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## Fear of Fatherhood

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2015

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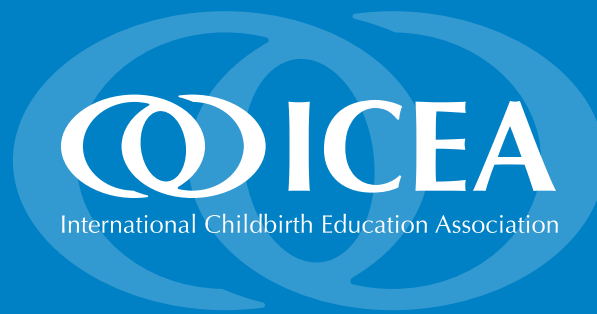
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*International Journal of*  
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***Fatherhood***

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VOLUME 30 NUMBER 1 JANUARY 2015

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# Fatherhood

by Debra Rose Wilson, PhD MSN RN IBCLC AHN-BC CHT

This issue examines and celebrates fathers and their role in the childbearing family. In the United States, there has been a crisis recognized. One in three children lives in a home without their biological father. Globally, children in father-absent homes are four times more likely to live in poverty and have seven times the rate of unplanned teen pregnancy. Children without fathers are more likely to experience emotional and behavioral problems, criminal activity, drug addiction, obesity, and abuse. Many factors have contributed to changes in the fatherhood role including shifting gender roles, financial trends, increased diversity in local populations, and changing of the “normal” family structure.

But we are making a difference with resources which include blogs, support groups, faith-based programs, the Responsible Fatherhood Clearinghouse, the National Fatherhood Initiative, Project Fatherhood, and the National Center for Fathering. The Fatherhood Institute in the United Kingdom is involved with program development to influence the changing paternal role, fatherhood rights in Germany are getting needed legal attention, and fatherhood groups in South Africa recognize fatherlessness as the largest sociological change influencing the well-being of children. To address gaps in research, program development and outcomes, the Father Involvement Research Alliance began in Canada in the past decade. Father-focused community programs are gaining popularity and funding.

I encourage members to reach out to clearinghouses and make available free brochures, booklets, and videos for the childbearing family from fatherhood.gov. There is a federal interagency working

group on responsible fatherhood that explores federal actions to remove barriers and encourage fathers to be engaged in their children's lives.

Discuss the importance of the father's role beyond childbirth and the first year. Make a ripple of change at the grassroots level, and become involved with local and national programs to assist the fatherhood movement. Take a moment to reflect on those who filled a positive father role in your own life and let them know they made a difference. Thanks Dad, I learned resilience and perseverance from you.

This issue includes articles on fatherhood, PP depression in fathers, as well as journal writing in the perinatal period, aromatherapy, PP weight control and maternal obesity, primary research on ectopic pregnancy, humor and health, electronic cigarettes, several book reviews on fatherhood, and more. Readers, do write me, tell me what you want to read about, suggest future themes for the journal, offer to do peer review, and write articles for your journal.

Thank you to Nancy Lantz, our past president of ICEA who is stepping down at the end of 2014. Your wisdom, clarity of thought, and involvement with the journal have been so much appreciated. I am so happy you are staying involved with ICEA to mentor the new board coming on in 2015.

Peace,  
Debra  
editor@icea.org



Debra Rose Wilson

# Lighting A Thousand Candles

by Connie Livingston, RN BS LCCE FACCE ICCE

*The Future Depends on what you do today. —Mahatma Gandhi*

As I step into the position of ICEA president, I am reflecting on the past thirty years as a member. Membership in this organization has always meant a great deal to me. The mission and vision of ICEA, freedom to make decisions based on knowledge of alternatives, has been the hallmark of evidence-based teaching. It was the basis for every single one of the childbirth classes I've ever taught. ICEA influenced how I and countless other childbirth educators and doulas have practiced. The future depended on what ICEA did then.

As the 2015-2016 Board of Directors begin their term, we will work to set goals for the term and define and clarify ICEA's position in the birth world. Our focus will be on collaboration with other like-minded organizations, much the way we did in 1997 in the joint formulation of CIMS (the Coalition for Improving Maternity Services). Some initial contacts have already been made with organizations such as the Association for Prenatal and Perinatal Psychology and Health (APPPAH), the National Perinatal Task Force, and the International Cesarean Awareness Network (ICAN). It is our hope that by cultivating alliances and collaborations, ICEA will be the catalyst to strengthen the Voice for evidence-based maternity care/best practice for every pregnant woman across the globe.

Our focus on the future will be deeply seeded in the work done during this term, including increasing the use of technology to bring ICEA to the membership. ICEA has an online Doula Training Program in place, and in the very near future, we will be offering more online opportunities. We understand that finances and geography play a big role in our members' lives and are actively taking steps to bring more to the members. Through social media (including Facebook, Twitter, the ICEA blog, and our soon-to-be launched YouTube Channel), ICEA be more impactful than ever before.

Past ICEA President Cheryl Coleman shared the values of ICEA in her president's message in the spring of 1998. These values are as true now as they were then:



Connie Livingston

- **Excellence** – ICEA is committed to providing the highest quality resources and to continual improvement in all its offerings to members.
- **Service** – ICEA strives to meet the ongoing and changing needs of all members, educators and customers.
- **Commitment** – ICEA is run by a working volunteer Board of Directors, Main Office staff and innumerable volunteers who have demonstrated intense loyalty to and pride in ICEA. This commitment has allowed the organization to achieve the level of leadership that it has.
- **Stewardship** – The ICEA Board of Directors is committed to careful and responsible resource management so we can provide our members with the greatest number of quality services at the best price.
- **Leadership** – We, as members and as a board, need to continue to color outside the lines, to think outside the box, to be not only visionary thinkers but also doers, so that ICEA can continue to grow and move forward into the future.

We have some big shoes to fill. Thanks to the leadership of ICEA President Nancy Lantz, the 2013-2014 Board: participated in the update of the Professional Childbirth Educator Program; began the Early Lactation Care Program; updated existing Position Papers and created new Position Papers; created the ITP – International Training Partners; developed the Military Mothers Initiative (to bring more childbirth education class opportunities to expectant women on military bases); made our certification programs more financially accessible to those affiliated with the military; and so much more. My personal thanks to the 2013-2014 Board for the incredible work they accomplished, and to Nancy for her mentorship.

*continued on next page*

Across the President's Desk  
continued from previous page

### *The future depends on what you do today.*

The ICEA Board invites you to embrace the spirit of volunteerism and join the movement toward best practice in maternity care for every woman. Help us support the membership to further our mission of freedom to make decisions based on knowledge of alternatives in family-centered maternity and newborn care. Make this 55th year of ICEA the year that you give a few hours of your expertise.

*If you want to touch the past, touch a rock. If you want to touch the present, touch a flower. If you want to touch the future, touch a life. —Author unknown*

*In your service,  
Connie Livingston  
ICEA President  
clivingston@birthsource.com*

The next issue of the journal  
is "Open Focus".

If you want to contribute, please  
send articles to [editor@icea.org](mailto:editor@icea.org)  
by February 1, 2015.

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# What Will You Do?

by Nancy Lantz, RN BSN ICCE ICD

## When I Am Gone

When I am gone what will you do?

Who will write and draw for you?

Someone smarter ... someone new?

Someone better ... maybe YOU!

—Shel Silverstein, “Every Thing On It”

This is my farewell editorial. I have been on the ICEA board for five years. The journey began for me when I committed to serve as Public Policy chair for a year, followed by a two year term as President Elect. I have served as ICEA President for 2013-2014.

The ICEA Board of Directors is composed of a variety of women from many different backgrounds. Their individual education, work history, location, social status, and age may differ when a member decides to actively commit to an organization. To have women with diverse thoughts, experiences, opinions, and reactions add to the board group dynamics. The women on the board have full time jobs, some have children at home, or adult children with spouses including grandchildren. Board members do not always agree but all do agree on two items. These two items are:

- Making birth better for all women
- Providing each woman with Childbirth Education and Doula Care

Each board member enters with energy and passion!! Each member has ideas. The board is directed to set the ideas into an action plan. Goals are established and come to fruition.

For many years, I enjoyed ICJ, using many articles for lectures and in clinically nursing education. I knew a few ICEA members, but was too involved in other professional organizations, going to graduate school and taking care of three children, to consider adding one more activity. Maintaining membership and attending ICEA conferences was my main involvement for many years. However, life choices have a way of shaping a person as to the direction they are to go.

People who knew me, professionally and personally, also have mentored me along the way. Maternal-child has always been my passion. Leadership and management is a skill learned along the way in other organizations, informal groups, teaching nursing students, and in hospital nursing. Traveling to other countries, sharing birth practices, and teaching women's health have impacted my healthy advocacy.



Nancy Lantz

Being a board member gives a voice to many areas in the perinatal world. A board member meets people from all over the world and shares a common experience... birth, breast feeding, and newborn care.

Whatever your journey has been and is now, consider saying YES to a group of birth advocates and step up to get more involved with ICEA. My active journey with ICEA began when another ICEA member asked me to get involved. I am asking you to call the office and get involved this year!!

Consider the following areas:

1. **Journal** – write a research article, be a guest editorial writer or proof reader. Our editor, Debra Rose Wilson will mentor you. Read a book and do a review summary. Contact Amber Roman for *eBirth*.
2. **Social Media** – contact Holly in the main ICEA office
3. **Education Committee** – there are always short term and long term projects
4. **Public Policy** – Be an advocate for birth! More!
5. **Board of Director** – Positions are available every year. A term last for two years. Contact Holly at the office.

‘Oh Baby Birth’ is my business. I provide Childbirth Classes to parents, practice as a doula, and offer consults to physicians. Being an independent contractor to parents, a hospital, and a birth center has empowered me in the childbirth world.

My five year journey as an ICEA board member has been the best! Now I am counting on YOU to be ...

**ICEA STRONG**

# Yesterday, Today, and Tomorrow

by Holly Currie, ICEA Executive Director



Holly Currie

Happy New Year! 2014 was another great year for ICEA. From new partnerships to a fantastic conference in Asheville, North Carolina this past September, we have had a lot of milestones this year.

ICEA has also experienced some changes. After the departure of long-time staff member Ryan Couch, I was named the Executive Director of ICEA in late August of 2014. Ryan, whom most of you know from calling and emailing the office over the last seven years, decided on a new venture, and the ICEA Board wishes him the best.

Allow me to introduce myself. I'm Holly Currie, and I attended East Carolina and North Carolina State University with a concentration in Sports Management. I have lived in Raleigh for almost twelve years. I enjoy any NCSU athletic event, as well as weekends at the beach. I was first hired by FirstPoint Management Resources in May 2012 and have worked with a total of nine other associations in various positions from membership director to support staff for conferences.

In August 2013, I became ICEA's Membership and Certification Director when Ryan became our Executive Director. While I have not started my own family (aside from my dog Lucy), I am the youngest of six children, so the concept of family is very important to me. The Board of Directors felt that I was able to take the association to new places with new visions. I am happy to move forward with ICEA as I plan to energize a new generation while maintaining the strong ICEA traditions.

Victoria "Vicky" Fouse joined the ICEA team in September 2014 as the new Membership and Certification Director. She will be your go-to gal for any questions, and of course I am always available as well. I would like to thank our Board members rotating off this year for years of hard work. Thank you to our outgoing President, Nancy Lantz. She has had such a great vision for where ICEA needed to be and took all steps in the right direction to get closer to that vision. Nancy's hard work and leadership have been assets to ICEA. I would also like to say thank you to Marlis Bruyere, Joan M. Smith, Alecia White Scharback, and Angela Swieter.

ICEA had a very successful annual conference in September 2014. Back to Your Roots was held in Asheville, North Carolina, at the Doubletree Hilton. We had three preconference workshops, as well as breakout sessions and general sessions with keynote speakers including Sarah Buckley and Kathleen Kendall-Tackett. While in Asheville, a group of us toured the Biltmore and enjoyed dinner on the grounds. The Board of Directors also conducted the annual membership meeting, hearing from each committee chair report on activities that had been accomplished this year and what to look forward to in 2015. Please mark your calendar for our 2015 joint conference with Lamaze at the Planet Hollywood in Las Vegas, Nevada, September 17-20.

In addition to providing a great conference, ICEA achieved many other goals this past year. In early 2014, ICEA began a partnership with Cryo-Cell. That brought new educational material as well as advertisement and sponsorship money to the association. ICEA is in the stages of rolling out our Early Lactation Care program, which will be a workshop that will be available for all members taught by our approved lactation trainers. The Board of Directors also worked on improving our IAT program. We take pride in our IATs and are continually improving the workshops so new members are receiving the best of the best in the workshops they attend with us.

The biggest news of 2014 is the completion of the revision of our Professional Childbirth Educator Certification program. Our Board of Directors worked tirelessly on this project. They reviewed and updated all of our reading materials and exam questions. They updated forms and made sure our objectives exactly expressed our ideas. Thank you to everyone who helped out on this enormous undertaking!

In closing, I would like to say that in the few months I have sat in the Executive Director's seat, I can already say that I have the utmost confidence, knowing that ICEA is going to be wonderful in 2015. To see the dedication of the Board of Directors, advisors, volunteers, and our members in continuously improving and educating themselves—and the association as a whole – is truly remarkable. Special thanks to Dr. Debra Rose Wilson for her patience with me as I learn my role in this great academic journal.

Cheers to the best year yet!

# Reaching Fathers

by Amber Roman, BS ICCE CD

Motherhood completely revolutionized my life. And motherhood revolutionized my husband's life as well. Fatherhood, it seems, is sometimes begun by proxy almost. Men do not experience the adjustment to new parenthood like we mothers do. Maybe because physically, and as a result of hormones also emotionally, men do not directly experience motherhood. They stand by and watch. They watch as our bodies change, as our moods swing, and ultimately as we give birth and then go on to breastfeed and nurture our new little ones through many sleepless nights. And as mothers we have the liberty to do all of these things with pride and license—after all, a man can't grow another human and then feed it. Ina May Gaskin said "There is no other organ quite like the uterus. If men had such an organ they would brag about it." And as much as a man might want to brag about the achievement of fatherhood, he can never overshadow the achievement of motherhood.

The fact is that fathers are just as influenced by these major life changes, although not in the same ways. A father may not be able to be pregnant, or give birth, or breastfeed, but he may yearn for that experience and that unique relationship that exists only between a mother and a child. Or, he may not want that exact experience, but he may struggle to develop his own unique relationship with his baby, and his relationship with his child's mother may suffer as a result. He may well have sleep deprivation as well as physical and emotional changes. He may struggle with the new responsibilities, the new pressures, or the changing family dynamics. He may have secret fears, anxieties, or nervousness about becoming a father. He may be overwhelmed by joy, in awe of his new role, and totally in love like never before. Integrating and expressing all of these changes is not only challenging because of the lack of support to do so, but also because of the traditional expectation placed upon men to be "fixers" and "doers," to internalize emotion and to "man up."

Such a cultural displacement of fatherhood may have something to do with what sometimes becomes a lack of parental responsibility on the part of fathers in today's society. We emphasize motherhood in our work as birth professionals—the life changing, multifaceted changes it brings to the life of a woman—sometimes to the total exclusion of the

father's experience, or lack thereof. How many resources are there that are directly focused on pregnancy, birth, and breastfeeding for the father? Or postpartum depression? Or adjusting to going back to work? Or sleep deprivation? They are out there, but there is a large disparity between the ratio of mothering resources and those for fathers.

As birthworkers, we can help change this. But how?

