can be microwaved and applied to the back/belly/legs, etc. during labor to help soothe strained muscles.

Aromatherapy

Various scents can evoke powerful memories and emotions. We often remember the smell of flowers from our wedding bouquet, the smell of the beach or our favorite vacation spot; even the smell of a favorite food can calm and energize. Aromatherapy in labor is no different, and utilizes essential oils to help promote relaxation and calm. Aromatherapy uses essential oils (oils derived from plants) to achieve desired physical or emotional states. Many of these essential oils also carry non-medicinal properties such as the alleviation of nausea, anxiety and tension.¹⁸ Oils may be found in liquid form so they may be added to diffusers or to a tub of water, others are incorporated into lotions and creams to be used in conjunction with massage.

*It is important to always check with the patient and her provider before using any type of essential oil or tinctures. Some patients are allergic to various compounds or oils. It is also prudent to remind you at this time that you are **not** a medical provider; as such, you cannot give the patient anything to ingest to induce or augment labor. There are many herbal preparations and “wives’ tales” concoctions that promise rapid onset of labor. If a patient asks you about any of these techniques, you are to refer her to her provider.*

As is the case with any intervention, safety must govern your practice above all else. If you are unsure as to whether or not a patient may utilize a specific technique, check with the provider first.

Chapter 8: Labor: Latent, Active and the Transition Phase

When the moment of labor finally arrives, mothers may feel a rush of emotions. They may be elated, relieved, scared or anxious. Your role as a doula will be to help the mother stay **calm, focused and communicative about her needs and her birth plan**. When you understand the stages of labor and the physical changes occurring with each, it is easier to help your patient and understand which interventions may “fit” better at certain times.

Labor is described in three stages:

First stage:

1. Latent labor which is dilation of the cervix from 0-4 cm
2. Active labor which is the dilation of the cervix from 4-8 cm
3. Transition, or the dilation of the cervix from 8-10 cm

Second stage:

1. The complete dilation of the cervix until birth of the infant
i.e. The “pushing” stage

Third stage:

Delivery of the infant until the delivery of the placenta

Women experience each stage differently. Some feel considerable pain even in the early stage of latent labor; other women sail through their labor and report very little pain and discomfort even at 9 cm. While there are generally accepted guidelines as to how long these stages and phases last for multiparous and nulliparous women, it is important to remember that these are guidelines. Certainly, there are outliers, and labor is affected by a host of factors which may shorten or lengthen the time spent in any one phase. The guidelines traditionally accepted by many practitioners are listed below:

Standard Length of First, Second and Third Stages of Labor^{18,24}

	First	Second	Third
Primigravida	8 hours; *latent labor can range from 1-20 hours	3 hours	30 min.
Multigravida	5 hours; *latent labor can range from 1-14 hours	2 hour	30 min.

In order to fully understand the stages of labor, it is important to understand that labor is defined as contractions which *lead to cervical change*. If the cervix is not dilating, there is no labor. There may be contractions, but they are not true labor contractions. It is important to note that this does not mean the woman isn't experiencing any pain. A woman may have very painful contractions in the early parts of labor, or even for days before the onset of true labor. Helping the woman to verbalize her feelings and validate them can go a long way in keeping a woman focused, calm and in control.¹⁸

When labor commences, the cervix will begin to dilate (open) and efface (thin out).^{18,24} The cervix begins as a very thickened, closed object, and, by the end of the first stage, is completely thinned out and dilated.

When the cervix is examined, the provider will note the position, consistency, dilation, effacement and station of the fetal head. You will remember from a previous section of this text that the station is the measurement of the fetal head from the ischial spines; (it is either sitting above the spines or below.)

A woman's labor is affected by many factors; there are five of these factors which are commonly referred to as the "5 p's." These are the passenger, passageway, powers, position, and psychological response.^{18,24}

The table on the next page describes these factors in detail, and gives you questions to ponder as they relate to each factor. Suggestions for how you may intervene and support the mother to help control and work with these factors are also listed. This list is not exhaustive; let your instincts, and the mothers' wishes and responses guide you.

The 5 “Ps” Affecting Labor^{18,24}

Factor	Who/what	Questions to ask yourself	How do you help?
Passenger	Baby and placenta	How big is this baby expected to be?	Position changes
		How long has this woman been in labor?	Ambulation
Passageway	Birth canal and pelvis	Signs of labor stalling?	Reassurance
		Is this a multiple gestation?	Encouragement
Powers	Contractions	Which part is presenting?	
		Is there any history of surgery/trauma that would affect the pelvis?	Position changes Reassurance
Position (maternal)	How is mom positioned	Any structural deformity which would adversely affect the vagina/cervix?	
		How often are these contractions coming?	Pain relief techniques Reassurance
Psychological response	How is mom responding to labor/pain?	How is the patient handling them?	
		Is this position working for this mom right now?	Position changes Reassurance
		Would she like to change positions?	Communication w/ provider
		Is there any history of abuse/trauma/violence which would adversely affect labor?	Reassurance Provide for safe environment
		How is mom coping?	Communication
		Who is her support system?	Pharmacologic and non-pharmacologic pain relief

The First Stage of Labor

This is the longest stage of labor, and represents the dilation of the cervix from 0-10 cm. It is further broken down into the latent phase, the active phase, and transition.^{18,24}

The main “tasks” of the body in the latent phase are to **efface the cervix and begin the descent of the presenting fetal part.**^{18,24} For a vaginal birth, this must be the head or the buttocks, although you will rarely see breech vaginal delivery in your work as a doula in a hospital setting.

During this stage, contractions are typically not as strong as they would be in active labor; they may be random in occurrence or infrequent. Women are typically able to ambulate, change positions, and carry out typical ADLs during this time. Some women don’t even know that their labor has commenced; they only report the feeling as “cramping” or “just not feeling great.” It is important to **continue ambulating, position changes, and for the woman to carry on as normal (if she is not yet in the hospital) during this latent period of labor.** The woman will make the decision with her healthcare provider (either CNM or MD) as to when to present to the hospital.

*As a doula, it is important that you encourage the woman to call her provider when she feels as though labor has started. The woman can then make the determination as to whether she should present to the hospital or continue to labor at home. This is **never** your decision to make, and you should never encourage a patient to stay at home, or go against the advice of their provider. Once the patient presents to the hospital, you may join them!*

As labor progresses, the woman’s cervix will continue to dilate and efface; the contractions will become more frequent, and will begin to assume a strong, predictable pattern. It will eventually dilate to 5 cm; this now marks the active phase of the first stage of labor. Many women will have contractions approximately every 2-3 or every 2-4 minutes. Because these contractions are quite strong, we expect (and do) see rapid dilation of the cervix and rapid descent of the presenting fetal part. Not surprisingly, pain sensations increase during this time, and the mother may require more encouragement, support and intervention to help manage this pain and anxiety.^{18,24}

It is important to note that as labor progresses, the mother *and* baby are doing strong work together.

Maternal circulatory changes occur; blood is shunted to the periphery. Pain, anxiety and sheer work cause respiratory rate to increase, and quite commonly, women are affected by **profound nausea, vomiting and diarrhea**.¹⁸ As you may recall, GI transit time is slowed in pregnancy; the same is true in labor. Any undigested food may cause nausea, vomiting in the laboring woman. As the labor progresses to the second stage or the “pushing” stage, a woman may report that she has the overwhelming urge to have a bowel movement.¹⁸ The best thing you can do in these periods of transition is provide quiet, calm support and comfort measures.

- ❖ What is your role as the doula when we talk about fetal monitoring?
- ❖ Are you allowed to interpret and provide information to the patient regarding the fetal monitor?
- ❖ How can you respond to the results of the fetal heart monitor without stepping outside your scope of practice?

As the mother works hard during labor, so does the baby. Each contraction brings a temporary disruption in their blood and oxygen supply; while expected and normal, this may manifest in FHR changes noted on the monitor. Attention must be paid to the baby’s response to labor; FHR patterns may prompt intervention as benign as maternal reposition, or as involved as change in route of delivery. Additionally, the baby must descend in the pelvis and travel through specific, intentional movements. These are often called the “cardinal movements” of labor and birth.¹⁸ These movements are, in order:

1. Engagement and descent
 - a. The baby descends into the pelvic inlet
 - b. Descent is the descent of the head through the maternal pelvis
2. Flexion of the fetal head
 - a. Flexion of the fetal head is brought about when it “...meets resistance from the cervix, pelvic wall, or pelvic floor...the chin is brought into closer contact with the fetal chest” (Lowdermilk et al., 2012, p. 382).
3. Internal rotation
 - a. Allows for expulsion of the fetus by rotating inwards allowing continued passage through the pelvis.
4. Extension
 - a. The head will extend after it reflexively moves off of the perineum. Muscle tone is critically important for extension to occur. This is when the fetal head will be delivered.

5. External rotation
 - a. After rotation, the head will reconstitute, or “turn” to the left or the right. After a brief pause while the baby does this, the shoulders will then be transverse, and the rest of the delivery will occur.
6. Expulsion
 - a. The shoulders and body are delivered.¹⁸

You may also hear providers and other doulas speak about the baby’s position in the pelvis. This can affect location and perception of pain, and it also may affect how the labor progresses if baby is not in an optimal position. **This is where non-pharmacologic pain relief techniques and position changes can make a significant difference.** A diagram of fetal head presentations is presented for you below. The other types of presentations (such as breech, transverse, etc.) are not covered here, because these patients will often not labor and have a c-section for delivery.

When you work with laboring mothers in the first stage of labor, it is important to remember that there is *great* variation among pain response and tolerance of this stage. Remember the “5 Ps”, and think about how they are affecting this particular labor. Some women move quite quickly through this stage, for others, it takes days. Fatigue, anxiety, disappointment, elation, and every emotion in between set in at some point. Remember that your mother is in control of her birth and her body. A pain relief technique that works wonders for one woman may be completely intolerable to another. The following table discusses some of the many position changes/techniques you will see and may utilize in your practice.

Always check with the patient’s’ care provider if you are concerned about the appropriateness of utilizing a specific pain relief technique. If the patient has epidural or any other kind of anesthesia, always verify with the nurse before repositioning the patient to prevent injury or fall.

Labor Interventions and Rationale for their Usage^{18,24}

Technique	When to use it	Rationale
Ambulation	Any time	Helps to facilitate cardinal movements of labor Keeps mom active and distracted through changes of scenery.
Distraction/Guided Imagery	Any time; frequently requested in latent/early active	Used when mother is still calm enough to focus and go along with the image Helpful in latent labor when contractions aren't as strong and distracting. Encourages mother to “gear up” for the hard work of active labor Encourages participation from other support persons at her labor and birth.
Counter pressure/double hip squeeze	Any time, though frequently requested in active labor	Helps counter the pressure/pain felt in back labor. Provides stability to fatigued, sore joints. Involves patient's partner and other support people.
Massage	Any time; latent labor	Non-invasive, gentle way to promote relaxation while the mother is still able to sit calmly through contractions. Promotes circulation to smooth muscle Promotes relaxation and full ROM of joints.
Birthing Ball	Any time; late latent	Sitting on the birthing ball allows

	and active phases	<p>the mother rest of her legs and relaxation.</p> <p>The counter pressure placed on the hips and lower back help alleviate tension.</p> <p>The contraction is “dispersed” across the back, legs, and thighs when sitting on the ball.</p> <p>Rolling and rocking can help to alleviate pain and help the mother establish a “rhythm” during contractions.</p>
<p>Paced breathing/breathing techniques</p>	<p>Active phase; transition, pushing</p>	<p>Helps to prevent respiratory alkalosis brought on by anxiety and hyperventilation.</p> <p>Allows the patient to focus on a “rhythm” during contractions.</p> <p>Pattern of breathing can change as the contractions become more difficult and painful.</p> <p>Involves other support persons as they can help coach/remind the patient of her techniques.</p>
<p>Hydrotherapy</p>	<p>Any time; active labor and transition</p>	<p>Helps to alleviate soreness, tension, pain brought on by frequent contractions.</p> <p>Allows for relaxation as water supports all of mothers’ weight and creates buoyancy.</p> <p>**Often a rule that mother</p>

		<p>must be at least 6+ cm before getting in the birth tub. This is b/c the tub may relax a mother too much in latent labor and slow the progression of labor. This is case by case dependent, however, and the suggestion to utilize the tub should always come from the provider. Discuss your concerns with the provider <i>before</i> offering it to the patient.</p>
<p>Squatting (independently or on bar)</p>	<p>Transition</p>	<p>Opens the pelvic outlet</p> <p>Allows for mom to support her own weight with her legs (large muscle group)</p> <p>Encourages descent of presenting part</p> <p>**If a patient begins grunting, pushing, or defecating, notify the provider or RN immediately.</p>
<p>Side lying positions</p>	<p>Any time, but may be particularly helpful with transition and pushing</p>	<p>Opens the pelvic outlet by abducting and flexing the upper leg.</p> <p>Great position for those with epidural anesthesia who can't assume other positions. Also a wonderful position for rest. Mothers need to take breaks; side lying positions promote fetal oxygenation.¹⁸</p>
<p>Hands and knees/kneeling</p>	<p>Transition and pushing</p>	<p>Opens the pelvic outlet</p> <p>Wonderful position of the management of potential</p>

Music, prayer, talking,
chanting, moaning

Any time; particularly
active and transition,
pushing phases

dystocia or when fetal
macrosomia is suspected²⁴

Allows the mother rest of her
legs by dispersing weight across
the entire back and arms

*Moms may find
pushing/transition phase is more
bearable if they can lean over the
side of the bed, or a chair, etc.
This allows them to “go limp”
between contractions, promoting
rest.

Listed last, but certainly not
least, never underestimate the
power of simply talking and
encouraging your patient through
her labor. Some women find it
particularly helpful to moan,
grunt, used paced breathing, or
pray during particularly painful
contractions.¹⁸ The repetitive
nature of grunting or moaning
gives them a pattern to follow
and focus on during the
contraction. These techniques
may also be used by any support
person there who wishes to
participate in the labor.

Just when your patient feels as though the labor can't get any harder, more painful or more impossible, transition sets in.

This is the phase of labor where the cervix is **8+ cm**, and rapidly dilates to 10 cm. Most everything you have seen stereotypically portraying birth (screaming, cursing, grunting, groaning, thrashing about, beginning to bear down and push uncontrollably) typically characterizes transition. Of course, not every woman behaves in this way; some are remarkably controlled, introspective and deliberate during their transition and beginning of pushing.

Discuss this with your expectant mother and her significant other (or other persons who will be at the birth) ahead of time!

Examples of safety words:

- ❖ “ice cream”
- ❖ “banana”
- ❖ “citronella”
- ❖ “purple penguin”

At this point, the woman may start to express that she is in too much pain, she can't “do it anymore”, and that she wants pain relief.¹⁸ It is important to note that these expressions and outbursts typically come with transition, but the mother shouldn't be ignored when she states that she needs intervention. Encouragement and short, simple direction and affirmation are needed in these moments. Your words should be directed to the mother in a steady, firm tone of voice. Examples **of positive affirmations** which may prove helpful and motivating include:

“You are in a safe place.”

“You are doing a wonderful/perfect/fantastic/amazing job.”

“Work with your baby. Work with your body.”

“Trust your body; you're doing it.”