Some thoughts to apply:

- Are your classes focused on the mother instead of both parents? Consider involving "veteran" dads in your classes. Invite them to speak, or have one class session reserved aimed at dads during which the men lead the class.
- Consider your wording in conversation, writing, marketing, and class content. Do you include references to fatherhood and the male parent as frequently as you do motherhood and the female parent?
- Are you familiar with local services, support groups, play groups and programs for dads?
- Do your business/services/classes appeal to dads? Think about the images and colors you use for marketing. Are they so feminine that they would be off-putting for fathers?
- Do you keep a resource list for dads? Books, CDs, DVDs and website links that would be helpful (and appealing) to dads can be a great tool to have on hand.

This issue explores the often-neglected topic of fatherhood and how we can help fathers integrate this experience as well as arm them with the tools they need to better support not only their partner through the many adjustments to parenthood, but also themselves. It can be easy to lose sight of fathers when so many improvements need to be made in the arena of maternal support and care—but part of supporting mothers adequately is taking into account that sometimes we may rely too heavily on the father being *part* of her support system instead of needing his own support. Changing our thinking from involving just the mother-baby dyad, and thinking about it in terms of a family triad (although not always applicable for every family situation) may help.



Amber Roman

# Oh, the Places You'll Go

by Vonda Gates, RN ICCE ICD IAT-CE IAT-D HUGS Trained Educator



Vonda Gates

It's the New Year and for the outgoing ICEA Board January, 2015, ends a busy two years. Under the leadership of Nancy Lantz, Board President, and Connie Livingston, Board President-Elect, this group of birth professionals has updated 14 ICEA Position Papers, revised and updated two certification programs, and successfully implementing ICEA's first on-line certification programs. There were numerous conference calls, too many form revisions, and much compromise and inspiration all at the same time to get the job done. This board has also recognized the first international educators as International Teaching Partners (ITPs). These educators are working to support ICEA in their respective cultures and will assist the board in reaching out and supporting members from around the world.

Nancy Lantz started our tenure as new board members with a theme from Dr. Seuss, "Oh, the Places You'll Go" and then lead the way, step by step, to get the work done together. It has been a memorable, as well as learning, experience but overall a joyful journey.

I hold the International Relations Advisory Committee Chair position on the board and am pleased to note how ICEA is traveling more in recent years. Marilyn Hildreth, IAT, has represented ICEA well in China and Qatar plus many other exotic locales. Connie Bach, IAT, is becoming a regular educator at a women's clinic in Guatemala and often invites

others to travel with her. PCBE and Doula workshops have thrived in Canada, Qatar, and Taiwan, just to mention some of our recent international venues.

If you are a new educator with ICEA, dare to dream big. When I joined ICEA in 1989, I did not foresee that being a childbirth educator would allow me to see the world – but that is a possibility in these times. Women everywhere deserve our attention and support. More than ever the workplace for the birth professional is international and ICEA is on the move.

As you support women and families where you live, here are five ways you can increase your involvement with ICEA right now:

- 1) Do a great job teaching in your community. If you would like help developing your local class, contact the ICEA Mentor Program. Or become involved as a mentor to support other educators.
  - 2) Read the ICEA *Journal*
  - 3) Read the ICEA *eBirth* blasts
  - 4) Write of something that you are passionate about, or review a book for the ICEA *Journal*.
  - 5) Attend and volunteer at the annual ICEA Convention. The next meetings are in Las Vegas, September 17-20, 2015.
- 2015 is unfolding as we speak, so make plans now for this year to be one in which you make a difference for the women and families where you teach. Allow ICEA to support you in your work and ...
- Oh, the places you'll go!

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# Sharing Experiences

by Virginia Coleman Smith, DNP FNP-BC MSN ICCE

Reading peer reviewed journals has been a significant activity during my nursing education, as a childbirth educator, and graduate student. Authors followed over the years seem like old friends as I've grown accustomed to their research focus and writing style. Often including their implications for practice into childbirth classes, nursing clinicals, or family practice, I have reaped the benefits of their findings and experiences.

Years of teaching childbirth education classes led to a topic question, Why don't pregnant women experiencing preterm labor symptoms notify their health care provider in a timely manner? This became the topic for research in graduate school. Further reading revealed areas to pursue from authors who had experience with pregnant women and preterm labor. As I continued to read, I gained a broader perspective and greater understanding of the topic. Beyond preparation for an important school assignment, I wanted to share what I had learned with others, just as I have continued to learn from journal reading.

As a member of International Childbirth Education Association and regular reader of the *Journal*, I contacted the editor, Debra Rose Wilson, to determine if there was interest in my area of study. Her encouragement, as well as her writing experience, was invaluable as I prepared my manuscript. Submission, edits, and resubmission and my article was published. I learned a lot in the process about my topic and the writing experience.

Practical teaching techniques, practice improvement, or symptom management ideas are generated daily in the practice of childbirth educators, nurses, and health care providers. I'm intrigued by the childbirth educators, doulas, nurses, and healthcare providers I meet at conferences or in practice who share insights and experiences that would make good articles for the journal. Regrettably, a familiar theme I run into when encouraging them to write and submit is, "Oh, I can't write!" That attitude is unfortunate, and it is the readership's loss.

Writing takes time and discipline to communicate thoughts, ideas, and experiences. There are as many styles of communicating as there are personalities of childbirth educators, nurses, and health care providers. The writer is communicating a point of view, one that may give readers pause to think or reconsider a point of view on a topic. Writing may be

on a continuum of simplicity to highly technical with wise readers discerning the significance and usefulness of each.

Webster defines *expert* as "one having special skill or knowledge because of what one has been taught or experienced." The field of maternal newborn care and education is broad-

ened when many are generous with their areas of expertise. Women, their families and babies benefit when there is a rich exchange among those whose desire it is to contribute to the childbirth experience.

Personal stories resonate with readers who enjoy sharing the experiences unique to childbirth. Nursing students frequently comment after a maternal-newborn hospital rotation, "I had no idea so much went into having a baby, and so many things could potentially go wrong." So, come on, folks, write up that experience, and submit it to the *Journal*. Your article will be reviewed by people with expertise in your topic who will make comments that are returned for you to revise. Addressing the edits leads to delving deeper into your topic, learning even more. The article, once re-reviewed will be set for publication and notification sent to you.

Someone new to the experience of childbirth education offers fresh insights into the process of childbirth education. A more experienced educator or healthcare provider may provide encouragement to those still building a foundation for practice. Both are enriched by the exposure to other's experiences.

Giving and receiving, isn't that what occurs when we open our latest issue to find who is contributing what? That's what I do. I enjoy sharing what research has revealed and learning what someone else has found in research. I look forward to reading the next issue!



Ginger Smith

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# Historical Role of the Father: Implications for Childbirth Education

by James G. Linn, PhD, Debra Rose Wilson, PhD MSN RN IBCLC AHN-BC CHT, and Thabo T. Fako, PhD

**Abstract:** *In this analysis we present recent sociological findings and historical information on how fatherhood has changed over time. This is intended to inform childbirth practitioners and those providing childbirth education about macro trends in fathering and implications for practice. We analyze the historical evolution of the western father role with a focus on the U.S., describe current expectations and performance of American fathers with comparisons to their counterparts in other nations, review recent research findings on the health and psychosocial consequences of modern fathering, and present the challenges of modern fatherhood for healthcare practitioners.*

*Keywords:* fatherhood, change, childbirth, childbirth education

## Introduction

Practitioners and childbirth educators would mostly agree that the performance of the father role has profound implications on the well-being of the infant and mother. This consensus is based on extensive individual, clinical, and teaching experience with mothers, fathers, and newborns from varied types of families. Rarely is this understanding of the importance of the father grounded in evidence based sociological and historical knowledge of the family and fatherhood and related health and psychosocial outcomes. Presentation of recent sociological findings and historical information provides insight on how fatherhood has changed over time. In doing so, practitioners and educators can be informed about the macro trends in fathering and their micro implications for childbirth and childbirth education.

## Fatherhood in Pre-Industrial Western Societies

Until the industrial revolution changed agricultural societies in Europe (beginning in the 18th century and later in the United States in the early 19th century), most people lived in extended families in rural communities (Parsons, 1960). Generally, these households had at least two biologically related nuclear families residing under the same roof – grandparents, the adult married children, and their young offspring. Living nearby in similar multifamily households were grown siblings, aunts, uncles, and cousins. Everyone was involved in agriculture and its sale for the family's subsistence. People were not mobile.

Gender role sociologist Judith Leavitt (2009) described the birthing roles of men and women before the onset of medicalization in pre-industrial extended families. Leavitt noted that before medicalization of childbirth women had considerable autonomy in organizing and controlling the process in their homes. They relied on the help of selected nearby friends and family to support them during the delivery, and men were routinely not involved in birthing (Leavitt, 2009). Deliveries occurred at home.

Despite their control of the birthing process, women were powerless in other areas of pre-industrial society. They could not own property, vote, or attend school, and their life was restricted to the home. Consequently, they were responsible for care of infants and older children until these became mature enough to work in the fields under their fathers' supervision. These limitations on women's roles were ordained by religion and upheld by the state (Cott, 2000).

## Changes in Traditional Marital Roles

Innovations in agricultural and industrial technology beginning in the 18th century in England and other European countries and in North America in the 19th century propelled the industrial revolution. Modern and more efficient farming methods and a growing demand for wage

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labor transformed historic patterns of agriculture and the traditional extended family. Families had to be mobile and migrate to where jobs were located. They no longer depended on local networks of kin and friends for their livelihood. People left behind their extended family and dependent elderly parents as they became financial burdens. In this historic process, which unfolded on two continents over the 18th, 19th, and early 20th century, the nuclear family, including two biological parents and their children, became the predominant family type (Benokratis, 2007).

Associated with these economic changes was a drop in the mortality of children and adults, improved standards of living, and a redefinition of the meaning of marriage (Cherlin, 2004). Marriage changed from an institutionally prescribed and sanctioned bond between two extended families to a companionate relationship between fathers and mothers (Burgess & Locke, 1945).

The feelings of the prospective spouses took precedence over the economic and political concerns of their extended kin in the decision to marry. In the United States, the evolution toward a nuclear family formed through a companionate marriage was hastened by the Depression and the Second World War. Apart from the acceptance of the concepts of love and companionship as the primary reasons to marry, there was near universal consensus that one could not have a sexual relationship or have children unless an institutionally sanctioned marriage ceremony was completed (Cherlin, 1992). Throughout the 1950s, the predominant type of American family included a single male breadwinner and his wife who was committed to homemaking and childcare roles. Marital contentment in the United States and Europe involved companionship, love, and the successful completion of culturally and gender defined family roles.

### *When doctor-assisted births in hospitals became the norm mid-century, women lost control of the birthing process.*

Until the late 19th century when medical doctors began to deliver babies, birthing roles of women and men in the United States remained largely unchanged, and women continued to control the birth process (Starr, 1982). As recently as the late 1930s, only about 50 percent of American



babies were born in hospitals; however, in less than 20 years, medicalization was complete, and 95 percent of births were in a hospital (Leavitt, 2009). When doctor-assisted births in hospitals became the norm in the mid-century, women lost control of the birthing process. They gave birth alone in maternity wards attended by nurses and physicians while their husbands were uninvolved in the birth. In fact, fathers were also uninvolved in infant and childcare. Their participation in childcare, except perhaps for recreation and vacations, was limited into their children's teenage years.

## Changes Affecting the Nuclear Family and the Definition of Fatherhood and Motherhood

In the 1950s, the majority of people in the United States lived in two parent families, however, by the 1960s, this dominant family form was being undermined by macro changes in the world economy, the expanding social movement of feminism in all highly industrialized western countries, and rising divorce rates (Ellwood & Jencks, 2004; Oppenheimer et al., 1995).

Automation in all types of workplaces resulting from postwar technological advances and competition from Japanese and other foreign nations (soon to be followed by outsourcing of production jobs) produced falling wages for men and women without college degrees in America. This downward economic trend, which became apparent in the first years of the 1970s, destroyed the effective earning capacity of many male blue-collar workers. Without well-paying jobs with health insurance benefits, they no longer had the essential economic requirements for marriage and normatively sanctioned fatherhood (Cherlin, 2010).

Beginning in the 1960s, a new role model was emerging for women in many highly industrialized Western European

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Countries and the United States. Feminists made a convincing argument that females should seek higher education, become employed in the work force, and manage their own money. Fathers, for the first time in Western history, were expected to participate equally in household and childrearing roles with their wives (Beck & Beck-Gursheim, 2012). Together with this monumental change in sex roles was a change in women's and men's views of marriage. There was a shift from companionate to individualized marriage. In the 1950s, husbands and wives obtained much of their marital satisfaction from the fulfillment of traditionally defined roles of breadwinner, homemaker, and mother. In the 1970s, the focus had shifted to individual fulfillment. Marriage was expected to enhance and facilitate self-development for both spouses. This process was to be supported by open communication and flexibility of marital and work roles (Cancian, 1987; Cherlin, 2004).

Birthing roles of both husbands and wives also began to be redefined in the 1960s. This meant that long held traditional expectations for fatherhood were challenged. Women protested the isolation of the maternity ward, separation from infants and routine medical procedures such as labor inducing drugs, pain relievers, and being strapped to a delivery table (Sullivan & Weitz, 1988).

A growing number of fathers, believing that they should be more parentally involved, requested from the medical authorities to be with their wives during the delivery (Leavitt, 2009). These requests were responded to by hospitals with natural childbirth classes and birthing rooms. A smaller group of husbands and wives wanted to take control of the birthing process away from the medical community. They chose home births attended by a lay midwife, called a traditional birth attendant in many developing countries (Sullivan & Weitz, 1988).



Tara Renaud

As American families experienced a worsening economic environment there were historic changes in sex roles and marital expectations. Divorce rates were on the rise reaching unprecedented highs of about 50 percent of first marriages around 1980 (Raley & Bumpass, 2003; Schoen & Standish, 2001). The legal recognition of consensual divorce in the United States and Europe facilitated the rising rate of marital dissolutions (Cherlin, 2004; Glendon, 1989).

Over the past 30 years, the rates of marital dissolution have differed significantly by the level of education. College educated couples who are married have experienced a decline in the rate of divorce, while those with less education have either experienced the same high rates of divorce as the 1970s or shown even higher rates (Cherlin, 2010; Martin, 2006). Given that both marital and divorce rates diverged by educational level, the education gap among Americans is an important driver of the substantial increase in cohabitation in recent decades.

## Current Family Structure in the United States and its Impact on Fatherhood

To accurately describe the structure of the contemporary American family with children, an imperative understanding is that never before in history have there co-existed so many alternative ways of organizing, mothering and fathering, living together (or apart), sexual relations, and the distribution of resources among parents and dependents (Coontz, 2004).

Scanning the current social landscape in the United States reveals nuclear families consisting of a married man and woman and their biological and/or adopted children; step-families including a married man and woman, their biological and/or adopted children, and children from former marriages; single-parent families that typically are comprised of an unmarried woman and her children; cohabiting families comprised of an unmarried male and female, their biological children, and children from other relationships; same sex families, which include a married or cohabiting couple and their biological or adopted children, and/or children from former marriages and relationships; and transnational families which mostly consist of a married man and woman and their children who are residing and working in different countries.

Using the best available data on the contemporary family in the United States (obtained from focused quantitative population surveys and qualitative studies), comparisons between the United States and other western industrialized  
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nations reveal the most significant development in family structure of the past forty years – greater cohabitation (Cherlin, 2010). The significance of cohabitation is that it increasingly is perceived to be an alternative to marriage, and it has dramatically affected fathering behavior (Cherlin, 2004). Further, it is estimated that one-half of the children born out of wedlock in America have cohabitating parents (Kennedy & Bumpass, 2008). This is a startling figure when one considers that 41 percent of newborns in the U.S. are delivered by unmarried mothers (Child Trends, 2012). Possibly most of these unwed mothers are cohabitating with a partner at one or more times during their childbearing years.