“This is all normal; that pain/pressure/feeling is normal.”

“Work with that feeling; great work.”

“Beautiful sounds; keep grunting/moaning/vocalizing.”

“Your body and baby are working so hard with you.”

“I am so proud of you. Look how strong you are.”

“Stay with this contraction; it will pass.”

“That's it; keep breathing/squatting/moaning, etc. Way to listen to your body.”

“This means you're getting close; hang in there.”

“Each contraction, each push brings you closer. Keep working.”

It is suggested that you have a **“safety word”** with your patient. If the patient uses this word twice, it means that she truly wants medical intervention for her pain. It should be a word that has *nothing* to do with the labor, or that could be

misconstrued, i.e., “I’m really done”, “this is awful; I need help”, and etc. Make sure that the word isn’t so obscure that the patient forgets it!

Involving the patient’s primary support team in ways that are meaningful and helpful to her are critical at this stage. While it passes relatively quickly in comparison to the first stage of labor, it seems like eons to the mother.

Ensuring a safe space where she feels empowered and validated in her choices, actions and behaviors is critical. What works for one mother won’t work for all; she should take the reins, and you should follow her cues.

Chapter 9: The Second Stage of Labor

The moment of delivery has arrived, and at this point, many women are excited and nervous. This energy may permeate the room, and other support persons and family members may feel it, too!

Maternal behavior varies significantly during this stage. As mentioned in chapter 7, some women are very calm, collected and introverted during this stage. Others are very vocal or even hysterical. In the absence of clinical indication to expedite delivery, the woman should be encouraged to tune into her own body and follow her own cues for pushing. This can lead to increased feelings of self-efficacy and accomplishment.¹⁸

The second stage of labor is further broken into the latent and active phase. As the titles suggest, the latent phase is a phase of passive descent and the active phase is just that: Active maternal expulsive efforts to birth her baby.¹⁸ Expulsive efforts take on many forms. Some of the various motions and actions which will move baby down include:

- Active pushing or “bearing down”
- Pushing to have a bowel movement
- Vomiting
- Grunting/groaning
- Playing “tug of war” with the provider or doula.
The mother’s pulling actions will tighten the abs and achieve a pushing action.

Current evidence based practice supports mother directed pushing. This means that even if the cervix is dilated 10 cm, pushing does not commence until the mother feels the urge to do so.¹⁴ Certainly, this can prolong the second stage, and there are clinical situations in which this would not be appropriate. These include, but are not limited to, non-reassuring fetal surveillance, maternal infection, suspected abruption, risk of hemorrhage, or maternal coagulopathy. The provider will indicate whether delayed pushing or “laboring down” is appropriate for your patient. Benefits to this type of pushing and less active management of second stage include “...less FHR decelerations,

What will you do to help assist your mother during this very difficult time?

When moms are pushing, they typically don’t want a lot of noise, talking, etc. It takes a lot of concentration. Take your cues from mom and remember: current EBP says that mom should direct her pushing efforts. This means:

- ❖ mom pushes when *she* feels the urge
- ❖ open vs. closed glottis pushing
- ❖ focus on quality, not quantity of pushes
- ❖ allowing for “laboring down” if the situation is clinically appropriate to do so.

fewer forceps-and vacuum-assisted births, and less perineal damage (lacerations and episiotomies)” (Lowdermilk, et al., 2012, p. 458).

When it comes time to push, you may be of tremendous help by assisting to hold the mother’s leg (if anesthetized or unable/unwilling to hold them herself), and helping her to direct her pushes. If a mother does not have any anesthesia, she will know *exactly* when her contractions are occurring, and will probably direct her own pushing efforts. Mothers with epidural anesthesia may require a cue from their provider or the nurse as to when they are contracting. When the contraction begins, you may help her push by:

- **Reminding her about good positioning during pushing (“sit up” position, chin to chest, legs flexed against the abdomen)**
- **Taking a deep, cleansing breath prior to pushing**
- **Holding the push for approximately 10 seconds**
- **Taking another cleansing breath and pushing again**
- **Each contraction ideally has three pushes with it to aid in expulsion of the fetus¹⁸**

In between contractions, praise the mother for her work thus far, and encourage rest.¹⁸ If she needs a cool compress to her head or neck, a few ice chips to hydrate, or a whiff of an aromatherapy scent, you may provide those comfort measures. Your continuous, unwavering support will be invaluable to the mother and her other support persons. Medicated or not, pushing is terribly hard work, and it is easy to become discouraged and tired. Affirmative statements and praise will go a long way in quelling maternal anxiety. Monitor your own reactions, too. It can be easy to think that things “aren’t progressing” or are moving slowly. Even if you are exhausted, make sure that your expression is one of genuine interest, encouragement and excitement. If you need to call in another doula colleague so that you may rest, do so. The patient will not mind, and will probably be flattered that you care so much about your total involvement in her labor and birth.

Make sure, however, that you are taking care of yourself! Pushing is a very involved, emotionally charged time for all involved. Have a bottle of water, a quick snack (such as a granola bar or some nuts), and excuse yourself as needed for bathroom/stretch breaks. You are no good to a laboring mother if you are tired, hungry and dehydrated.

While no definite, inflexible guidelines exist as to the length of time for the second stage, there are general guidelines followed by most providers. These guidelines, as reported by researchers Battista and Wing are,

Gravida	Regional Anesthesia	No regional anesthesia
Nulliparous women	2 hours	3 hours
Multiparous women	1 hour	2 hours

Every laboring woman is different, and there are times when women will exceed the recommended pushing time. There are also times where the decision will be made to proceed with operative vaginal delivery or c-section *before* the recommended pushing time has been met.

These situations are upsetting and discouraging for most women and families. In this situation, it is of utmost importance to remember:

- 1. You are not a medical provider. It is not your job to argue the decision of the provider, nor question it.**
- 2. Support your mother and her family in the best and most professional way you can.**
- 3. Encourage the mother and her support person(s) to voice concerns and feelings in an emotionally supportive environment.**
- 4. Help the mother to remain enthusiastic and excited about the birth of her child. A deviation in plan, while upsetting and anxiety provoking doesn't mean that "all is lost." Your attitude should reflect this.**

Very rarely does a decision to proceed with operative vaginal or c-section delivery occur spontaneously and without some forewarning. The provider should talk about their decision and the data supporting it with the patient in a non-threatening, compassionate manner. All risks/benefits and alternatives should be discussed. If the patient truly feels that this did *not* take place and *voices this concern to you*, you may take your concerns to the provider. To do this, excuse yourself from the patient's room and follow the patient's nurse outside. Politely ask them for a moment of their time. Then, you may *respectfully, succinctly and clearly* relay the patient's wishes. Examples of statements include,

"Kathryn really feels a bit overwhelmed right now. I know that she's been at this for 2 hours, but she really thought she was making progress. Is there any way we can talk to Dr. _____?"

“Ms. _____ really wants to avoid c-section, as I know we all do. She has asked if we can try pushing in _____ position. What do you think?”

Note the language in the previous statement. If the *patient voices a concern, escalate it*. It does not say if *you* are upset with the decision, escalate your concerns. It can sometimes be frustrating to those who work in birth to see women struggle during their second stage, and to see birth plans deviate from anticipated vaginal birth. Remember though, that it is not our job to project our feelings and thoughts of what a “normal birth” is onto the patient. If the patient is okay with a c-section or operative vaginal delivery, or is even excited about it, go with those emotions! Again-changes from the plan are not “failures” or “derailments.” They are simply variables, and actually, offer the mother and her support person a firsthand glimpse into parenthood! Very rarely do children go “according to plan”; flexibility, and a sense of humor and perspective is needed in every situation.

At the end of the day, we are proponents of healthy birth. We are proponents of families and empowering women on their journey to motherhood. We are proponents of healthy mothers and healthy babies. However these come to pass, birth is a joyful and exhilarating time.