Smok and Gupta (2002) concluded that in the early 2000s, the United States was positioned between the Mediterranean countries and the Northern European nations on the cohabitation scale. The U.S. has surpassed the stage when cohabitation was merely a step in the modern life cycle toward marriage and has attained the stage where it was regarded to be a long-term living arrangement. The family structure of American families differs significantly from the forms predominating in many developing nations. In these more traditional societies, extended families are the norm. There are small numbers of nuclear families often including foreigners from Europe or the U.S. Cohabitation among middle or elite strata is not common, although it happens with greater frequency among the poor who cannot afford a formal wedding ceremony. In villages with a high prevalence of HIV/AIDS, such as many of those in countries in the southern cone of Africa (e.g., Namibia, Zimbabwe, and South Africa), growing numbers of households are headed by children. Because they lost their parents to disease, they depend on kin and peers for support (Fako, 2010; Ruiz-Casaes, 2010).

The contemporary model for fatherhood in the United States and other developed societies is “new fatherhood” (Marsiglio & Roy, 2012; Roy, 2014). New fatherhood encompasses the traditional roles of providing (i.e., housing and other necessities including health insurance) but adds the more modern responsibilities of caring for and nurturing prenatal moms, infants, and children. Optimally, there is a balance between the providing and caring roles expected of fathers today. Particularly within the United States, but also within other developed nations, attainment of modern fathering as defined by the “new fatherhood” model is deeply



See Shell's Photography

affected by economic and social inequality (Smeeding, Garfinkel, & Mincy, 2011). Men with more resources, such as education, income, and social status, are better positioned to add caring and nurturing roles to their responsibilities as economic providers (Plantin, 2007). As professionals, they have more flexibility to adjust their work roles to provide time for infant and childcare including playing with children, transporting and monitoring them, and feeding, bathing, and cleaning up after them (Sayer, Bianchi, & Robinson, 2004). Furthermore, since they typically are married they can access further support and assistance for their nurturing and caring roles from their wives and a family network (Matta & Knudson-Martin, 2006).

Low-income men are far more challenged than their more affluent counterparts are to fulfill the expectations around the “new fatherhood model” (Furstenberg, 2011). Without a college degree or other specialized technical education beyond high school, young men have very limited opportunities to obtain a “good” job, which is one that will pay sufficient wages to support a family, place the down payment on a house, purchase health insurance, and save for the

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children's college education and their own retirement (Furstenberg, 2011). Perhaps the best current data on the fathering activities of low-income males in the U.S. comes from the Fragile Families and Child Well Being Project (McClanahan, 2012). Information gathered longitudinally on over 4,000 low-income fathers showed that about 50 percent reported low involvement and about 25 percent indicated high involvement with their children (McClanahan, 2012). Difficulties arise in generalizing from existing data the patterns of fathering behaviors for low-income men because they live in such varied social contexts (i.e., married, cohabitating, non-residential, single or stepfathers). Whatever the aspirations for fathering of low income men, the challenges are great particularly in light of the fact that over one third of children in the United States reside apart from their biological fathers. These children are more likely to be poor or children of color (Debell, 2008).

In countries experiencing difficult economic conditions such as Korea and Russia, men may seek to fulfill the caring roles included in the new father model, but they cannot become highly involved in childcare roles because they are preoccupied with performing the provider role (Kwan & Roy, 2007). Men in developing countries, even though they may believe the ideology of sharing childcare with their spouse, also may not become highly involved in these roles because their work outside the home takes up all of their time (Fako, 2010).

Young women with limited education and income in the U.S. who wish to marry and have children usually find relatively few good prospects for marriage among their peers (Carbone & Cahn, 2014; Coontz, 2014). Furthermore, divorce is disproportionately high among low-income couples (Cherlin, 2010). Women in these circumstances with children often find themselves living alone in poverty or near poverty, or cohabitating for intermittent periods (McClanahan, 2012). This can take a substantial physical and psychological toll on a mother (Child Trends, 2012). Family research has shown that low-income women who work often bring the stress of the workplace into their parenting roles (Gassman-Pines, 2011). Mother-lead low-income families lack health insurance and other organized support (Montez, Angel, & Angel, 2009). Essential self-care, including good diet, exercise, and leisure time, may not be an option. Low-income single mothers and their children are often obese

and struggle with related illnesses of diabetes and hypertension (Smith, 2009).

The children of these families cope with the stress of living in a low-income household without a committed and caring father as one or more adult males who partner with their mothers come and go (Osborne & McLanahan, 2007). Choi (2010) observed that non-residential fathering may negatively affect children's cognitive development and behavior. Additional research on children raised in these conditions report that they tend to have a relatively poor self-image and high anxiety and depression (Amato, 2000a, 2000b; London, Scott, Edin, & Hunter, 2004).

## Challenges in Assisting Fathers

There are many challenges to childbirth practitioners and educators posed by fathers. To begin with, effective training for fathers differ in approach because men in many cases learn differently than women. Kirven (2014) noted that men are more likely than women to primarily seek their information on pregnancy, childbirth, and infant care from websites and male peers in their social networks (i.e., friends and family members) than women are. Therefore, they might be less receptive than women to attending traditional formal classes dealing with these topics.

Secondly, adoption of an ethos that facilitates the development of effective childbirth educational services for fathers across the wide spectrum of current family structures is necessary. This means recognizing that the relationship between marriage and other macro social and economic institutions has been fundamentally changed (Cherlin, 2004). Moreover, biases for a preferred form of family must be removed. Instead, educators must "help men in a wide array of different committed relationships minimize their shortcomings and maximize their solidarities" (Coontz, 2004, p.165).

Thirdly, educators must acknowledge that social inequality in the United States and other developed and developing nations profoundly affects fatherhood. Fathers with more education and income in stable relationships will more easily adopt the "new fatherhood" model. Having internalized modern egalitarian norms regarding pregnancy, childbirth, and infant care, they will probably require far less education and support on these topics. However, low income fathers with limited education and social resources, despite an equal desire to effectively parent their children, are more likely to be separated from them and their mothers by divorce, commitments to other children, incarceration,

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immigration status, and personal problems of stress and depression. Nevertheless, when they seek more information on pregnancy, childbirth, and infant care, their needs may be more effectively met through several intervention strategies suggested by Kirven (2014) and others (Bishop, Wallace, & Ault, 2008; Capuzzo, Sheppard, & Uba, 2010), including:

- Personalized case management focused on mediation and building healthier relationships with the child's mother and family;
- Collective education sessions of peer support such as the Boot Camp for New Dads (BCND), which encourages active paternal involvement from pregnancy through birth and infancy and later development;
- Linkage and referrals for fathers to medical, social services, and home visits, which will have content designed to teach fathers about newborn parenting, child development, healthy relationships, and follow-up with school achievement; and
- Identification of community assets to support employability and training for the father.

The specifics of additional new programs that would address the challenges presented by fathers should come from clinicians and childbirth educators. There is a clear need for innovative programs in nutrition, healthy lifestyles, positive stress, and postnatal depression management. Fathers in migrant and transnational families should have culturally and linguistically appropriate pregnancy, childbirth, and infant care classes. The structure of families and the roles of fathers will continue to change and present new and often daunting challenges to health professionals committed to assisting families in the childbearing years.

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# *And Daddy Makes Three:* Spotlight on Men's Peripartum Mental Health

by Daniel B. Singley, PhD

*Abstract: Although men are now expected to be more involved in the birth and care of their infants than ever before, there may still be a pervasive belief among the public and medical professionals that the parenting of infants is really just “mothering.” This perspective undervalues the clear benefits that children, mothers, and fathers experience when new fathers are highly engaged with their newborns and infants. Men commonly experience a very rich psychological transition as they become fathers, and this article gives an overview of psychosocial theory and research about men’s peripartum mental health.*

*Keywords: fathers, men, mental health, involvement, depression*

## Introduction

The 1990’s were dubbed “the decade of the disappearing father,” because there were nearly double the number of U.S. children living apart from their biological fathers since 1960 (Blankenhorn, 1995). The current decade might be framed as “the decade of the reappearing father” in that considerable practice, research, policy, and resources are promoting the importance of fathers to the well-being of their children and partners (Lamb, 2010). This shift is reflected in President Obama’s Responsible Fatherhood and Strong Communities initiative and his statement regarding the role of fathers in healthy families, “We need fathers to realize that

responsibility does not end at conception. We need [fathers] to realize that what makes you a man is not the ability to have a child - it’s the courage to raise one.” (Whitehouse.gov, 2012). This perspective is closely aligned with the broader “generative fathering” movement, which asserts that a key element of adult development is rooted in broadening the sense of self to include subsequent generations via a sense of “generativity” in terms of being responsive to the needs of their children (Hawkins & Dollahite, 1997).

For many men, the lack of clear guidance and models in relation to being an engaged, generative father results in behavioral and psychological issues that often go unnoticed until a crisis emerges. There is a maturing body of research and theory regarding how factors such as a history of mental health issues, masculine socialization, the strength of the parental alliance, men’s peripartum hormonal changes, fathers’ self-efficacy, mothers’ “other-efficacy,” degree of social support, and fathers’ involvement in the care of their infants relate to key outcomes for every member of the family (Pleck, 2010). However, few clinicians or educators have a clear understanding of how to apply this evidence base in their work with new and expectant fathers in the peripartum period spanning from conception through one year postpartum. Compounding this issue is men’s difficulty in connecting with their own internal experience when problems arise (Berger et al, 2005), and their historical underutilization of mental health services (Vogel, Wester, Hammer, & Downing-Matibag, 2012). One in 10 dads develops peripartum depression (Kim & Swain, 2007). When neither the fathers themselves nor those who care for them are adequately prepared to recognize, conceptualize, or work effectively with this at-risk population, we are faced with a widespread health disparity for men’s peripartum mental health treatment. The information below clarifies key aspects and interventions

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for educators and healthcare providers to consider in order to work most effectively with men making the transition to fatherhood. The intent is to give health care professionals concrete ways to apply this information. The “recommended interventions” below are not meant to offer a comprehensive treatment plan. The emphasis in these passages is how to put these principles into practice to empower new and expectant fathers as well as their partners.

## One in 10 new dads develops peripartum depression

### Mental Health History

The strongest predictor of men developing peripartum issues such as depression and anxiety is the mother’s own experience of peripartum mental health problems. The father having a history of psychiatric illness also predicts the development of these types of issues during new parenthood (Paulson & Basemore, 2010). The stress related to adjusting to new parenthood can easily be a catalyst for a relapse, yet many new fathers avoid acknowledging the prospect of having mental health problems at a time which they expect to be among the happiest in their lives. While men do develop depressive symptoms even when their partners do not, the fact that approximately 13% of all mothers experience symptoms of major depressive disorder during the perinatal period (Ross & McLean, 2013) underscores the need to address how men manage their own mental health needs. Fathers who develop peripartum depression commonly exhibit symptoms of irritability, self-isolation, overworking, substance use, and feeling hopeless, in contrast to more “expected” reactions such as crying or intense sadness (Kim & Swain, 2007).

It is important to note that the DSM-5 psychiatric criteria for Major Depressive Disorder with Peripartum Onset include the stipulation that the peripartum modifier may only be used when symptoms occur during pregnancy or in the four weeks following delivery. However, it is well-documented that while women’s peripartum issues spike immediately before and after birth, men’s tend to develop 6-8 weeks postpartum, with a tendency to increase six months to a year after the birth (Kim & Swain, 2007). The tendency

of men to underreport mental health issues and the lack of awareness about men’s peripartum mental health amongst healthcare providers is compounded by a disconnection between the diagnostic criteria and men’s typical development of peripartum mental health concerns. There is a clear need for childbirth health care providers and educators to make extra efforts to ensure that fathers are included when taking a family-wide approach to provide peripartum mental health services.

### Recommended Interventions:

- Taking a thorough health history – including any history of psychiatric issues - of both parents
- Assessing both mothers and fathers using a valid instrument such as the Edinburgh Postnatal Depression Scale
- Educating clients about how men’s peripartum mental health issues affect nearly 10% of all new fathers
- Outlining the need to be mindful of how their previous histories and mental health can affect their expanding family system during the peripartum period.

### Masculine Socialization

David and Brannon (1976) distilled the essence of masculine socialization from a variety of research and theory, and posited that the four major themes of traditional masculinity in the United States are:

- Anti-femininity – “No sissy stuff”
- Status and Achievement – “Be the big wheel”
- Inexpressiveness and Independence – “The sturdy oak”
- Adventurousness and Aggressiveness – “Give ‘em hell”

Absent from these themes are some essential elements for the effective parenting of babies and children, including nurturance, warmth, emotional awareness, and working as a team with mothers. It seems clear that any new father who clings rigidly to one or more of these themes would be unlikely to strap on a Baby Björn, pack up the diaper bag, and head to a play group with other babies - yet, these are exactly the types of activities that dads are now commonly expected to do with their infants. Furthermore, both men and women receive this socialization about what it means to be a man and, more specifically, the father of an infant (Parke, 1996). In this way, both the father and his wife might simultaneously feel the need to have the father more involved with his infant, while unknowingly putting up barriers for him to be more involved due to outdated beliefs about “what makes a man.” In this sense, new parents – mothers

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and fathers alike – are caught in a kind of generational gap. New fathers today typically had fathers who were not very involved with their care as infants. These same dads are left to find their own way toward generative fathering without much in the way of models or guidance. Most men are aware that they are socialized by their families-of-origin, but tend to misunderstand how the threat of violating traditional masculine gender norms can keep them from fully engaging with their babies and partners.

### Recommended Interventions:

- Have fathers read chapters 1 and 8 of Christopher Kilmartin's *The Masculine Self* to set the stage for a discussion of how their own masculinity relates to their fathering.
- Have fathers and mothers reflect on their own experiences and discuss their stereotypes about “the ideal dad” to identify areas of overlap as well as concerns.

## Men's Peripartum Hormonal Shifts

New fathers' attentiveness to their children may be related to changes in hormonal levels that mirror those of mothers' throughout the peripartum period – specifically, an increase in levels of prolactin, cortisol, and estrogen (estradiol) with a decrease in levels of testosterone around the birth of their infants (Storey, Walsh, Quinton, & Wynne-Edwards, 2000). Each of these hormones has implications for different aspects of how men behave with their newborns and partners, which suggests that imbalances in these levels may account for psychological and/or behavioral issues. Although there is as yet no research that definitively links these phenomena, there is some initial evidence that peripartum depression may have a biological basis, which potentially links to changes in hormone levels (Ramchandani, Stein, Evans, O'Connor, 2005).

### Recommended Interventions:

- Providing fathers with information about how their own biological systems are changing along with their partners' throughout pregnancy and birth. Beyond educating new dads that there are biological correlates of the psychological role change they may be experiencing, this practice would also give men the “I can go talk to someone because it's a medical issue” pass if they develop peripartum mental issues.

## The Parental Alliance

It is a well-established finding that a couple's relationship satisfaction decreases significantly after the birth of their first child, in large part due to role conflicts and restrictions in their freedom (Twenge, Campbell, & Foster, 2003). The fact that mothers' experience of peripartum mental health issues such as depression is a very strong predictor of men's mental health issues (Condon, Boyce, & Corkindale, 2004) is a testament to how key the parental alliance is for the health of the family system. A recent study about this relationship found that maternal and paternal postpartum depression are indirectly related through pathways of impaired spousal support and reduced relationship satisfaction (Don & Mickelson, 2012). It seems clear that new fathers need to give and receive support from their partners in order to thrive during the transition to parenthood. It is also a clear indicator that childbirth professionals should evaluate both mothers and fathers for mental health issues whenever possible.