The next chapters will discuss your role in operative vaginal delivery and c-section delivery should they become necessary for your patients.

Chapter 10: Operative Vaginal Delivery: Forceps and Vacuum Extraction

There are many indications for the use of forceps and vacuum extraction to achieve a vaginal birth. One of the most common that you will see is **maternal fatigue**. You can imagine that after pushing for 2-3 hours with full force and vigor, you too, may be quite exhausted and simply unable to push a baby any further.

The indications for use of forceps and vacuum vary depending on which device the provider chooses to use, and specific variables surrounding the health of the mother and baby.¹⁸ These will not be discussed here, because they are beyond the scope of your practice.

For your consideration and for your practice, know that pushing will continue as it has before the use of instrumentation. The only difference is that considerable traction will be placed on the baby's head as the mother pushes to aid in the baby's expulsion.^{14,20} It is very important to remind the mother that she still must push with the same effort and determination as before; operative vaginal birth is not "passive" with the baby simply being "pulled out."¹⁸

In some hospitals, you may move to a larger room (typically an operating room) to allow for more maneuvering room, and the ability to progress to a c-section if operative vaginal delivery does not occur. Additionally, the neonatal resuscitation team should be called for these deliveries due to the traction placed on the baby at the time of birth.¹⁸ You can help remind the patient that this team of doctors and nurses will be there for their baby as a precaution; it does not mean that anything is necessarily wrong.

Your mother and her support persons will still need emotional support and encouragement. Help them to understand what is going on, and reiterate education given by the nurse; do not undermine the decision or promote animosity amongst providers and between the patient and her provider.

Chapter 11: Caesarean Section Birth

Simply described, caesarean or “c-section” birth, is the “birth of a fetus through a transabdominal incision of the uterus” (Lowdermilk, et al., 2012, p. 807). To women who undergo c-section, however, it carries much more significance. There are emotional, psychological and physical aspects to a c-section which must be understood and acknowledged by providers and all who work in birth.

Studies abound which discuss the psychological ramifications of a birth plan which doesn't go as the mother expected. One study conducted by Beck and Watson, referred to particularly strong and telling language by one mother who felt as though she “...had committed a ‘sin’ by failing to have a normal birth...” (as cited in Elmir, Schmied, Wilkes & Jackson, 2010, p. 2150). Other research points to disruption of breastfeeding, maternal/child bonding, self-esteem, and lowered self-concept.^{10,11,18}

When the decision is made for your patient to undergo c-section delivery, this may occur antenatally or during the labor. If it occurs in the antepartum period, take this opportunity to discuss the implications for her birth. Questions you might use to spark conversation and sharing of feelings include:

1. How do you feel about c-section birth?
2. What do you know about c-section birth?
3. Have any of your family/friends had a c-section? What have they told you?
4. What are your concerns about c-section?
5. What are your fears?
6. What is something positive that you associated with c-section?
7. What are you most excited about when you think of your birth?
8. How do you perceive that this will change your birth experience?
9. Who would you like to be with you in the operating room?
10. Is there anything I should know about you or your history which may make the c-section uncomfortable?
 - a. Example: During the c-section, the mother's arms are restrained at her sides. If a woman has a history of abuse or trauma, this may trigger flashbacks or extremely unpleasant, unsettling memories. A foreknowledge of these issues can be helpful to you and other providers.

Your role as a doula is still important during c-section birth! We want to maintain an emphasis on the joy of the birth and the arrival of the child, not on the medical

procedure that is about to occur.¹⁸ This doesn't mean that we trivialize, mock or ignore expressions of doubt, fear and anxiety, but rather acknowledge them, and help the mother to understand and work with them rather than against them.

Things you can do to help support your patient and alleviate anxiety once in the operating room include:

- Reorient them frequently to people in the room
 - o It will be difficult to recognize people, as they will have on surgical caps and masks. Saying things such as “Your nurse ____ is still here, I am still here, Dr. _____ is still here” can be comforting.
- Explaining the rationale for bright lights and colder temperatures
 - o Help to maintain visibility and sterility during the procedure
- Using non-pharmacologic pain relief techniques to allay anxiety and pain
 - o Breathing
 - o Prayer
 - o Distraction
 - o Visualization

For some deliveries, it may be possible to engage in a more holistic, calm c-section delivery. In these instances, lights may be dimmed, music may be played, and the baby may be brought right onto the mother's chest after delivery! Of course, this requires advanced planning and agreement by all members of the care team, and is not appropriate in emergency situations, or when fetal compromise is expected (i.e., non-reassuring fetal surveillance.) This technique was pioneered in Europe, and is featured in the video clip below.¹⁵

<http://www.youtube.com/watch?v=m5RIcaK98Yg>

During the c-section, you will be permitted to enter the operating room at the VCUHS. This may be different in other community hospitals, and you are asked to respect the policies and procedures of the hospital in which you are a guest. If an acute event occurs during the surgery, or the need for general anesthesia arises,

If you end up staying in the mother's labor room, you are not useless! You can:

- ❖ **Tidy the room for her return**
- ❖ **Make sure that the grandparents (or those left behind) are hydrated, have snacks, etc.**
- ❖ **Take care of yourself! brush your teeth, eat something, grab a bottle of water, etc.**

you will be asked to leave the room. This is so the anesthesiology team has maximum space in which to work and care for the patient.

After the c-section, you will continue to stay with the mother postpartum and encourage her to begin breastfeeding (if this is her wish.) Pain management and other post-operative concerns will be managed by her nurse. Certainly, if your mother verbalizes any concerns to you, you may raise them to her nurse or her provider at the appropriate time.

Chapter 12: Postpartum Physiology: Maternal/Newborn Care

The postpartum period is one of enormous change for women and families. **Physical, emotional, psychological and spiritual changes occur, and role changes also occur within the family.**^{18,24} Women need a **strong support system** in the postpartum period just as they do for labor and birth. It is a misconception that after the baby is delivered; the work is “done.” Rather, it is just beginning.

If you want to stop by the hospital and visit mom, please feel free! She would probably be very happy to see you and begin to discuss/debrief her birth!

This is a very important part of postpartum-telling her story. Let her do that as often as she needs to.

The current hospitalization time for a delivery is two days for a vaginal delivery and three days for a c-section delivery. This does not leave much time for education and anticipatory guidance for the family. Anything you can do to help ease this transition will be much appreciated by the mother, her family and the hospital staff!

Physical assessment of the postpartum maternal/child couplet is the job of the registered nurse or delivering provider. However, your interactions with the mother and her family can glean important information for the provider, and you can continue to offer holistic psychosocial support and encouragement as this mother transitions into her new role. In fact, many doulas work in a postpartum capacity only. They assist the mother in the hospital, and then continue their working relationship once the mother is discharged home. The length of time they continue to serve is pre-determined by the mother and the doula.⁸ You will not be serving in this extended at home capacity with your mother. You are welcomed and encouraged to visit your mother and her newborn in the hospital, but for legal and safety reasons, we cannot permit you to visit the new family in her home. In some instances, home visits will be appropriate, but you must be accompanied by a faculty member when you go.