### Recommended Interventions:

- Assessing the strength of the couples' relationship in order to determine the extent to which the parents' relationship is characterized by satisfaction and support.
- Referring for brief couples counseling can help fortify the relationship as needed, especially by focusing on communication skills such as assertive communication, productive conflict resolution, along with best practices in effective co-parenting.
- Couples purchase and read together the first six chapters of *Making Marriage Work for Dummies* (Simring & Simring, 1999). This book is very clearly written with a sense of humor that invites clients to continue reading and following the evidence-based information in the book.

## Social Support

While parental alliance is one highly important element in a man's transition to fatherhood, it is critically important that both parents continue to nurture their broader networks of support to buffer and reduce the impact of the stress of birth and new parenting (Crnic et al., 1983). Men in the U.S. are generally socialized to look to romantic relationships in order to get their emotional closeness and support needs met; however, during a period that involves both parents experiencing some stress, the ability to get support from a broader network is critical (Castle, Slade, Barranco-Wadlow,

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& Rogers, 2008). In the rush of friends and family to meet the new baby, men are likely to remain largely focused on the mother and baby, even to the exclusion of involvement in activities with others that they typically find energizing (I commonly hear men make comments such as “She’s up all night with the baby – I can’t ask to go play golf”). Women are commonly the “Social Chairs” in a partnership, and men tend not to reach out to others as often, particularly if one is a father but the other is childless.

### Recommended Interventions:

- Emphasizing to new fathers that they need to have a “diversified support portfolio.” Men can often connect well to this concept, since it draws on their “Big Wheel” socialization by clarifying the parallels between the strategy of having multiple sources of financial assets to minimize risk of failure, and needing to have diverse sources of social support. This model assures that they are not overly reliant on any one person for support.
- Because social support is essential for mothers as well, new dads should also be encouraged to care for the baby so that mom can get out and connect with her own supports.

## Efficacy

Albert Bandura’s social cognitive theory (1997) posits that in order for parents to employ parenting behavior successfully, they need to believe that it will produce the desired outcome and have confidence in performing the specific task. Other research has found that parenting self-efficacy (PSE) is a likely predictor of adequate parenting practices, as well as an indicator of risk (Reece & Harkless, 1998; Jones & Prinz, 2005). The primacy of PSE for the transition to parenthood becomes apparent with the realization that, according to social cognitive theory, self-efficacy strongly influences how a person behaves in the face of challenges as well as whether or not they decide to undertake a given task. With respect to a new father’s parenting self-efficacy, if he has low confidence in his ability to feed, swaddle, bathe, or soothe an infant, then he is unlikely to take on these tasks. Not surprisingly, a recent research study determined that supportive or engaged parenting behaviors were predictive of paternal parenting self-efficacy (Murdock, 2013).

As the peripartum depression research cited above suggests, mothers’ beliefs and behaviors regarding new fathers’ ability to care for a newborn plays an important role in the dynamics of the recently-expanded family. A mother’s “other-efficacy” regarding the father’s ability informs his own self-efficacy via covert and overt messages which she gives him about his fitness to parent. In this way, overly-anxious “gatekeeping” behavior on the part of mothers can deprive new fathers of the much-needed practice and connection they need to feel more confident and bond with the baby.

### Recommended Interventions:

- Encouraging expectant fathers to practice caregiving activities such as bathing, diapering, swaddling, soothing, and feeding an infant prior to the birth. Once the baby is born, the couple should work to give the father the opportunity to be alone, caring for the baby as soon as possible. I regularly tell new and expectant parents that “Moms should do the nursing, and dads should do everything else.”
- Assessing the extent to which the mother and father feel confident in caring for their baby, along with *their sense of each other’s competence* in doing so is a key aspect of the newly-expanded family system.

## Father Involvement

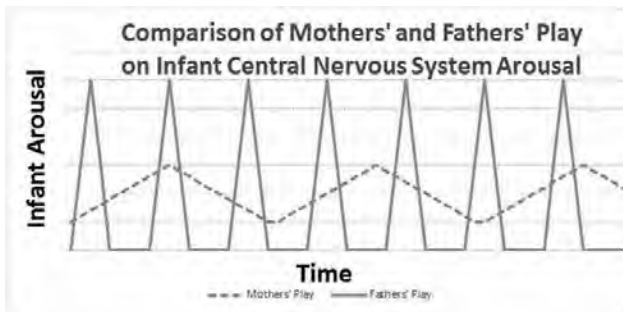
Fathers’ involvement with their infants has been shown to have a host of positive outcomes for children, mothers, and fathers alike (Parke, 1996; Pleck, 2010). Children whose fathers are highly involved with them, especially from birth, have been shown to be more emotionally secure and confident in exploring their environment, and to have better social relationships with peers as they grow older (Yeung, Duncan, & Hill, 2000). These children are also less likely to get in trouble at home, school, or in the neighborhood (Harris, Furstenberg, & Marmer, 1998). Fathers spend a considerably higher percentage of their time alone with their infants in playful high stimulation interactions (Parke, 1996). By playing with dad, children learn how to regulate their feelings and behavior (Fletcher, 2011). For example, rough-and-tumble play with dad can be a way in which children learn about appropriately managing aggressive interactions and physical contact without losing control of their emotions. The graph below emphasizes another means through which fathers’ involvement with their babies relates to subsequent mental health functioning:

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Essentially, fathers stereotypically have highly-arousing yet shorter bursts of interaction with their babies (think of a father tossing his baby in the air several times and then setting her/him down), while mothers commonly have more sustained lower-intensity interactions with them (feeding, reading, rocking, soothing, etc). The benefit from fathers' play style is that it gives the baby repeat opportunities to calm down to baseline from a highly aroused state on their own. Over time, this experience may impact the development of the child's ability to self-soothe and regulate emotion.



### Recommended Interventions:

- Normalizing fathers' more "jazzed up" play style so that both mom and dad understand that it is good for the baby so long as they follow basic safety guidelines.
- It is also very helpful to encourage fathers to talk with other new dads and to give them a clear understanding of how their direct involvement with their newborns and infants impacts the child's subsequent social, emotional, intellectual, and academic functioning.

## Conclusion

The information presented here regarding key psychosocial considerations in men's transition to fatherhood is by no means comprehensive, but rather is intended to give educators and practitioners a clear list of considerations in working with men and couples in order to take a father-inclusive whole-family approach to the peripartum period. While new parenthood is by nature a "learn-on-the-job" endeavor, there are a number of important means (such as those listed above) to optimize the transition. It is my hope that by making this information more readily available to those who serve them, new and expectant fathers will be more likely to receive needed care in order to thrive during this new chapter of their lives.

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International Childbirth Education Association

# The African American Father Does Matter in Parenting

by Maria A. Revell, PhD MSN RN COI

**Abstract:** *The African American fatherhood experience is complex and involves retrieval and use of resources, cultivating relationships, and acquiring fathering skills. Parenting is an important part of child rearing. It is important for nurses and child birth educators to include African American fathers in child birth activities and infant educational activities when at all possible. African American fathers can successfully fulfill their role in the family structure with support of care providers who recognize that their presence does matter.*

**Keywords:** African American, fathers, fatherhood experience, parent

*There is no single father's role to which a father should aspire. Rather, a successful father, in terms of his children's development, is one whose role performance matches the demands and prescriptions of his sociocultural and familial context. (Lamb, 2004, p. 11)*

## Introduction

The African American fatherhood experience is complex and involves interactions of multiple components (see Figure 1). These include retrieval and use of resources, cultivating relationships and acquiring fathering skills. Parenting is an important part of child rearing that fathers must continue to be involved with in order for children to achieve maximum potential resulting from involvement of both parents.

It is important that care providers and childbirth educators include African American fathers in childbirth activities and infant educational activities when at all possible. This article strives to bring awareness to the importance of the African American father in parenting.

Figure 1. The African American Fatherhood Experience



## Fatherhood Research: Past and Present

Fathers and father figures play a key role in a child's well-being (Lamb, 1997). Early research focused on the role of father as breadwinner (Rasheed & Rasheed, 1999) and viewed them as unimportant to childhood development (Lamb, 1975). This research on fatherhood developed an attitude of unimportance and promoted misunderstanding among society. This research promoted perceptions of fathers as ineffectual and peripheral to family functioning (Rasheed & Rasheed, 1999). Historical research related to family structure also identified risks for adolescents, including an increased high school drop-out rate related to absent

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African American fathers (McLanahan, 1985), a relationship between single parent and step-parent homes, an increased risk for drug and alcohol use (Cooper, Pierce, & Tidwell, 1995), and reduced probability for condom use that resulted in an increased potential for fathering a child (Jemmott & Jemmott, 1992).

Current research has revealed a very different picture of father involvement. Wade (2014) reported that based on the Centers for Disease Control and Prevention, African American fathers were just as involved with their children as those of other races. These fathers were also more involved in the daily care of their children than Caucasian or Latino fathers (Wade, 2014). The Pew Research Center (2013) corroborated these findings of African American father involvement. The Pew Research Center identified that 67 percent of African American fathers who did not live with their children saw them at least once a month, which exceeded the percent for Caucasian and Hispanic fathers. These findings parallel results found in Black Caribbean men by Hauari and Hollingworth (2009) who identified that many Black African and Black Caribbean fathers spent substantial time with their children whether or not they resided in the home. Hauari and Hollingworth also identified that fathers describing little paternal involvement in their own childhood tended to be more motivated subsequently to increase fathering involvement with their own children. Hunt (2009) found that fathers in Black Caribbean and Black African families were more involved in their children's education than fathers in other heritage groups.

## Barriers to Parenting for African American Fathers

Parenting involves the promotion of physical, emotional social and intellectual development in children from infancy through to legal adulthood. African American fathers face numerous barriers to fulfilling this parenting obligation. These include financial burdens, reduced opportunities for employment resulting in a high unemployment rate, racism and oppression (Shiele, 2005), longer commutes between their place of residence and their place of employment (Harms, 2014), the perception that African American fathers are insignificant to the parenting role (Hrabowski, Maton,

& Greif, 1997; Mazza, 2002), and insecurities of the fathers themselves (Julion, Gross, Barclay-McLaughlin, & Fogg, 2007).

Single fathers comprise almost 1.7 million of the U.S. population of fathers (U.S. Census Bureau, 2012). Many of these fathers experience economically based hardships that affect their ability to provide financial stability for their family and children. Financial burdens arise in part from the lack of programs aimed at assisting fathers who fall on financial hard times. Many social welfare policies and programs target children and families. African American men with low incomes often have children who live in neighborhoods that are identified as high crime areas (Rasmussen, Aber, & Bhana, 2004) which place these children at risk regardless of presence or absence of fathers (Simms, McDaniel, Monson & Fortuny, 2013).

Racism is marked by discrimination, prejudice, and antagonism. These appear in the literature related to fatherhood, and promote stereotypes that convey a sense of inferiority regarding African American fathers and their interactions with their children (Culp-Ressler, 2014). Racism is demonstrated in the disproportionate number of African Americans in prisons when compared to total prison populations (National Association for the Advancement of Colored People, 2014). Racism can be a precursor to feelings of inferiority which can spill over into parenting and relationships. These perpetuate the attitude that African American fathers are failing in their parenting duties.

Sixty-seven percent of African American homes are single parent (National KIDS COUNT, 2014) with 49.8 percent being matriarchal (The Heritage Foundation, 2014). This promotes maternal mediation between father and child. As a result, mothers often have the power to affect access of fathers to their children. Trustworthiness of fathers is important to availability of their children to them (Center for Research on Child Well-Being, 2007). Mothers who view fathers as good role models are more likely to promote the father-child relationship.

## Promoting the Role of African American Fathers

The role of father can be encouraged through father or male family member mentoring early in the lives of young men. This can start at the birthing process. Presence at the birth of a young male may serve to generate a bond that prevails throughout life. Through male to male talks, family

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members can give a positive perspective to the fathering role and demonstrate active involvement that can be carried forward when these young males grow up and have their own children. This mentoring can provide a positive fathering role acquisition. Mentoring can also occur in church as this is often the center of the African American community. Mentoring by men in church can serve as a source of socialization and support which can promote learning the role of father. In a study by Roberts, Coackley, Washington and Kelley (2014, men spoke extensively “about church, God, Christ, the Bible and spirituality” when referring to their fatherhood responsibilities (p. 8). This led Roberts et al. to recommend a church-based resource for fathering and personal problems.

The White House Office of the Press Secretary (2010) released the President’s Fatherhood and Mentoring Initiative, which is a call to action to address fatherlessness in the U.S. This initiative evolved from the White House under the Obama administration in order to address responsible fatherhood and is supported by the White House Office of Faith-based and Neighborhood Partnerships and the Office of Public Engagement (The White House Office of the Press Secretary, 2010). These offices serve as distribution and organizational storehouses for activities that are designed to promote effective fathering. These activities include forums in various parts of the country, distribution of e-letters that address tips and resources for individuals working with the initiative, and collaboration with national and local organizations in order to target citizens who are fathers. The National Responsible Fatherhood Clearinghouse (n.d.) provides additional support for this initiative by serving as a repository for information for distribution and accessibility to the public at large. A toolkit is available at <https://www.fatherhood.gov/toolkit/home> that is a starting point for supporters of fathering activities. This national initiative serves to open up conversations on fatherhood, validate the personal responsibility of these individuals to their family, and convey the importance of their involvement in family and child rearing.

The Black Fatherhood Project (Thierry, 2013) is a film documentary that takes viewers through the exploration of fatherhood in Black America. Thierry (2013) addresses the impact of African history, slavery, and institutional racism on the underpinnings of the current African American family and brings about awareness of what it is to be a Black father

in the U.S. from the times before slavery through racism including recent challenges like incarceration, the influx of illegal drugs, and its effect on fatherhood activities. Thierry (2013) included personal narratives that occur among a diverse group of Black fathers who were exposed to fatherhood in various forms. These included loss of their own father to experiences related to being absent for their own children and other fatherhood experiences. These African American fathers give their perspective on the value system they use in order to raise their children and talk openly about their experiences as Black fathers, including their challenges and triumphs (Thierry, 2013). Using informative films such as this can give African American fathers a resource for modeling behavior that is successful and promote finding solutions that ensure involvement in child rearing.



*Two generations of African American fathers.*

## Practitioner Role in African American Male Parenting

It is important for practitioners to be aware of research in order to deliver the best care possible for all patients – for children both born and unborn. It is imperative for nurses to recognize the societal change in what is meant to be a family and the cultural context of family in the American society. Practitioners should support father figure roles and involvement in parenting (McCullough-Chavis & Waites, 2004). They can support fatherhood by encouraging healthy relationships between mothers and fathers. It is important for practitioners to recognize contributions of both parental roles to family dynamics and child rearing. It is imperative that nurses promote mechanisms for fathers to be involved with their children whether they live inside or outside of the home. They can develop strategies to incorporate non-resident fathers in health care needs of children, starting in the womb. This can be done by using alternate forms of communication during prenatal and post-delivery visits when fathers cannot be physically available (e.g., allowing mothers to talk, giving visit information over the phone).

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## The African American Father Does Matter in Parenting

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Practitioners can develop and refine empowerment based self-help interventions for African American fathers which may increase their involvement (Fagan & Stevenson, 2002). Working with social service programs may improve family support and build family structure. Promoting involvement of all family members in child rearing can serve to further increase self-esteem of both parents, especially fathers.

Just as in other areas of nursing involving patient relationships, education is a critical part of promoting father-child involvement. Historically, society has stereotyped African American fathers as persons who are absent and not involved in child rearing. Nurses must promote healthy engagement of fathers in activities that promote closeness with their children from conception and through all child rearing activities. Practitioners must educate the public, social service agencies, and family members about the importance of involvement of the African American father and the multifaceted nature of this role (see Figure 1). Childbirth educators must also be politically engaged in ongoing activities to promote policy recommendations that facilitate work-life balance for fathers. Accomplishment of this balance allows fathers the ability to fulfill their financial family obligations as well as their role of parent and caregiver. These policies also must address increased financial and family support for men in order for them to be engaged in the important fathering role.