Physical Changes in the Postpartum Period

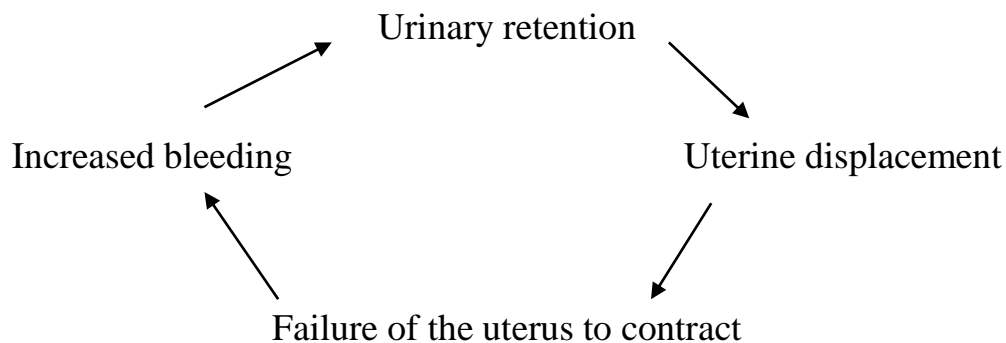
While many changes occur in the postpartum period, we will focus on the major physical changes which you are most likely to see during a patient’s hospitalization.

The uterus will begin the process of involution, or return to its pre-pregnancy state. You will recall from an earlier chapter that the superior, rounded portion of the uterus is called the fundus. The fundal height is measured in centimeters using the

umbilicus as a reference mark in the postpartum period. The uterine fundus should approach the umbilicus and eventually sink below it as it returns to its pre-pregnant state. As the uterus involutes, it contracts and expels blood and other tissue debris. The contractions are felt as cramping pains, and the blood expelled from the uterus is called lochia. This bleeding is heavier and darker in color initially, and then tapers in color and quantity over the next few days and weeks.^{18,24}

Be aware that breastfeeding will increase lochia flow related to the release of oxytocin, and that blood will pool in the posterior vagina if the mother is lying or sitting for prolonged periods of time. Thus, if a mother is sitting in bed for a few hours, breastfeeds her child and then gets up to ambulate or use the rest room, there will probably be a slight pouring of blood. While you shouldn't be alarmed, you should notify the provider and make sure that it is safe for the mother to be out of bed. Remember-assessing the fundal height and lochia flow are outside of your scope of practice.^{18,24}

Another concern in the immediate postpartum period is the status of the mother's bladder. If the mothers' bladder is full, the uterus cannot contract adequately. If the uterus cannot contract adequately, bleeding continues and hemorrhage can ensue.¹⁸ This relationship is shown below in pictorial format. Because of this, the registered nurse and other delivery providers will be paying special attention to urine output and signs of urinary retention. If bleeding increases, or if the mother cannot void her bladder within a few hours of delivery, a straight catheterization will probably be performed to ensure the bladder is empty.



When we discuss the newly postpartum mother getting up for the first time, it is important to mention patient safety. Even if the mother did not receive regional anesthesia, it is important to note that blood loss, fatigue and weakness all adversely affect gait and balance. The postpartum mother should *always* be assisted on her first trip out of bed. If she had regional anesthesia, a licensed care provider should assess and confirm that the anesthetic block has appropriately

receded prior to ambulation. Always confirm with the patient's care provider before assisting in ambulation.¹⁸

Physical changes to the breasts will be discussed in the breastfeeding chapter.

Emotional and psychological changes will be discussed in the mental health chapter.

Newborn Care

The newborn baby is one of the most miraculous beings; they undergo such vast physical changes during their first moments of life, and then channel energy into growing and thriving.

With physical assessment and care of the newborn falling to the nurse and the newborns' parents, it is still important for you to understand basic principles of newborn care. Parents have come to trust you as a valued member of their support system, and may ask you general questions about their baby's health in those first moments. While complex questions and questions about a specific diagnosis or treatment plan should be redirected to the provider, basic questions about infant care or appearance may be answered at your discretion.

Transition to Extra-Uterine Life

In the first minutes of the newborn's life, they must transition to living life independent of their mother's support. A score is given to the newborn to ascertain how well they are transitioning in these first moments. The baby is scored at 1, 5 and 10 minutes in the categories of heart rate, respiratory effort, muscle tone, irritability and color.^{18,24}

Newborn Appearance

Newborns will appear generally flexed at birth; this is because that is the position they assumed while in utero! If the baby was breech, you will note that the legs are flexed at nearly 180 degrees. Do not force the legs or arms into any position after birth. Allow the baby to assume whichever position is most comfortable for him.¹⁸

The skin of the newborn should be warm, dry and intact. If the newborn was born via forceps or vacuum extraction, there may be some facial bruising or swelling of

the scalp tissues. Similarly, if the mother pushed for a considerable amount of time, the tissues of the head and face may also be slightly edematous from the counter pressure placed on them by the cervix and pelvic floor.¹⁸

Remember that the newborn heart must master the task of pumping blood to the entire body immediately after birth. Initially, blood is shunted to the core, leaving the extremities cyanotic. This is termed acrocyanosis, and is normal. It shouldn't persist long, and as the heart perfuses the entire body, the color of the extremities will eventually match the color of the core. Persistent cyanosis or central cyanosis are always cause for concern.

Respiratory changes are also significant in the newborn. As they transition to extrauterine life, many newborns may experience slight grunting with respirations, nasal flaring, or retractions of the intercostal muscles. Of course, prolonged or marked variations of these findings are cause for concern, and the registered nurse will continue to watch the newborn closely.

GI and GU systems should be fully functional at birth, and the baby's genitalia should be clearly male or female. While there are variations of normal and genital abnormalities, they fall outside the scope of this training. The newborn will be capable of urination and defecation. Failure to produce a meconium stool or void within 24 hours is cause for concern, and may be a sign that the baby is not receiving adequate PO intake. The baby's nurse should be notified.

Newborn feeding cues will be discussed in the breastfeeding chapter.

While only a brief overview, this chapter serves to give you insight into the common postpartum course for the mother and her newborn. If possible, stay with your patient for a few hours postpartum and visit her on days one and two. You will probably learn a lot from the nurses and providers who are caring for your patient and it will be a valuable learning experience for you to see the patient start out on the postpartum continuum. Furthermore, it will provide you an opportunity to conclude your working relationship with your mother and say goodbye to she and her family.

Chapter 13: Breastfeeding: It beings right after birth!

<http://bfconsortium.org/>

Arguably one of the most powerful and beautiful ways a mother may bond with her child, breastfeeding is one way that a newborn may be nourished. While many healthcare providers and birth workers routinely say, “breast is best”, it is important that we be able to articulate *why* that is. The table below lists some of the many benefits of breastfeeding on individual, family and societal/global levels. Talk to your patient to see how breastfeeding may positively impact her, her newborn and her family.

The website to the left is the Breastfeeding Consortium website. For Virginia residents, training on breastfeeding education and support is FREE! (You will have to provide your address when you register to verify residency requirements.)

We *strongly* encourage your participation in this program; it is free CEUs and an invaluable learning experience.

Benefits of Breastfeeding^{17,18,24,29}

Maternal	Child/Family	Societal/Global
Increased maternal self-efficacy	Breastfed children are generally healthier (less DM, obesity, asthma, ear infection and GI disturbance/food allergy rates)	Increased awareness and normalization of breastfeeding (particularly in public)
Heightened bond with baby	Breastfed children generally have higher IQs	Children and mothers who are generally healthy do not utilize the healthcare system as frequently, saving money and resources.
Increased feelings of empowerment	Specific, tailored nutrition made <i>just</i> for that baby.	Decreased waste from formula cans and bottles/liners, as well as waste from the production costs of formula.
Increased rate of pregnancy weight loss	Benefit to the family budget in that formula will not have to be purchased.	
Decreased risk of obesity, DM, breast cancer	Encourages communication between mother and her partner as he helps with positioning/latching/recognizing infant feeding cues.	
Immediate contraception; Lactation Amenorrhea method		

While the benefits abound, it is important to realize that some women do not wish to breastfeed. This decision is deeply personal and intimate, and is influenced by a host of factors. Some of these factors include^{17,18}:

- Lack of support from partner or family
- Lack of knowledge about breastfeeding/pumping
- Embarrassment/uncomfortable feelings when latching baby
- Concerns about supply or breast size
- History of abuse or trauma which makes breastfeeding uncomfortable and shaming
- Concerns about returning to work and being judged/penalized for pumping
- Having other family/work/school responsibilities which would not support a rigorous pumping schedule
- Lack of proper storage facilities for expressed milk
- Lack of access to resources to help establish/maintain a supply such as lactation consultants and high quality breast pumps
- Taking a medication which is contraindicated with breastfeeding (chemotherapy, illicit drugs, etc.)
- Having a medical condition which is contraindicated for breastfeeding (i.e., HIV +, or a patient who is status post mastectomy for breast cancer)

As a doula, it is important to understand and respect these barriers to breastfeeding in your patient. While it may not be the decision you would make, it is important to respect it. If the patient has been given non-biased, complete, evidence based information, it is then up to her to make an informed decision. If she chooses to formula feed her child, this is okay. Again—we are to empower and support women so that they have the birth *they want*. If that positive experience does not include breastfeeding, we must embrace that.

Consider also women who have special medical needs that related to breastfeeding or an inability to breastfeed. Women who have had bilateral mastectomy are not able to breastfeed, but surely, they are capable of bonding with their children! The same is true for women who are HIV+. When we look at other conditions which are not medical in nature, we see adoptive mothers and lesbian couples, for example. In these instances, breastfeeding may not be possible. Yet we would certainly encourage maternal/child bonding through other ways. What are some ways you can encourage bonding without breastfeeding¹⁸?

- Holding the baby skin to skin (this can also be done by the partner!)
- Touching/holding/stroking the baby
- Singing/praying/reading with the baby so that he gets used to his mother's voice
- Giving the baby his baths, changing clothes, and performing other care tasks
- Bottle feeding the baby formula or expressed breastmilk
- Spending lots of time "en face" with the baby
- Cuddles, play and frequent touch

If your patient makes the decision to breastfeed, and both she and the baby are stable, you may help the mother with this first latch. If the mother has never breastfed before, she might be nervous and unsure of her abilities. She may feel clumsy as she tries to bring the baby to the breast and support her head. You can help with all of these things! Certainly, lactation consultants are available for difficult cases, but you should try to assist the mother first.

Latching

The latch is the most important aspect of breastfeeding. Poor latches can lead to incomplete milk transfer (leading to infant hunger and dehydration), incomplete breast emptying (which lead to pain, engorgement and mastitis in the mother), and skin breakdown on the nipple (which leads to pain, infection, and a decreased willingness to continue on behalf of both the mother and the baby.) You can see how this quickly becomes a vicious cycle. It is of utmost importance that the mother knows how to properly latch her baby.

When the baby starts to show signs of hunger, have the mother bring her to the breast immediately. Crying is a late sign of hunger. Earlier signs include the rooting reflex, bringing the hands to the mouth, sucking on her hands/fingers, and actively searching for the breast.^{17,18,24,29}

When the mother or partner observes these cues, bring the baby skin to skin with the mother. Skin to skin means just that: Not "t-shirt to hospital gown", not "naked baby to mother's bra", it is naked baby (but for a diaper) and a bare chested mother. This skin to skin contact not only enhances bonding, but also assists the baby with thermoregulation.

There are multiple positions in which to breastfeed, and the position used by the mother is driven by her preference and the affinity of the baby to latch the breast while in the position. The most common positions are^{17,18,24,29}

- Cross cradle
- Cradle
- “football”
- Side lying

Neither position is “wrong”, and again, should be driven by maternal preference. Some positions are more suitable for women who have just had c-sections (i.e., the football hold) as they take the pressure off of the abdomen. Side lying may also be helpful for c-section mothers as it allows them to move and not sit straight up on a fresh abdominal scar.

After a position has been selected, the mother will latch the baby. The important pieces of guidance to remember and offer are^{17,18,29}.

1. The baby comes to the breast; the breast doesn’t go to the baby.
2. Baby should open her mouth wide; mom then brings her to the breast.
3. Baby should be in a straight line. The ear, shoulder and hip should line up.
4. Baby takes in areolar tissue *and* the nipple. Just “chomping” on the nipple will lead to pain and is not an effective latch.
5. Mom’s nipple will be on the roof of baby’s mouth with the tongue underneath.
6. Baby will start to suck in bursts, and the milk will let down!

Signs that the latch is successful and that milk is transferring include

- Tingling in the breast on which baby is latched and on the opposite breast
- Leaking of milk from the other breast
- Cramping/increased lochia
- Baby’s “burst” sucks change to rhythmic, longer sucks and swallows
- Milk starts to leak from around baby’s mouth
- The breasts feel “empty” after a feed

Some mothers will have babies who are admitted to the neonatal intensive care unit, or NICU. These babies are unable to be with their mothers for rooming in and frequent skin to skin contact. Breastfeeding is still critically important for these babies, particularly since they are getting mom’s antibodies and gentler,

easier to digest nutrition. Mothers with babies in the NICU should *always* be set up with a breast pump, and should begin pumping as soon as possible. The nurse or IBCLC will set the patient up with a breast pump and the needed parts. Their pumping schedule should follow an infant feeding schedule. Preterm mothers will take longer for their milk to come in, and this is normal. Remind the mother that her body wasn't ready to make milk so early, so it takes a few days to "wake up" and realize that the baby has been born!

One of the most difficult concepts to get across to new mothers and their partners is the concept of "supply and demand." The body does not magically start producing milk; it has to perceive a need. How does it do that? It notes a suckling baby or the action of a pump. The more the mother places baby to breast, or the more that she pumps, the more milk she will produce. From a professional standpoint, we know that this is a hormonally mediated feedback loop.

A simple, direct way to explain this to your patients is this:

"Your baby needs to really 'live' on your chest skin to skin. Why? Whenever your baby latches your breast or even licks/spits/snuggles your breast, your brain releases a hormone called oxytocin. This hormone tells your breast to "let down" the milk, and it also helps you bond with your baby. When you "let down", your breasts are ready to breastfeed. You may feel them get tingly, very full, and they might even start to leak. This is good! When your baby feeds, the breast empties. After that, your brain says, 'Oh ok! We needed milk at that time. I'll remember that and make more.' If you don't feed your baby at that time, the brain says, "Oh, I guess we don't need that milk. I'll tell the breasts to slow down and stop making so much. The more you put your baby to breast, the more milk you will make. Your baby should go to your breast 8-12 times per day for at least 15 min. on each breast. If she wants to nurse longer than that, let her!"

Again, there are many complications which may arise and special needs of babies as they begin their breastfeeding journey. This is where the provider and the IBCLC are helpful, and can set up outpatient follow up, counseling and support for the mother. However, if you can assist the mother with this first latch and this first bonding moment, she will be forever grateful. You might also find that in the moments right after a delivery, mom is intoxicated from endorphin and oxytocin release; this may be a good time to broach putting the baby to breast. If mom has previously been ambivalent, you can gently mention bringing the baby to breast. Certainly, if mom has emphatically declined breastfeeding, or if there is clinical contraindication, this should not be offered.

Chapter 14: Psychosocial Concerns in Childbearing

This chapter could be a curriculum unto itself; our goal here is to provide a brief introduction to the vast number of psychosocial complications which may arise in pregnancy, and how they affect the labor and delivery experience.

As is the case with all topics presented in this book, but especially these topics: *Safety must prevail.*

If a mother verbalizes any suicidal or homicidal ideations, or you have any reason to believe her safety or the safety of her child is imminently threatened, you must report that to your faculty member, nurse or provider immediately. You are not to attempt to manage an unsafe situation by yourself, nor are you to make independent home visits under any circumstances. This is for your protection.