### Summary

Fathering is critical to support for African American children and can serve to form a solid foundation for the family as a whole. It is imperative that the role of father be viewed as an important one beginning with the childbirth process. Nurses and childbirth educators can serve to influence the role of the father through education of family and society as well as through political involvement and policy development. African American fathers can successfully fulfill their role in the family structure with support of care providers who recognize that their presence does matter.

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# *The Role of the Father in Pregnancy in Jamaica*

by Shanett A. Davis, BS MS

*Abstract: The fatherhood role is influenced by culture, religion, social factors, and economic norms. In Jamaica pregnancy is often treated as a female only event. Women are left to visit their clinics alone and have support from female family members. The man's focus is providing financial support. In the past fathers were subjected to migrant labor and left their families for long periods. This tradition remained even when they were not working. Today, men are taking on more of the role of fatherhood, becoming involved and supportive and experiencing the privilege of pregnancy though of a secondary nature through their partner's body.*

*Keywords: fatherhood, pregnancy, culture, transition, cultural competence*

In developing countries men rarely go to visit doctors with their pregnant spouses, childbirth classes are not available to most individuals, private doctors or medical professionals are only for the privileged, and some individuals will visit maternal clinics as recommended but there are many who only seek prenatal care if they experience complications. Culture plays an imperative role in the behavior of fatherhood in pregnancy. Some men may have the desire to be more involved while their partner is pregnant but many find cultural background or environment restricts this.

Education and exposure to various cultures play a significant role in the pregnancy process. Those who have experienced a broader perspective may be less influenced by cultural expectations and find ways to be closer to their partner and their unborn child. Educated men are more likely

to be responsible, have empathy and experience, transition into fatherhood and take on the responsibility (Bettany, Kerrane, & Hogg, 2014). Even though fatherhood is influenced by culture, expectations have changed over time with education and technology, which have fathers adjusting to fatherhood in a more personal way than in the past. According to Bettany, Kerrane, and Hogg (2014) technology such as the media and the internet has influenced the male transition into fatherhood and facilitated different styles of fathering and masculinity.

As Jamaican men transition into their fatherhood role it is important that they are given as much respect, support, and recognition from midwives, labor and delivery nurses, doulas, and OB/GYN medical professionals as the pregnant woman. Effective actions from medical personnel can guide the lives of these men and help them to become responsible fathers (Townsend, 2010).

In most cultures men are not given the opportunity to describe what they experience in the role transition to fatherhood. One retired nurse/midwife from Jamaica who has been in charge of eight Community Clinics stated that during her 45 years as a nurse/midwife she has never seen a man (whether married or unmarried) accompany his pregnant partner to the clinic on regular visits. When she would visit their homes the men would often excuse themselves. Any men who presented as being involved in the pregnancy process were educated individuals who could afford a private medical professional. Pregnancy is a short-term process and for men to change their cultural orientation they have to be ready. It is important not to impose expectations from other cultures as they learn to define their new role, but to support those who are willing to begin fatherhood with the pregnancy process.

*It is important not to impose expectations from other cultures as fathers define their new role*

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## The Role of the Father in Pregnancy in Jamaica

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During pregnancy and transition to fatherhood, factors such as physical, emotional, and financial readiness need to be considered. The influences of relationships from older generations will shape the transition to fatherhood. In most developing countries physical and emotional support by the man for the pregnant partner is scarce (Premberg & Lundgren, 2006). Pregnant women are expected to conduct their daily chores, washing clothes by hand, carrying water on their heads, and helping out in the fields right up until the child is born. Times are changing. Individuals in Jamaica are becoming more modernized. Offering social, emotional, and educational support prenatally will prepare both parties to cope with this special event, and may enhance a healthier experience for all involved.

Men in stable relationships transition better into fatherhood and are more accepting of changes that take place in their lives than men in unstable relationships (Townsend, 2010). They are more involved and willing to go through the experience of the pregnancy, the birthing experience, and they are more accepting of the gender of the child. Jamaican men often prefer the gender of the first baby to be male and may be more involved in a pregnancy where the gender is known to be male. These beliefs may be a barrier for some to experience fatherhood and the role transition during pregnancy. They would feel supported by cultural beliefs that the womb of the woman is blessed, a male child is proof of their manhood, and this child will carry on the genetic line.

Men who grew up with these cultural beliefs and leave the developing country for a more industrialized country, have changed their perspectives on fatherhood in pregnancy. They have adapted to the new cultural beliefs, which gives them the opportunity to bond with the baby before birth. Change is happening and Jamaican men, like men in many other cultures, are more likely to hug and love their child, something they may not have experienced as a child. Jamaica is becoming modernized and men are just recently more willing to experience and engage in the pregnancy, regardless of the relationship or the gender of the child. Rural areas are slower to make these changes. The role of a man during pregnancy is primarily to provide physical and emotional support to his partner all while trying to redefine himself.

The experience of fatherhood is different from that of the pregnant woman, and their experience is considered to

be a secondary account of the pregnancy. Viewing the activities of the fetus through ultrasound and their movements through their partner's body creates opportunities for reflection. Through this transition the father may have confirmed their status as expectant father and have put some of their learned cultural experiences behind them. This engagement in the pregnancy may be done either privately or publicly.

## Tips for Teaching Childbearing Families From a Different Culture

The culture of individuals shapes their perceptions, attitudes, values, and responses. Fatherhood has received less attention than motherhood. Changes in society and the economy have allowed fathers be considered more than breadwinners (Hubin, 2013). Cultural competence will affect the interactions that take place between childbirth educators and prospective parents. It is of utmost importance that these educators assess how culturally competent they are, educate themselves about backgrounds, and learn to effectively interact. Even though preparing men for fatherhood has become relevant (Premberg & Lundgren, 2006), childbirth educators cannot assume that childbirth preparation techniques are "one size fits all." Prospective parents from diverse cultures may not be able to comply with different childbirth practices. Educating oneself and becoming more culturally competent will prevent bias, stereotyping, and insensitivity to the perceptions, attitudes, and beliefs of individuals from different cultures. Ongoing changes where education from a culturally sensitive perspective has been integrated into

### Some Tips to Remember:

- Be culturally aware.
- Do not make assumptions, but ask questions.
- Find out the meaning of certain words and in what context they are used.
- Even though it is one culture, people have their own personal beliefs and should be treated as individuals.
- Pain and hardship are viewed differently and in certain cultures pregnant women do not complain about pain even when the pain is extreme, so be extremely careful and find ways to help them express their pain level.

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## The Role of the Father in Pregnancy in Jamaica

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health care have proven to be successful. Fathers no longer need feel helpless in the fatherhood role transition during pregnancy (Premberg & Lundgren, 2006).

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# Fear of Fatherhood

by Wendy Sponsler, BSN RN ACM, Christopher Weatherspoon, MSN APRN FNP-BC, Deborah Weatherspoon, PhD MSN CRNA COI, and Dorothy Campbell, BSN RN

**Abstract:** *Childbirth is a transitional time for both the mother and father, and the new parental role may cause excess stress. This is especially true for first-time parents. Traditional roles placing emphasis on the mother as the caregiver are changing to include fathers as primary caregivers. Additional support of fathers through specific childbirth education and techniques to increase paternal attachment is needed to address this trend. This article examines the importance of paternal-infant bonding or attachment, barriers to attachment, and interventions that childbirth educators may use to ease a father's fear of fatherhood.*

*Keywords:* fatherhood, bonding, attachment, Kangaroo Care

Childbirth, while anticipated as a joyful experience, is a transitional period that may be stressful, fraught with anxiety, and fear. Fear of childbirth is estimated to occur in as many as 13% of fathers; these fears are described as potential threats to the life and health of mother and baby, feelings of helplessness, and powerlessness (Bergstrom, Rudman, Waldenstrom, & Kieler, 2013). Fathers report intrusive thoughts and avoidance behaviors. This fear may inhibit the man's ability to support his partner and prepare psychologically for fatherhood (Bergstrom et al., 2013). There may be interventions, before and immediately after birth, to help identify and overcome these negative attributes. Attention to pre and antenatal education and engagement are posited to improve attachment with the new father and his infant. Childbirth educators and health care providers may assist fathers in identifying and understanding these are not uncommon reactions. This could lead to a decrease in feelings of anxiety and promote an increase in confidence through

education and attachment strategies. The purpose of this article is to promote increased education for expectant fathers and to discuss interventions found to promote or enhance essential bonding between father and infant.

## Perinatal Education

There is a discrepancy between what fathers are learning from childbirth education classes and the presumed intent of paternal childbirth education. Media sources, which often portray birth as painful but short-lived, often only focus on the mother and what she will experience. Often the emphasis is on strategies to help her cope, without including coping skills for the father. A similar message occurs when the focus of newborn care is directed to the mother. The message fathers receive might be that they should leave responsibility for the baby to the mother (Erlandsson & Haggström-Nordin, 2010).

Childbirth education strategies might further help clarify the information fathers need and mitigate their paternal fears. Strategies may include antenatal classes that use the successful "promotora" model for men. The promotora model reaches underserved or hard-to-reach populations through peer education, which includes other family members or friends that are trusted companions (Hanson, Hunter, Bormann, & Sobo, 2009). An experienced father acts as a mentor to a father-to-be. A practical application includes fathers-facilitators in childbirth education classes, or separate men's groups and breakout sessions with male mentors, and contemporary coping techniques for men (Hanson et al., 2009).

The results of these "men-only" forums showed that 99% of the fathers found the sessions helpful in their role as a father (Friedewald, Fletcher, & Fairbairn, 2005). Elements fathers verbalized as particularly helpful included having a relaxing atmosphere with an opportunity for everyone to share fears and concerns where the focus was on the fathers' concerns and their new roles, not the mothers' roles. The fathers felt more at ease expressing their fears in an all-male group, and reported that sharing their common fears gave them reassurance (Friedewald et al., 2005).

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## Fear of Fatherhood

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Traditionally, immediately following birth, health care workers focus on the mother and the baby. This extends to include promoting bonding between mother and infant and education on the care of the infant in preparation for discharge. However, in the past few decades, the trend has changed, and fathers are assuming more responsibility for childcare (Helth & Jarden, 2013). Increasingly a collaborative effort for parenting that includes fathers, whose role previously was only supportive, now are choosing to be a partner or primary caregiver for infant care. Circumstances, such as Cesarean birth or other medical conditions, may thrust fathers into the primary caregiver role immediately. Alternatively, there may be a plan for fathers to assume a primary role of infant/childcare while the mother returns to work. Regardless of the reason for change, it is apparent that fathers desire and deserve support in caring for their children (Feeley, Waitzer, Sherrard, Boisvert, & Zelkowitz, 2012; Hollywood & Hollywood, 2011). Whether the father's role is supportive to the mother, or as a primary provider, it is important to establish a connection or attachment between the newborn and both parents in the early hours after birth.

*it is important to establish a connection or attachment between the newborn and both parents in the early hours after birth.*

## Attachment

Attachment is an emotional bond between infant and caregiver that is strong and continuous (Ozlüses & Celebioglu, 2014). This attachment may apply to the mother, father, or other caregiver. Previously, maternal attachment was the focus of research; however, paternal attachment and interventions that support it are an important topic. Although a philosophy of family-centered care dominates healthcare, the psychological status of first-time fathers and the attachment they have to their infants have received little attention (Yu, Hung, Chan, Yeh, & Lai, 2012). A review of current literature provides practical points for holistic care of the family, including the new father.

## Education

Recognizing a need to understand better the transition into fatherhood, Yu et al. (2012) conducted a study to identify predictors of father-infant attachment after childbirth. Age, socioeconomic status, marital status, and psychological state did not contribute significantly to attachment (Yu et al., 2012). However, the relationship between mother and father showed that the greater the intimate relationship between the mother and the father and the support the fathers received from their partner were the strongest indicators of the attachment between the father and the infant (Yu et al., 2012). Recommendations include that the couple, rather than the mother or the father, needs education and support during perinatal period.

## Cutting the Umbilical Cord

Brandão and Figueiredo (2012) studied the effect of the physical cutting of the umbilical cord by the father to determine if it promotes attachment/bonding with the infant. Brandão and Figueiredo indicated that while fathers who do not cut the umbilical cord demonstrate that the bond increases from before birth to the first days after birth, the attachment may decrease during the first month after birth. In the group that cut the umbilical cord, bonding increased continuously before birth and through the first month after birth (Brandão & Figueiredo, 2012). In conclusion, Brandão and Figueiredo asserted that it is vital for midwives to encourage fathers' participation in the entire childbirth experience. Though midwives facilitated the birthing experiences in this study, the findings apply to all healthcare professionals and the need to support bonding between fathers and their newborns.

## Skin-to-Skin Contact

Studies regarding attachment include the use of early infant skin-to-skin (STS) contact, known as Kangaroo Mother Care (KMC) (Conde-Agudelo & Diaz-Rossello, 2014). Kangaroo Care (Ludington-Hoe, 2011), or simply Skin-to-Skin care. KMC originated as an intervention for facilitating low-birth-weight infants' transition from intra-uterine to extra-uterine life and for supporting the maternal role in neonatal care (Conde-Agudelo & Diaz-Rossello, 2014).

Research on this intervention spans more than three decades and demonstrates benefits to both baby and mother. However, some conditions, such as cesarean section, interfere

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## Fear of Fatherhood

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with KMC. The focus turned from KMC to the inclusion of fathers in STS care and its effectiveness. The World Health Organization (1993) reported that the use of this technique by the mother, or the father, led to greater bonding, and as a result, the infant was calmer and less stressed. Studies that are more recent support the use of the same technique between father and infant, and this is simply termed Kangaroo Care (Ludington-Hoe, 2011).

An intervention of STS contact has proven benefits, both physiologically and emotionally for the parents and infant (Hunt, 2008; Nichols, 2013). Cong et al. (2012) reported infant physiologic changes such as regulating body temperature, improving breathing and oxygen saturation, and decreased pain during STS care. Many of the benefits of STS care for newborns revolve around their feelings of safety, warmth, and comfort. In addition to physiologic benefits for the infant, STS contact promotes human attachment and bonding for both the mother and father.

Helth and Jarden (2013) studied the psychological benefits of STS for parents, especially fathers. The aim of the study was to explore how fathers of premature infants, in a neonatal intensive care unit (NICU) experience the STS method of care (Helth & Jarden, 2013). Helth and Jarden identified three themes related to fathering, including competent parenthood; parental role and the division of roles between the parents; and balance between working life and time spent with the infant. The participants reported that the STS time increased their confidence by feeling more skilled and competent in handling the infant.

An interesting point for health care providers and childbirth educators is the theme of gender role that emerged in the study. Fathers reported STS care helped them see value in their role (Helth & Jarden, 2013). This theme identified a prevalent feeling that fathers often felt that they were less important than the mother in the caregiver role. This gender bias was frequently, and more likely unintentionally, reinforced by many of the nurses, though some did seek and value the father's opinion. The third theme was finding a balance between work and time with the infant in NICU (Helth & Jarden, 2013). The time spent with the infant in NICU empowered the fathers' perception that they were more competent of their care-giving abilities; however, fathers in this study reported some time away was also good in that going to work provided "breathing space" and enabled the



father to better support his partner (Helth & Jarden, 2013). Evidence supports that STS provides significant benefits for premature infants and their parents, and it has become widely used in neonatal units (Helth & Jarden, 2013).

Erlandsson, Dsilna, Fagerberg, and Christensson (2007) showed that fathers engaging in STS for the first two hours following birth had infants who tended to stop crying and fall asleep sooner (average 60 minutes) than fathers who sat beside their infants for the first two hours following birth (average 110 minutes). Fathers can facilitate positive newborn behavior and fulfill the role of primary caregivers during mother infant separation (Erlandsson et al., 2007).