Before we discuss sequelae of psychosocial complications, we must first define what one is. We typically think of intimate partner violence (IPV) and abuse as psychosocial complications, and they most certainly are. However, complications can include many other things that you might not have considered:

- Lack of partner support
- Partner or mother incarcerated
- IPV
- Lack of financial resources
- Unemployed
- Uninsured
- Unsafe living environment (no electricity, plumbing, HVAC, etc.)
- Lack of proper baby supplies (namely car seat and crib)
- Teenage pregnancy
- Pregnancy as a result of rape
- History of trauma, rape or violence
- Pregnancy and human trafficking
- Limited English proficiency/immigration issues

Remember: you are a doula, not a nurse.

All suicide/homicide ideations must be reported to clinical faculty immediately. There are no exceptions to this rule. Ever.



It is our goal to support and advocate for women who have mental health concerns during pregnancy.

Always let your faculty know if someone has a mental health issue or psychosocial stressor. You are never alone fielding these concerns.

- Mother or partner with mental illness
- Substance use during pregnancy
- Chronic medical condition making self-care difficult
- Other children/elderly parents for which the mother is the sole provider
- Undesired pregnancy
- Lack of transportation/limited access to care

This list is certainly not exhaustive, and could be much longer. Truly think about all of these variables. Which apply to your patient and her family? Which could pose a problem to her during the pregnancy or in the postpartum period? Which could adversely affect her labor and delivery experience?

We will examine postpartum depression and history of abuse/violence as they relate to the childbirth experience.

Postpartum Depression

Postpartum depression is a highly prevalent mental illness, yet it is highly stigmatized. The media is flooded with pictures of celebrities with perfectly trim, toned bodies mere weeks postpartum, and these women talk about juggling yoga, exercise, childcare and family responsibilities. Of course, these women have an entire team of personal chefs, chauffeurs, nannies and housekeepers, but still; “ordinary” women measure themselves against this unattainable ideal. Society has also stigmatized postpartum depression, criticizing women for feeling depression at all during such a beautiful and sacred time in their lives.

It is important for birth workers to understand the link between high risk mothers and postpartum depression. If a mother has a high risk pregnancy (be it high risk for medical or psychosocial reasons), she is at an increased risk for developing postpartum depression.^{16,18,24} If she has any pre-existing mental health conditions such as depression, postpartum depression, substance abuse, or any of the aforementioned psychosocial risk factors, she is at an increased risk of developing postpartum depression. Because of this, the mother and her partner must be taught to recognize the signs and symptoms of postpartum depression, and to report them promptly so that interventions may be implemented. It is vitally important to stress to patients that asking for help is not a sign of weakness, nor a sign that they are an unfit mother. Rather, it is a sign that they are brave, and wanting to be the best mother than can be.

The postpartum “blues” are a condition affecting approximately 60% of women, and they last for the first few weeks after the birth.^{18,24} The mother might feel weepy, generally sad, and may report just feeling “hormonal”, similar to the feelings she may experience as part of premenstrual syndrome, or PMS. She is still able to care for herself and her baby, and her moods are stable. These feelings do pass within weeks, and do not require medication or therapy to manage.²⁴

If the feelings of sadness persist past a few weeks postpartum, they become suggestive of postpartum depression. PPD begins to affect the mothers’ activities of daily living. She finds little interest in caring for herself or her baby, and may report that her moods have sunk into great depression. PPD is also characterized by irritability; suicidal or homicidal ideations may be present, and are grounds for *immediate, crisis intervention*.^{18,24} Again, this is not within your scope of practice to intervene, but it should be reported to the patient’s provider immediately.

There are a few instruments available that measure postpartum depression scores in women. Mothers answer questions about their moods, feelings and temperament; their score correlates to the probability that they fit diagnostic criteria for postpartum depression. The most commonly used scale is the **Edinburgh Postnatal Depression Scale**⁵, and it is given at the patient’s postpartum visit. The tool asks the mother questions on a Likert scale regarding her moods and her stability. Higher scores are associated with the likelihood of a postpartum depression diagnosis.^{5,18,24} Recognizing, however, that one measurement is often not suggestive of a cumulative number of weeks or months, and that symptoms may express later, pediatricians have taken to providing the scale to mothers when they bring their children in for routine “well baby” visits.

The IPV Survivor in Labor and Birth

<http://www.vawnet.org/elearning/DVBasics/player.html>

http://mchlibrary.info/KnowledgePaths/kp_domviolence.html

<http://www.marchofdimes.com/pregnancy/abuse-during-pregnancy.aspx>

This is such a delicate topic, and one that, again, could be a curriculum unto itself. As a doula, you must understand that a woman's previous experience with domestic violence and sexual assault will affect her childbirth. This may be a positive or negative influence, and we will discuss this later in this chapter. She may not know this until she begins to labor, or she may be aware of it in the prenatal period.²⁶

The links to the left are sources and sites which deal with intimate partner violence (IPV) in pregnancy and birth.

If a woman discloses that this is a part of her history, treat this information with the reverence and attention it is due. Thank her for sharing something so intimate, and ask how you may be of the best help as she moves towards her labor and birth. Questions to consider asking based on your perceived level of her comfort and willingness to engage include:

1. How do you think your past is going to affect your labor and birth?
2. What scares you the most about your labor and birth?
3. Have you talked to anyone such as a counselor or a nurse about your past history of abuse?

If a patient reveals to you that she is currently in an abusive or violent situation, you need to report this to her provider. Her provider will be up to date and aware of mandatory reporting laws, and will make sure that, if appropriate, the concerns are escalated to the proper persons or authorities. Much as you may want to, you are not to try and intervene, remove a patient from a violent situation, nor make independent home visits.



When you read the statement that a history of abuse may have a positive or negative effect on labor and birth, you may be puzzled as to how this could be positive. Some women view their labor and birth as an opportunity to reclaim their bodies, their autonomy, and that they will have control over the situation.²⁶ These are empowering thoughts, and they use these thoughts as motivation.

Other women, however, fear their impending labor and birth. They see it as another time in which they will have no control, they will be in excruciating pain, and be victimized all over again. They may also view their birth as traumatic.¹¹ It is very important that if you know a woman to have an abuse history, that she share that with her provider so that the proper counseling and healing may begin prior to the onset of labor.

If you find yourself working with a patient who has experienced intimate partner violence, make sure that you are very judicious with your use of touch. Other helpful hints include:

- Careful use of touch.
- Never approach the patient from behind without announcing your presence.
- Tell the patient what you are doing before you do it. Do not take her by surprise.
- Be cognizant of the words you use. Phrases such as “Relax”, “open your legs”, “good, good” may conjure upsetting memories, and may have been phrases her assailant had used.
- Ensure the patient’s privacy during examinations and during labor.
- If she does require c-section delivery, stay with her and ensure her comfort, particularly during restraint of her arms and legs.
- Keep the woman “in the present.” If she appears to be flashing back, encourage her to open her eyes, see the people around her, and reiterate that she is in a safe space.
- Do not assume that everyone in the room knows the patient’s story. Some family members, friends or other providers may not know what you know.

Caring for a woman who has been the victim of IPV, or the woman with mental illness in pregnancy can be some of the most difficult, yet rewarding opportunities. Take the opportunity to learn from your patient, her partner, and/or her family. Encourage open and honest communication which puts patient safety and autonomy above all else. Help to teach this woman that she may advocate for herself, that she is important, and that her wishes are valuable. By affording women these basic respects, we work wonders for their self-esteem, self-worth and

feelings of positivity as they embark on becoming mothers. The healing process is long, and it is not easy, but childbirth can be a vitally instrumental piece along that road. You can help to make it one piece of her healing.