Premature or sick infants also benefit from STS care. Erlandsson et al. (2007) provided early support that STS care maintains infant body temperature as well as an incubator. Blomqvist, Rubertsson, Kylberg, Jöreskog, and Nyqvist (2012) reported that in addition to physiological benefits, fathers experienced feelings of "doing good" for their infant and revealed that they spent more time with the infant than if they had not participated in STS care. Blomqvist et al. (2012) also indicated that the physical environment of the NICU and the sometimes-conflicting staff statements influenced their opportunity for, and experience of, caring for their preterm infants.

Feeley et al. (2013) also studied fathers of premature infants and found that infant size, the NICU environment, their personal attitudes regarding fatherhood, as well as need affected their participation. In situations of multiples, such as twins, fathers tended to volunteer care activities more readily simply due to the logistics of two babies. Stressors involved with childbirth may even be higher when a child is born prematurely or has congenital abnormalities. Fathers may not feel they do not have the knowledge or skill to care for these

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## Fear of Fatherhood

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infants and do not fully engage with the infant leading to a lack of attachment. This may indicate that a stronger encouragement in all newborn situations will help fathers overcome fear and anxiety and be more involved in infant care.

In another study by Hollywood and Hollywood (2011) fathers of infants born premature identified barriers to their participation. The fathers related feelings of fear of touching the infant and causing harm, feeling helpless, and fear of the unknown. Other fears included concerns about the child's future, including potential disabilities (Hollywood & Hollywood, 2011). Hollywood and Hollywood also revealed fathers' feeling left out. In one example, the nurse suggested to the mother of a dying infant that she should kiss her baby goodbye; the father related that he wanted to kiss the baby too but felt left out.

Fathers are not always ready to assume a direct caregiver role immediately following birth, but complications such as a cesarean section suddenly present a need. In an effort to understand the perceptions of fathers' caring for their newborns immediately following birth, Erlandsson, Christensson, and Fagerberg (2008) found fathers felt unprepared and anxious when faced with the role of primary caregiver. Gaps identified in the prenatal education process highlighted that fathers were not included in many aspects of initial newborn care secondary to an attitude that the mother would be the provider (Erlandsson et al., 2008). The lack of inclusion of fathers as potential primary caregivers, or lack of paternal active participation, has other potential consequences. Erlandsson and Häggström-Nordin (2010) noted that fathers who were not supportive of women during pregnancy were still uninvolved and unsupportive a year after birth. The need for including fathers in all aspects of care during prenatal and antenatal education is an area for improvement in childbirth education. Fathers reported that although anxious in the beginning, after some experience they felt more confidence and suggested that nurses tell them what to do and they would be more willing and comfortable in caring for the infant (Erlandsson et al, 2008).

STS enhances the fathers' ability to play a caring role in their infant's life. Fathers consider themselves less important, as compared to the mother in relation to their infant. STS enhances an understanding of their own role as a father. Health professionals should focus on promoting the abilities

of both parents and on ascribing the fathers an equal and important role in their infant's care.

## Infant Massage

Cheng, Volk, and Marini (2011) completed a mixed method study to determine if father infant massage decreased paternal stress and increased bonding. Local advertising offering infant massage classes facilitated recruitment of fathers for Cheng et al.'s study. Cheng et al. concluded that the fathers who participated in infant massage experienced a decrease in stress and an increased feeling of capability regarding the care of their infants. Some of the fathers also expressed that it was helpful to meet other fathers who had babies of similar ages during the class, as they did not feel as isolated in their experience (Cheng et al., 2011).

Infant massage is a potential technique that healthcare providers could incorporate into childbirth and post-partum classes for parents. Findings support that additional educational support for fathers targeting their fear of harming the baby and supporting an increase their interactions with the baby through massage may increase attachment.

## Conclusion

Fear of the unknown is a common human emotion. Often men transitioning into the role of father, especially first time fathers are fearful because they lack the confidence that accompanies knowledge and experience. Currently many support mechanisms and education are directed primarily toward the mother. Health care providers should focus on the physical health of the mother and fetus, but also on the relationship between a mother and a father. Including the father in all aspects of the pregnancy and encouraging involvement before and after birth can result in stronger and more intimate relationships for the family.

While maternal support is important, emphasis on paternal support should be incorporated into childbirth education. Childbirth educators and healthcare providers have the opportunities and expertise to facilitate fathers in their new role. Multiple opportunities and interventions that positively affect attachment between father and infant can be incorporated into childbirth education. The promotora model has been successful for providing support of new fathers by experienced fathers. Support groups of men who have participated in the births of their children may also have a positive effect on fathers' confidence levels. Health-

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## Fear of Fatherhood

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care providers and childbirth educators should promote hands-on experiences for fathers to ease fears and encourage their active participation in caring for their baby. Examples of interventions proven to increase paternal infant attachment include cutting the umbilical cord, providing skin-to-skin contact, and infant massage. With support, education, and training, new fathers can be present and have an integral role, not only in the birth of their child, but throughout their childhood.

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# *Birth: A Write of Passage Process*

by George A. Jacinto, PhD LCSW CPC, Olga Molina, DSW LCSW, and Joshua Kirven, PhD

*Abstract: Pregnancy is a significant life event. The pregnancy journey can be transformative and result in growth on several levels for the mother. The use of a journal to explore feelings, ideas, and plans can be helpful to the expectant mother. The article suggests journal writing ideas for various issues that may arise during pregnancy. The birth educator can be an important ally as the mother and child journey through the pregnancy processes. Suggestions are presented for each stage of the pregnancy rite of passage. The article concludes with a discussion of implications for birth education and practice.*

*Keywords: journal writing, pregnancy, rites of passage*

In a previous article, the author explored Birth as a rite of passage (Jacinto & Buckley, 2013). Many mothers keep journals about the experience of pregnancy and the child's pathway through childhood. The childbirth educator is a fellow traveler on the birth journey who can facilitate the expectant mother in journal writing. There are many aspects of journal work, which may include planning for the future of the child, examining approaching health issues, and addressing the range of feelings that accompany pregnancy and birth.

Discovering that one is pregnant begins the journey. As pregnancy progresses the development of a journal documents milestones, other experiences, and hopes and dreams of the mother for her child. Due to the many events that happen during pregnancy, birth educators may assist new mothers in the facilitation of journal writing for themselves and their child.

*Documenting the peak experience of birth from the mother's perspective while using a journal will assist in anchoring lifelong memories*

Documenting the peak experience of birth from the mother's perspective while using a journal will assist in anchoring lifelong memories about the gestation, birth, and childhood experiences shared by mother and child. The birth educator is a fellow traveler along the path of pregnancy. The resulting peak experience at birth culminates with many emotions and experiences that can be used in journaling as an anchoring point for future reflection. Reflecting on the feeling of being betwixt and between during the pregnancy can assist the mother in visioning and preparing for child rearing. Reflecting on self-care as well as caregiving are important issues that many may want to explore in their journal work.

Journal sections that involve logging experiences and dialoguing with experience and wisdom figures may help bring insight and positive energy to the transition toward birth and beyond. The mother may explore spiritual notions and religious beliefs associated with birth, which may assist her in understanding the significance of birth and the contribution motherhood brings to the formation of a well-adjusted individual. The documented birth experience of the mother can be an important narrative for the child to read as the child ages and is able to understand the circumstances around birth.

Keeping a journal has been a practice of many across the centuries. Journals are a good collection point for memories as one grows older and the distance of time creates a fog about the past details of life. Journals are a way to keep pictures, personal items, and thoughts that can be accessed throughout one's life. The act of writing helps to anchor the content of one's life. Internet-based tools can be used to permanently save memories in a journal that is impervious to damage by fire, natural disasters, or other events.

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## Birth: A Write of Passage Process

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There are a number of journal writing techniques. These include keeping logs that list experiences and ideas; dream journals; conversations with self, others, and life events; collections of personal reflections about life; unsent letters; scrapbook sections to collect a range of memories, and a photo album to name a few examples (Bruner, n.d.; Center for Journal Therapy, 2013; Chavanu, 2014; Lee, 2014; Progoff, 1992; Robson, 2014). The *Write of Passage Process* (WPP) allows the mother to start a journal for self and for the child that can be a life-long companion. The journal process allows the parent and then the child a place to log experiences and interact with those experiences. It is a tool used to plan goals for life, chronicle experiences in reaching goals, work through emotional issues, and find inner wisdom.

The time of pregnancy is the initial rite of passage period for the child. Each stage of pregnancy establishes the condition for the mother to document her experiences during pregnancy and her hopes for the soon-to-be born child. During this time, a mother would write about unique challenges and questions that arise may result in teachable moments that the birth educator uses to assist in the journey toward birth. As the mother journeys through the nine months her creative energies are at a peak, and she is able to anchor the experience for herself and her child in a narrative that will be a rich resource for their life journeys.

Anticipation of future role responsibilities can assist mothers in preparing for child rearing. The assumption of a new role and responsibilities raise a number of concerns that birth educators may facilitate new mothers in documenting through their pregnancy experiences in their journal. The birth educator in working with the expectant mother may direct her in various forms of journal work as the pregnancy progresses.

## A Write of Passage Process Associated with Rites of Passage

The expectant mother may want to write about her experiences at each stage of pregnancy. Additionally, having the mother keep a journal section entitled Key Events may provide a place to file important feelings and ideas during her pregnancy. She may want to keep a log of notable events and another section where she can dialogue with various events as they arise. There are a range of issues that could



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benefit from journal keeping some of which may include health issues, use of substances which may negatively affect mother and child, cultural mores, accidents, and a range of other factors that may contribute to stress, anxiety, joy and healing.

This journal work will assist the mother in successful transiting through postpartum issues. The new mother enters a new period that requires parenting with its many roles such as parenting demands. The expectant mother will be referred to as client in this discussion. Some suggestions for use of the *WPP* at each stage of the rite of passage are offered in the following discussion.

### First Trimester

The birth educator might begin journal work at the time of the client's first visit. The separation stage in the rite of passage is characterized by a range of feelings depending on the client's personality. This would be an opportunity to ask the client if she would like to keep a journal for herself and her child during and after the period of pregnancy. If the client answers yes, then the educator can discuss with her the key experiences she would like to memorialize. This dialogue process may put the client in touch with her own feelings and experiences during her current pregnancy. There are many possibilities regarding journal techniques. Only a few will be offered here as examples for each stage of the birth process.

The awareness that one is pregnant brings with it a range of feelings of which the client might be aware. The birth educator may have the client begin her journal with a Period Log and Period Discussion (Progoff, 1992). The Period Log can be easily facilitated by completion of the *continued on next page*

## Birth: A Write of Passage Process

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*Somewhere Along the Road* worksheet (Jacinto, 2014) and can assist in positioning the client in her current period of life. It has the client reflect on current obstacles in her life path, current changes in her life direction, feelings and questions that are unclear to her, the people, things, and places that help energize her and give her hope, her companions on the road (people, animals, things, thoughts, health conditions), and her view of the horizon or future. After completing the worksheet, the client looks at it and determines which areas she may want to reflect on in more detail. She may choose the feelings of joy she is experiencing and write about her feelings and expectations in the journal. She may have other feelings such as sadness, surprise, or fear.

Many issues and concerns emerge at this time. Clients may experience ambivalence about the caregiving parent role. In this case having a client send a letter to herself as if she was her mother giving her supportive advice might be helpful. What would her mother say? If she does not have a good relationship with her mother then another supportive person in her life could be the focus of the advice. The letter is one approach. The birth educator could also have the client visit a person she trusts for the advice and support. The mother-to-be experiences a shift in her societal role and separation from her past life. Soon she will be engaged in attending to the every need of her child; however, before birth she may undergo a journey that may bring her to the edge of death and back.

### Second Trimester

Journaling during the second trimester may focus on feelings of ambivalence and insights about the role of parent. Several journal techniques can be used here. Building on the Period Log and Period Discussion, the Steppingstones and Intersections sections to the journal can provide the client with a way to review significant life events from birth to the present (Progoff, 1992). Often events that are emblematic of various periods of life inform clients about resilience and strengths they have used when facing adversity and life transitions. As the client completes the two sections she will most likely have brought into focus past experiences that may assist her in negotiating current concerns and challenges.

The theme of the Limen Stage (second trimester) is the sense of feeling betwixt and between. As the client leaves

her previous state in life behind and embraces the role of the child's mother, she may want to dialogue with her old and new roles. In a section of the journal titled Parenting Plans, she may want to explore how she will parent, how she will feed the child, what she will do in the way of self-care, and who will be her social support. There are many opportunities for dialogue during this time. The client may want to dialogue with her body, the child, other persons, events, and society regarding long-term commitment of parenthood and other related issues.

### Third Trimester

At birth, the client encounters the reentry stage. The birth educator has assisted her in constructing a journal that has brought resolution and insight about many questions associated with her new role as the child's mother. In the first few days, it would be helpful for her to have completed a list of her own needs during the early years of the child's life.

It is important not to lose sight of the child's journal. Developing a section of her child's journal called Milestones would begin with the birth of the child as the first milestone. Each child brings a special temperament to life and each child's journal will contain many memories of her or his early years. It is a wonderful gift that a mother can provide for the child.

## Implications for Birth Educators

The pregnancy journey brings with it many questions, expectations, and hopes that can be memorialized in a journal for the mother and child. Documenting human feelings taking place during pregnancy from sadness to ecstasy, from anger to joy can help the mother process her adjustment to parenting the child. The journal affords the mother and child with a chronicle of this special period in their lives. Through journaling, the client works through the meaning of the pregnancy, the uniqueness of the newborn, and the miraculous experience of birth, both in her journal and in the life of the child. Birth educators are fellow travelers along the road toward birth. The journal can be a helpful tool in providing the mother and child with a process by which to chart their journey through life. In conclusion, journal work is a way to anchor significant insights, feelings, dreams, and visions in relationship to the mother and child. These thoughts and images may be a source of strength during the post-partum period.

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# The Importance of Safety When Using Aromatherapy

by Sylla Sheppard-Hanger, LMT & Nyssa Hanger, MA LMT

*Abstract: This paper focuses on the safety issues concerning the use of aromatherapy with childbirth and child care, as practiced by various healthcare professionals. This paper covers topical and environmental/inhalation methods of application of essential oils in childbirth and child care, the reasons certain oils are to be avoided, and an emphasis on the risks of undiluted application on the skin. Through a synthesis of existing safety data, this paper offers guidelines for safe practices to avoid harm to the practitioner, mothers, and their children.*

*Keywords: aromatherapy, essential oils, sensitization, essential oil safety*

There seems to be an abundance of misinformation about the powers and safety of using essential oils for various effects. In the field for almost 40 years, the authors have seen countless unnecessary injuries to adults, babies, and animals from overuse of undiluted essential oils. Many unfortunately believe that since essential oils are “pure and natural”, they are therefore safe. Misuse, especially by overuse, can lead to injury. This is especially true when working with special populations like pregnant women and their children.

## What is Aromatherapy?

Aromatherapy is the inhalation and application of essential oils from aromatic plants, flowers, trees and shrubs to restore or enhance health, beauty and well-being. Essential oils have a wide range of biological activity, but they are not universally safe.

*Essential oils are not universally safe and misuse can lead to injury.*

## What Are Essential Oils?

Essential oils are the highly concentrated extract of plant matter. These tiny droplets are present in particular glands, hairs, or specific structures of the plant and contain some of the active principles of the plant. Essential oils are phytochemicals with particular biological properties distinct from herbal preparations. Non-oily in texture, these highly concentrated substances are obtained by steam distillation, peel pressure, and solvent extraction methods. (Sheppard-Hanger, 2008).

## How Do Essential Oils Work On the Body?

Essential oils are a great alternative for some traditional medical treatments. Essential oils are less toxic than synthetic antibiotics (Pereira et al., 2014) and can support health working with the body’s own natural healing abilities (Miller et al., 2012). Oils can directly or indirectly affect the body’s physiological systems. For instance, inhalations of peppermint or eucalyptus oils can relieve respiratory symptoms of congestion because of their mucus thinning properties (Sinclair, 1996), and inhaled peppermint can calm nausea (Sites et al., 2014). Used topically for their antiseptic and soothing qualities, essential oils diluted in carrier oil can successfully treat minor skin conditions and muscle aches (Gbenou et al., 2014).

## How Do Essential Oils Work on the Mind?

By sniffing an aroma, a person’s whole mind-set can shift. Think about the last time you walked into a place that smelled horrible; or conversely, a place that smelled inviting. The odor of a place will affect our perception of that location. In commercial retail scenting specific areas or products has been shown to encourage sales and create brand recogni-

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tion by using the abilities of essential oils to affect associative learning and emotional processing (Bradford & Desrochers, 2009).

Because of the effect of relaxation on the brain and the subsequent sedating or stimulating of the nervous system, essential oils can help normalize other body systems, such as blood pressure and the possibly aiding in balancing of hormonal secretion. This relaxation effect, such as with PMS, (Freeman, 2010) has been shown by modulating neurochemicals like dopamine (Yun, 2014). Many healthcare providers are starting to utilize aromatherapy as a tool in their practice.

Olfaction's direct connection to the brain, via the limbic system, allows essential oils to have immediate effects on emotions and mental states. Perception of odors can have a major impact on memory, learning, emotions, thinking, and feeling. Scents can uplift spirits and calm the nervous system. For example, lavender is calming and has a sedative effect (Sayorwan et al., 2012); basil, rosemary and peppermint are uplifting and stimulating (Umezu, 2012); while jasmine and



David Foster

ylang-ylang are exciting or euphoric (Hongratanaworakit, 2010). See Table 1 for more information on general categories of essential oil's mental effects.

### How Are Essential Oils Used?

The easiest and most common method essential oils are used is through inhalation. Direct inhalation of the oils can have psychological effects through olfactory links with the limbic system. In addition, physiological effects are possible because inhalation is the fastest route into the bloodstream. Inhalation is most useful for respiratory symptoms and can be done by: sniffing an inhaler, a few drops on a tissue, or sitting near a diffuser. Using essential oils through a spray or a diffuser may help to set the tone or feeling of the room. This method of use may help in preventing colds and flu spread by helping to kill germs in the air.

### Aromatherapy Safety

The number one safety concern with all topical aromatherapy treatments is the risk of sensitization. Sensitization is an irreversible allergic reaction that a person can acquire after repeated undiluted use of an essential oil. Certain oils are known sensitizers (See Table 3) and topical use should be avoided. Even repeated undiluted use of gentle oils, like lavender, has been known to cause a sensitization response. Sensitization typically takes several applications before adverse effects occur. Special populations such as pregnant women or their infants are at particular risk for sensitization.

One of the safety experts in our field, Robert Tisserand, agrees on the importance of diluting essential oils. He says: the importance of diluting is to avoid skin reactions which

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**Table 1. General Categories of Mental Effects of Essential Oils. (Sheppard-Hanger 2008)**

Essential Oil	Action
Jasmine	<i>Euphoric:</i> uplifting to emotions, enhances sensuality, lifts mild depression, possible light narcotic and euphoric effect
Rose	
Sandalwood	
Ylang-Ylang	
Clary sage	
Lavender	<i>Sedative:</i> calms emotions, relieves anxiety, reduces nervous tension, sedates
Sweet marjoram	
Neroli	
Mandarin	
Geranium	<i>Balancing:</i> regulating, uplifting to emotions
Bergamot	
Rosewood	
Clary Sage	
Grapefruit	
Rosemary	<i>Stimulant:</i> awakening, mental stimulant
Basil	
Peppermint	
Lemon	

## The Importance of Safety When Using Aromatherapy

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can take the form of irritation, sensitization and photosensitization. In addition, diluting will help prevent any adverse toxicity effects. In pregnancy this is extremely important because fetal toxicity is possible through the overuse of essential oils since fetus shares blood with mom and is affected by what she is exposed to. Risk of adverse reaction is dose-dependent. Doses in aromatherapy are measured by percentage of concentration of the essential oils within carrier oil (for example coconut or jojoba). With this understanding, undiluted use of essential oils is considered a high risk factor for creating an adverse reaction (Tisserand, 2014). As health-

### In an effort to “do no harm,” the following safety guidelines are recommended:

- When using essential oils on the skin, *always dilute*. For a massage blend on an adult, 2.5% is best, less for pregnancy, and much less for children (1% or less).
- Avoid internal use. Oral use may risk serious injury to GI track, liver, kidneys and other organs: and oral dosing may interfere with medication and aggravate other medical conditions.
- Documented injuries are recorded. (See Atlantic Institute of Aromatherapy First Injury Data Report 2014 - ongoing collection site which documents reported injuries from unwise use <http://www.atlanticinstitute.com/injury-report-2014>)
- Essential oil use on newborns or infants up to three months is not recommended as their organs are still developing and skin is quite permeable. Essential oils may interfere with optimal bonding that occurs with mother’s own scent.
- Be wary of using cold-pressed citrus essential oils of bitter orange, lemon, lime, and bergamot, on the skin. These essential oils are phototoxic and can cause pigmentation changes and skin burns up to 12 hours after application when exposed to the sun.
- It is wise to vary oils and blends for safety and variety.
- Do not use the same blend or single oil for extended periods.

care providers, be aware that using essential oils undiluted directly on the skin creates a risk for adverse effects on both the practitioner and the client.

### Aromatherapy for Pregnancy

Pregnancy is a time of both excitement and normal discomfort as the woman’s body gestates new life and prepares for a major lifestyle transition. A pregnant woman’s sense of smell changes during this time. Many scents that were previously pleasant before may not be so in pregnancy, and may change throughout the pregnancy.

During pregnancy, the use of essential oils should be treated the same as medications; if you do not need them do not use them. However, for many of the ailments that can occur during pregnancy, essential oils are a safer alternative to chemical drugs (Tisserand, 2014). There is little debate about which essential oils are appropriate and safe to use on a pregnant woman. See Table 2 for a list of oils commonly considered safe for pregnancy. Avoid oils that are known sensitizers (Table 3) and always do the “mom sniff test.” Allow the mom to first sniff any oil that you’d like to apply. Even if the oil is known to help with relaxation, for example, if mom does not like the smell, then it is not going to do her as much therapeutic good than if she found the smell pleasant.

The safest application of aromatherapy for pregnancy would be environmentally (in the air) or on the skin with a carrier oil. The typical safe recommended dilution for a massage blend is 2.5% (15 drops in a 30 ml. of carrier oil).

**Table 2. Essential Oils Considered Safe for Pregnancy (Guba, 2001)**

Essential Oil	Botanical Name
Cardamom	<i>Elettaria cardamomum</i>
German and Roman chamomile	<i>Matricaria recutita, Anthemis nobilis</i>
Frankincense	<i>Boswellia carterii</i>
Geranium	<i>Pelargonium graveolens</i>
Ginger	<i>Zingiber officinale</i>
Neroli or Orange Blossom	<i>Citrus aurantium bigaradia</i>
Patchouli	<i>Pogostemon cablin</i>
Petitgrain	<i>Citrus aurantium</i>
Rose	<i>Rosa damascene</i>
Sandalwood	<i>Santalum album</i>

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Though we do not promote undiluted use on anyone, this is especially true for pregnancy because of risk of sensitization and the fact that whatever is put on mom will get to the baby through the bloodstream.

### Aromatherapy During Childbirth

In practice, the authors have encountered several mothers and midwives that used aromatherapy in the birthing process. Some will use a massage blend to help mom relax in between contractions, or a spray to help set the tone of the room. Though aromatherapy can be very helpful, when used improperly it can create quite the opposite effect. Here are a few ways to use aromatherapy safely and effectively during the birthing process.

First, be aware of the laboring mother's heightened smell sensitivity during her pregnancy. Aromas that she likes at the beginning of labor may be repulsive several hours later. Check with the mother before integrating any scents into the air, since they affect us so deeply and can be hard to remove from the air or her body if she does not like it. It is best to first spray or rub a little of the aromatherapy blend into your hands and let her smell it. Your hands can easily be washed if she does not like the aroma.

Second, once it is known that the mother likes a scent, the next step is to use it safely. All essential oils applied to the skin need to be diluted to 2.5% (15 drops in one ounce of carrier oil) and can be applied during labor for relaxation. It is possible to over-use, which can cause headaches and nausea for mom or others in the room. A good general rule is to have an hour break after each hour of use in the air or on the skin. If the laboring mom finds the aromatherapy helpful, you may not need to break for so long but first check in with the other people in the room, especially if they are a part of the medical or support team.

Finally, if the laboring mother is using a tub or is preparing for a water birth, do not place *essential oils in the birthing water*. Essential oils do not mix with water and can burn eyes and mucous membranes of anyone in the water including baby. There is also the chance that they may be inhaled by the baby after it is born which could irritate the lungs. Essential oils can be put instead in the air through a spray, diffuser or used as personal inhaler.

## Table 3. Essential Oils Known to Cause Adverse Effects (Sensitization) on Skin

Essential Oil	Botanical Name
Cassia	<i>Cinnamomum cassia</i>
Cinnamon bark	<i>Cinnamomum zeylanicum</i>
Peru balsam	<i>Myroxylon pereirae</i>
Verbena absolute	<i>Lippia citriodora</i>
Tea absolute	<i>Camellia sinensis</i>
Lemon Myrtle	<i>Backhousia citriodora</i>
Turpentine oil	<i>Pinus spp.</i>
Inula	<i>Inula graveolens</i>

Watt (2013). Used with permission from: *Essential Oils during pregnancy: Myths Exposed and Some Facts*. Retrieved from <http://aromamedical.org/PDF/oils-in-pregnancy.pdf>

### Aromatherapy in Parenting and Childcare

Using essential oils on any infant under three months, no matter what dilution percentage, is not recommended. After the first three months, essential oils can be used at a very low dilution, we recommend 1% or less (about 6 drops in a 30 ml bottle). Children over six years can safely use 2.5% or more. We only recommend using documented safe oils, staying away from the oils listed in Table 3.

Children often react to the strength of the odor, rather than the odor itself (Engen, 1974). Children begin learning odors early on. A baby can identify its mother's odor at six hours after one exposure (Porter & Winberg, 1999). A mother can pick out her own newborn's clothes from those of other babies by scent almost as quickly (Engen, 1974) and can be calmed by her scent (Rattaz, Goubet, & Bullinger, 2005). A child can use a mother's garment, which would have her smell or perfume, when having to be away from her as a calming device.

Essential oils should be kept away from children, so they are not mistaken as harmless risking overexposure or ingestion. Or they may copy adults using oils and want to try it. Children may love the smell of some oils and may confuse them with candy. Certain oils, like peppermint and eucalyptus, include components that can trigger a reflex in really young children which slows breathing down significantly. For more info, see *Essential Oil Safety: For Health Care Professionals*, 2nd Edition, by Robert Tisserand and Rodney Young. These are commonly used oils that can be helpful for respiratory conditions in very small amounts for adults, but

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you can use pine and conifer oils like spruce and fir instead for children and understand that less is more.

Essential oils can be used on children over two years old the same way they are used with adults with the exception of using only a small fraction of the same amount of oil. A parent may give a child a massage with a relaxing blend for example, but the dilution would be 1% or less. With safe methods, essential oils can enhance the well-being of the whole family.

In conclusion, aromatherapy provides health and body care on a completely natural basis, and the subtle qualities of

### Safe and Effective Ways to Use Aromatherapy with Families:

- Have on hand diluted blends for bug bites, first aid, sunburn, and other minor injuries. A starter kit might include German and/or Roman chamomile, Tea tree, Lavender, Rosemary, and Pine.
- Use aromatherapy to clean the air and prevent the spread of germs via diffusion. You can run diffusers with an anti-infectious blend when the family is sick or use citrus or other light oils for a calm and clean atmosphere. Alternately, sprays or drops on a tissue in air vents disperse through air.
- To help kids go to sleep, use lavender and marjoram in the bath (equal parts, 2-3 drops), or in a carrier oil for relaxing back massage before bed.
- To help with focus and homework, use oils that are stimulating like rosemary, lemon, or peppermint. Scents will also help with memorization; children learning a word list with a scent can recall the words later with same scent. For example, a child could study with orange, then take orange on a tissue to class when they go for the test.
- To help kids to calm themselves (along with punching bag to burn off anger and excess energy), use relaxing scents to help soothe emotions when upset. Make a special aromatherapy spray to ward off 'monsters' or nightmares.
- Make craft projects using essential oils (make aromatic clays, jewelry, perfume, bath salts).

the oils lend themselves best to a gradual experience. Hopefully, the need for a safe approach to the use of essential oils is evident. As highly-concentrated substances, essential oils can have a powerful effect on physical and mental states. As healthcare providers, we always want to make sure the effects are positive so we can continue to change the lives of our clients and patients in helpful and healthy ways.

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# Postpartum Weight Control and the Contribution of Exercise

by Robbie Cochrum, ABD HFS CSCS

**Abstract:** *Postpartum weight retention is a troublesome condition for many new mothers. Retention of even a few pounds of gestational weight can increase the risk for overweight and obesity-related health conditions, particularly in those who lead sedentary lifestyles. Exercise has been suggested as a possible weight loss initiative for those in the postnatal period. Thus, this report discusses the issues relating to postpartum weight loss difficulties and recommendations for mothers on how to reduce weight safely, quickly, and permanently through physical activity and exercise.*

*Keywords:* postpartum, exercise, lactation, postnatal, gestational weight gain

Weight gain during pregnancy is natural, healthy, and contributes to the growth and development of a healthy baby. According to the American College of Obstetricians and Gynecologists (ACOG, 2013), recommendations for weight gain during pregnancy ranges from 28-40 lbs. for those with a pre-pregnancy body mass index (BMI) of less than 18.5 to, up to 11-20 lbs. for those with a BMI greater than 30. Gaining more weight than that recommended by the ACOG is related to higher levels of weight retention in the postpartum period (Gunderson & Abrams, 1999), as well as a significant increase in the risk of becoming overweight after a pregnancy (Gunderson, Abrams, & Selvin, 2000).

Postpartum weight retention varies in severity with the average weight retention ranging from 1-6 pounds. Some women, particularly minorities, may be at risk for retain-

ing as much as 39 pounds or more (Gore, Brown, & West, 2003). Perhaps more concerning is the finding that one year postpartum, 14 to 20% of women have retained more than 11 pounds gained during pregnancy (Walker, 2007). For those women already advanced beyond a healthy weight before, during, and after pregnancy, retention of virtually any weight can compound their risk for type-2 diabetes, endometrial cancers, cardiovascular disease, and arthritis (O'Toole, Sawicki, & Artel, 2003). The child may also be affected. Sonnevile et al. (2011) found an association between higher offspring BMI at age 3 and maternal attempt to lose weight at six months postpartum and beyond. To further stress the importance of reducing gestational weight within six months, Rooney and Schauburger (2002) argued that failure to lose pregnancy weight by six months postnatal is a risk factor for long-term obesity. Therefore, an early postpartum diet and exercise intervention is suggested in order to reduce gestational weight gain in a safe, effective, and timely manner.

## Weight Loss During the Postpartum Period

A review of the literature has shown diets with a goal of energy deficit to be a consistent weight loss tool (Amorim Adegboye, Linn, & Lourenco, 2007). Yet a new mother choosing to breastfeed must maintain a certain calorie intake in order to maintain bone mineral density and possibly adequate milk production (Lovelady, Garner, Moreno, & Williams, 2000; Shapses & Riedt, 2006). Therefore drastic diets may not only be difficult, but also unhealthy for both mother and infant.