Chapter 15: Care of the Special Needs Family

During your work as a doula, you may have the privilege of working with families who are expecting to deliver children with special needs. Sometimes, these needs are diagnosed in the prenatal period by ultrasound, and the family has time to prepare. Other times, due to a host of factors including late or no prenatal care, denial, or lack of follow up, parents do not know that their child has been born with special needs until he delivers.

Screening and testing for these conditions in the prenatal period is not mandated, and some parents chose to forgo this testing. This may be for any number of reasons including access to care, limited financial means (many of these screening and diagnostic procedures are considered elective and not covered by insurance), or they chose to forgo testing because of religious or cultural reasons.¹⁸

Your psychosocial interventions and support are very much needed in these situations. It is said that “the desired and expected outcome of every wanted pregnancy is a normal, functioning infant with a good intellectual potential” (Lowdermilk, et al., 2012, p. 873). This is a definition most of us can agree upon, and you can see how parents may have to grieve the loss of their expectations if they find out that their child has special needs.

“Special needs” is a very wide, non-specific term which covers many conditions including physical and intellectual special needs. Common physical special needs include cleft lip/palate, congenital heart defects and club feet.¹⁸ Intellectual special needs include Down Syndrome.¹⁸ Depending on the need identified, and whether or not it exists in isolation or as part of a syndrome, care during the labor and birth of the child may be altered. For example, a child with a congenital diaphragmatic hernia will most certainly need the NICU team readily available at his birth for intubation and transfer to the NICU.

If possible, talk to the mother and her partner prior to the birth so that you can understand her priorities and wishes for the birth of her child. Help her to see that her baby is not just a “diagnosis”, but still her child. Her birth can still be magical, empowering and uplifting despite extra levels of intervention and care. “The feelings stemming from the real or imagined threat posed by a congenital anomaly are as varied as the people being counseled. Responses may include apathy, denial, anger, hostility, fear, embarrassment, grief, and loss of self-esteem” (Lowdermilk, et al., 2012, p. 891).

By allowing the mother and her partner the opportunity to express feelings and emotions in an emotionally supportive environment, you are affording them the opportunity to vent those feelings and begin to work through them in a safe space. While it is not your job to counsel the patient, you can still provide solid psychosocial support and empathy.

Perinatal Loss

Of all the fears of a birth worker, perinatal loss is one of the greatest. Taking an emotional and spiritual toll on the providers who work with this mother and her partner, the toll on the family is also great.

Perinatal loss takes many forms; this could be a miscarriage, ectopic pregnancy, “still birth” or fetal death, or the death of a baby shortly after the birth.¹⁸ Women and their partners grieve these losses in many ways, and the reactions will be varied. Factors such as personal experience, history of perinatal loss, mental illness, overall physical health, quality of support systems, and cultural/religious factors all impact how and when families grieve the loss of their children. Understand that the family’s response is the “right” response. Encourage their release of emotions in a safe, therapeutic space.¹⁸

The patient’s nurse and other healthcare providers will discuss things such as postpartum care, referral to community agencies for mental health support, and suppression of lactation. Your biggest role in this type of situation is providing holistic psychosocial support to your mother and her partner/family.

Encourage the mother and family (as they are willing), to hold their baby, take photographs and name their child. Again, these are all highly personal decisions, and should never be imposed, but they can be helpful. Sometimes parents don’t feel as though this is appropriate, or that they may be thought of as odd. Give them permission to do these things.¹⁸ It is perfectly okay to name a child who has died, and to hold them. “Choosing a name helps make the baby a member of the family so that the baby can be remembered in a special way. Once the baby is named, the nurse should use the name when referring to the baby” (Lowdermilk, et al., 2012, p. 938).

As you can well imagine, perinatal loss is a risk factor for postpartum depression. Some women are at risk for developing what is termed complicated grief.¹⁸ As defined by Badenhorst and Hughes, this “...differs from what is considered normal grief in its duration and the degree to which behavior and emotional state are

affected” (as cited in Lowdermilk, et al., 2012, p. 948). If you are still in contact with a mother in the postpartum period, and you suspect this pattern of grief, encourage her to follow up with her provider immediately for help. There are also community resources which can help the mother with counseling and crisis hotlines.

To help a family through a perinatal loss is a tremendous undertaking, as it will require great emotional strength from you as the doula. Know that parents will remember you and all of the help you provided them as they navigated those tumultuous days and moments. Every birth can be beautiful and special, even in the face of perinatal loss. Help your patient to see that she is a mother, regardless of whether or not her child is alive with her. That bond she has with her child can never be erased, and she can find meaningful ways to commemorate the memories of her pregnancy, labor and birth.



“A Wave of Light”, Mellssa Doroquez, <https://www.flickr.com/photos/merelymel/1584030646/>

Chapter 16: The Next Chapter in Your Professional Career

We cannot thank you enough for your energy, dedication and interest in the volunteer doula program at VCU. We know that you are here and engaged because women's health and the care of families are important to you. Whether you are motivated by your own experiences, the need for social change/justice, or a sheer interest and love of birth, we value your individual opinions and experience. Each one of you brings a unique perspective to this training, and to your patient interactions. Each one of you would approach the same mother and labor with a different framework and different ideas; this is what makes our work so special and individualized.

As you continue with this program and through nursing school, many of you will begin to seek out employment opportunities in the field of women's health. This next section talks about various opportunities for you so that you may continue your doula work if so desired, and hopefully enter the field of women's health nursing!

Nursing jobs in women's health are typically difficult to come by. They have low turnover rates, and many require previous nursing experience. Fields of maternal/child nursing at the entry/baccalaureate level which may be interesting to you include,

- Labor and delivery
- Postpartum/Antepartum nursing
- Newborn nursery
- Neonatal intensive care unit (NICU)
- Pediatrics
- Women's surgical nursing
- Outpatient women's health
- Outpatient pediatric health
- Community health with women/family advocacy groups or home health agencies

Advanced Practice Roles

- International Board Certified Lactation Consultant (IBCLC)
- Women's Health Nurse Practitioner (WHNP)
- Certified Nurse Midwife (CNM)
- Clinical nurse specialist (CNS) in women's health
- Clinical nurse educator (CNE)

Many of you may also choose to continue your doula work and obtain national certification. As we mentioned earlier in this curriculum, this course does *not* prepare you for certification, nor can it be used as required education for such a program. It was designed specifically for our doula base at VCU, and tailored to speak to the needs most commonly addressed in our predominately high risk obstetric population.

However, if you choose to continue your doula education, you are encouraged to seek out the following resources. It is important to note that the faculty and staff at VCU do not endorse any program. The views and material taught in each course are the opinions of the organizations and instructors providing them, and we assume no responsibility for the quality and accuracy of information you may receive from them.

Each agency and certifying body has their own unique requirements for continuing education and certification, and you are encouraged to be in contact with each of those bodies for individual questions.

Association of Labor Assistants and Childbirth Educators (ALACE)

IBWP

P.O. Box 390436

Cambridge, MA 02139

1.877.334.IBWP (4297)

<http://www.alace.org/>

Doulas of North America (DONA) International

35 E. Wacker Dr., Ste. 850

Chicago, IL 60601-2106

(888) 788-DONA (3662)

Local: (312) 224-2595

Fax: (312) 644-8557

http://www.dona.org/develop/birth_cert.php

to Labor*

PO Box 4410

Richmond VA 23220

804-320-0607

<http://tolabor.memberlodge.org/>

*to Labor is the organization run by executive director, Thérèse Hak-Kuhn out of Richmond, Virginia. Thérèse was wonderfully gracious and accommodating when the VCU doula program started. She offered our doula training at a reduced rate so they could begin their work in the community. As the program grew, we moved our training “in house”, so that we could train more doulas in a shorter, more standardized fashion. Our relationship with to Labor remains strong, however, and you are welcome to attend her workshops to obtain your certification as a labor doula.

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