Conversely, exercise has been established as a healthy means of contributing to an energy deficit via increased energy expenditure while also providing a host of other health benefits (Josse, Atkinson, Tarnopolsky, & Phillips, 2011). However, exercise as a stand-alone method of creating a sustained energy deficit and subsequent weight loss is

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relative. A thorough review of the literature concerning diet and exercise interventions during the postpartum period was conducted by Amorim Adegboye et al. (2007). They found that the diet plus exercise interventions were the most effective at promoting weight loss, improving cardiovascular health, and preserving fat-free mass. Studies using a diet-alone intervention produced weight loss as well; however, the majority of the weight loss was due to the loss of fat-free mass, as body fat percentage was not affected (Amorim Adegboye et al., 2007). The loss of lean tissue with weight loss could be responsible for a plateau in weight loss during a dietary weight loss intervention (Josse et al., 2011). Along with the health benefits gained from exercise (Sullivan, 2014), the addition of diet is significantly more effective at maintaining weight loss compared to diet-alone interventions (Curioni & Lourenco, 2005). Therefore, from an overall health perspective, a diet plus exercise program could prove more worthwhile than dieting alone.

### Exercise During the Postpartum Period

Along with providing a component for weight loss, exercise during the postpartum period has been found to contribute to the promotion of health-related quality of life and self-esteem, improved cardiovascular fitness, less lactation-induced bone loss, less urinary stress incontinence, and reduction in postpartum depression symptoms (Daley, MacArthur, & Winter, 2007; Evenson, Aytur, & Borodulin, 2009; Haruna et al., 2013). Exercise has also been shown to benefit both mother and baby, as a mother's participation in regular exercise after childbirth may encourage regular physical activity habits in her children (Larson-Meyer, 2002). Therefore, constructive physical activity should only be discouraged by the postnatal healing process and with medical permission.

Many women report decreases in moderate and vigorous physical activity during pregnancy that persists at six months or more postpartum (Pereira et al., 2006; Symons Downs & Hausenblas, 2004). Along with the physical healing needed following delivery, many barriers to postpartum physical activity exist, with lack of time and issues with child care being the two most common (Evenson et al., 2009). In addition, a small number of women experience a major depressive episode during the first three months postnatal,



with onset following delivery that could make initiation of an exercise regimen more difficult (Daley et al., 2007). Subsequently, exercise program recommendations for postnatal mothers should account for these barriers.

### Strategies for Postpartum Exercise Initiation

For most women, commencement of a weight loss-inducing physical activity program should begin with a gradual reintroduction or increase in intensity and duration of exercise and can begin within a few days of delivery (Artal & O'Toole, 2003). Further recommendations for the first six weeks after delivery have been developed by Clapp (2002), who suggested that the main goal is to obtain personal time and redevelop a sense of control in addition to the following: 1) beginning slowly and increasing gradually; 2) avoiding excessive fatigue and dehydration; 3) supporting and compressing the abdomen and breasts; 4) stopping to evaluate if it hurts; and 5) stopping exercise and seeking medical evaluation if experiencing bright red vaginal bleeding heavier than a menstrual period.

To overcome initial barriers to an exercise program, Gaston and Gammage (2011) used the theory of planned behavior to assess motivation to exercise in the postpartum period. Participants who received a persuasive message concerning the important health benefits of postpartum exercise reported significantly more positive attitudes, stronger perceived behavioral control, and greater intention to exercise (Gaston & Gammage, 2011). Thus, a first step in promotion of weight loss in the postpartum period is to provide useful information concerning the importance of diet, exercise, and weight loss while the mother is in the latter stages of pregnancy.

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*a first step in promotion of weight loss in the postpartum period is to provide useful information*

O'Toole et al. (2003) studied the effect of an individualized, structured diet and physical activity intervention on weight loss in overweight women during the first year postpartum. The women in the experimental group met for 12 weeks and kept daily food and activity diaries, while the control group received a single 1-hour educational session concerning diet and physical activity (O'Toole et al., 2003). Results indicated the women in the structured intervention had significant weight loss, decrease in percent body fat, and maintenance of fat-free mass compared to the women participating in the control group (O'Toole et al., 2003). Additional strategies for promotion of weight loss intervention in postpartum women include working in pairs, rather than groups, as well as home-based options that utilize mail, telephone, or internet/email strategies of encouraging a healthy diet and physical activity (Ostbye et al., 2009). Further research has shown that a woman's partner and family members most strongly influence their postpartum exercise behavior (Ostbye et al., 2009; Symons et al., 2004).

Ultimately, the incorporation of exercise into the daily regimen will prove useful for lifelong health. Thus, adoption of lifestyle change interventions to include physical activity, such as incorporating physical activity throughout the day in a gradual and moderate intensity, could prove as useful as participation in a more structured program (Evenson et al., 2009). Both cognitive and behavioral strategies should be utilized to help sedentary adults achieve physical activity goals (Dunn et al., 1999). Though cognitive strategies alone may not be completely successful in changing physical activity patterns, they can help shape behavior and move individuals to a new stage of change (Evenson et al., 2009). Cognitive strategies include increasing knowledge about activity, understanding the risks of not being active, caring about the effect on others of not being active, comprehending the benefits of activity, and increasing opportunities to be active (Evenson et al., 2009). Behavioral strategies could include attempting to exercise at times when one otherwise would not (e.g., exercising while watching television in the evening), enlisting social support, rewarding oneself, com-

mitting oneself to being active, and reminding oneself about being active (Evenson et al., 2009). According to Evenson et al. (2009), the adoption of these strategies by health care providers, the spouse, or other family members or friends could help postpartum women overcome barriers to exercise and physical activity.

## Current Aerobic Exercise Recommendations

Specific exercise recommendations for women in the postpartum period have not been identified. According to the American College of Sports Medicine (ACSM, 2014), healthy women should get at least 150 minutes of moderate-intensity aerobic activity throughout the week during and after their pregnancy which can be accomplished through 30-60 minutes of moderate-intensity exercise, five days per week. Moderate intensity aerobic exercise includes, but is not limited to, walking briskly (3 miles per hour or faster), water aerobics, bicycling (< 10 miles per hour), tennis (doubles), ballroom dancing, and general gardening (Centers for Disease Control and Prevention [CDC], 2011). Healthy women who already do vigorous-intensity aerobic activity or large amounts of activity can continue doing so during and after their pregnancy as long as they remain healthy, and the volume and intensity of exercise is discussed with their health care provider (CDC, 2011). Specific vigorous aerobic exercise recommendations include accumulating 20-60 minutes of vigorous-intensity exercise, three days per week (ACSM, 2014). Vigorous exercise includes, but is not limited to, race walking, jogging, running, swimming laps, tennis (singles), aerobic dancing, bicycling (> 10 miles per hour), jumping rope, heavy gardening, or hiking uphill or with a heavy backpack (CDC, 2011). For those women introducing an exercise program to their postpartum weight loss plans or for those women still recovering from the puerperium period, breaking exercise sessions into 10-minute segments may be the safest and least stressful method of exercise progression.

The current ACSM (2014) aerobic exercise recommendations are typically prescribed for general health benefits. For those women wishing to rely on exercise for more than strictly health-related purposes, additional structured physical activity may be needed. In situations where modest loss or maintenance is desired, 150-250 (~ 1200 to 2000 kcal.wk-1) minutes a week of moderate-intensity physical activity is recommended; however, for clinically significant weight loss to occur, 250 to 300 minutes a week (~ 2000 kcal.wk-1) is recommended (ACSM, 2014). Practically, a 60 kg (132 lb.)

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woman could attain this physical activity volume by walking at 3 mph for 1.8-2 miles per day over the course of a week (ACSM, 2014).

### Current Resistance Training Guidelines

Unfortunately, no known research has assessed the impact of resistance training as an exclusive postpartum weight loss component. Thus, specific recommendations for engaging in resistance training rather than or with aerobic exercise as part of a postnatal weight loss regimen cannot be made. However, resistance training has repeatedly been identified as a method for maintenance or improvement in lean body mass (ACSM, 2014). Thus, any increase in muscle mass will contribute to enhanced resting metabolic rate and in turn, total energy expenditure. Consequently, resistance training could prove useful as a weight loss component, along with a diet focused on moderate energy restriction and an aerobic exercise regimen.

Beyond the puerperium period, most healthy women can begin and gradually progress to the minimum resistance training guidelines recommended for all healthy women (ACSM, 2014) as per their health care professionals advice. The current ACSM (2014) guidelines for resistance training include the following:

- Train each major muscle group two or three days each week using a variety of exercises and equipment.
- Very light or light intensity when beginning a program
- Two to four sets of each exercise to improve strength and power
- For each exercise, 8-12 repetitions improve strength and power, 10-15 repetitions improve strength, and 15-20 repetitions improve muscular endurance
- Load lifted is based on repetition volume. For more repetitions, lift a lighter weight; for fewer repetitions, attempt to lift a heavier weight

### Diet-Specific Energy Restriction During the Postpartum Period

The effect of energy restriction during lactation in an effort to stimulate weight loss has yielded consistent results (Amorim Adegboye & Linn, 2013). However, the specific treatment necessary to promote consistent and healthy weight loss remains unclear. McCrory, Nommsen-Rivers,

Mole, Lonnerdal, and Dewey (1999) implemented a 35% reduction in recommended calorie intake and reported an average weight loss of 1.9 kg (4.18 lbs.) in lactating women during a short term (11 days) diet. Lovelady et al. (2000) found that a moderate calorie restriction (500 kcal.d<sup>-1</sup>) combined with increased aerobic exercise resulted in significant weight loss (10.56 + 3.74 lbs.) and no adverse effects on infant growth (weight or length) from 4 to 14 weeks postnatal.

However, in studies investigating very low levels of energy intake (405 to 1000 kcal.d<sup>-1</sup> or < 55% of recommended intake) or in studies with rapid weight loss (> 14%) that occurred during short periods of time (< 3-4 months), significant decreases in bone density have been revealed (Colleran, Wideman, & Lovelady, 2012). However, Colleran et al. (2012) found an average energy restriction of approximately 613 kcal.d<sup>-1</sup> (+ 521 kcal), combined with an aerobic and resistance training program, resulted in significant weight loss in overweight breastfeeding women, with no deleterious effects on bone mineral density or subsequent infant growth. Therefore, based on current guidelines established by the U.S. Department of Agriculture (2012), for women of childbearing age (1800-2000 kcal.d<sup>-1</sup> depending on activity levels) and lactation-induced dietary needs, weight loss of approximately 4.5 pounds per month is healthy and readily attainable by reducing daily caloric intake by 500 kcal (Institute of medicine, 1992).

### Breastfeeding and Exercise

Further weight loss opportunities exist for women who exercise while also nursing and reducing energy intake. However, many women may be concerned about the effects of exercise on lactation. Various authors have indicated exercise while nursing can promote cardiovascular fitness, weight loss, energy expenditure, and psychosocial well-being compared to non-active nursing women (Wright, Quinn, & Carey, 2002). Therefore, it is only natural that a mother would want to both exercise and nurse her infant.

In terms of nursing performance while exercising, ensuing research has established the quality and quantity of breast milk and infant acceptance of the milk are not affected by moderate exercise (Dewey, Lovelady, Nommsen-Rivers, McCrory, & Lonnerdal, 1994; Wright et al., 2002). For those mothers wishing to exercise or train more vigorously, Wright et al. (2002) found infant acceptance of breast milk to be similar both one hour before and one hour after moderate or maximal maternal exercise intensities. However,

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for those mothers still concerned as to whether exercise and breastfeeding are compatible, the following are suggested: 1) maintain low-to-moderate intensity exercise (<13 repetitions as rate of perceived exertion); or 2) nurse before strenuous exercise; or 3) store pre-exercise milk for later consumption; or 4) wait 60-90 minutes after exercise before nursing.

## Application for Childbirth Educators

To conclude, postpartum weight retention can be a potentially serious health concern, particularly in already overweight or obese sedentary women. Return to prenatal weight within six months has been identified as promoting more positive weight control outcomes for both mother and child than weight loss that continues beyond six months. Exercise has been identified as a means for weight reduction, along with improved overall health and is only limited by the approval of the health-care professional and the natural healing process. Childbirth educators should advise their clients that long-term weight loss maintenance is rarely attained through a diet-alone intervention and thus should be combined with an appropriately graded exercise program. Further, educators should emphasize gradual weight loss that proceeds at a rate of approximately 2 pounds per week, by means of a diet and aerobic exercise-induced energy deficit of ~500 kcal.d<sup>-1</sup>. Childbirth educators should attempt to communicate this information to their clients early in the pregnancy cycle and continue providing this information post-pregnancy through periodic phone calls, emails, and group or paired diet and fitness interaction.

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# The Consequences of Maternal Obesity

by Valeria Balogh, MS IHC PYT

***Abstract: Obesity is increasing in every country in the world and is especially critical in women of childbearing age and children. These offspring populations are sensitive to the developmental outcomes of maternal obesity including, but not limited to, obesity at birth, in childhood, and adolescence which has been suggested to increase risk for most non-communicable diseases later in life. Health educators can make a difference for these populations by emphasizing whole food nutrition at all stages, but especially during the critical developmental periods of pre- peri- and postnatal life, changing health education from a reactive strategy to a proactive one.***

*Keywords: obesity, intrauterine environment, chronic disease, epigenetics, nutrition*

The etiology of obesity is complex. Many disparate factors such as economic and political environments, the industrialization and commercialism of food, lifestyle choices and food preferences, individual socioeconomics, neurophysiological drivers, and local environment weave an integral web that supports or challenges the health of a population (Swinburn et al., 2011). It is important to explore the potential for improving global health through optimizing the developmental environment for the health of the fetus and that of young children. This potential improvement includes factors of maternal health such as nutrition and weight management, correction or prevention of insulin imbalance, and stress management, as well as management of the health

of the family reflected in the home environment and the parental modeling of healthy behavior for the child.

Many studies indicate that improving the health of women and children may be a key to preventing the global obesity epidemic, by reducing the cycle of mother to child obesity (Barker, 2012; Bruce & Hanson, 2010; Drong, Lindgren, & McCarthy, 2012; Wang, Walker, Hong, Bartell, & Wang, 2013). While there is agreement that lifestyle has a mitigating effect on obesity and chronic diseases the heritability of these diseases may be connected to epigenetic, intrauterine programming resulting from early life conditions (Drong et al., 2012). Chronic diseases, including type 2 diabetes (DM2), certain cancers, and cardiovascular disease are connected to obesity. The World Health Organization (WHO, 2013) states that these diseases “are driven by forces that include aging, rapid unplanned urbanization, and the globalization of unhealthy lifestyles” (p. 1). Unhealthy lifestyles may be seen as intermediate risk factors for chronic disease by leading to obesity, insulin resistance, hyperlipidemia, metabolic syndrome, and increased blood pressure (WHO, 2013). The potential for heritability of common obesity can be as high as 70% (Herrera, Keildson, & Lindgren, 2011). However, if this percentage can be reduced in utero, then the potential for reducing epigenetic heritability in future generations may be significant.

## Contemporary Issues

Herrera et al. (2011) reported that by 2030 there will be 1.12 billion obese people on the planet with an additional 2.16 billion overweight individuals. Obesity and overweight burden medical systems and global productivity and most importantly reduce individual quality of life and potential lifespan (Drong et al., 2012). Patti (2013) estimated that approximately 50% of incidence of DM2 in young people may be traced to maternal obesity and DM2.

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*by 2030 there will be 1.12 billion obese people on the planet with an additional 2.16 billion overweight*

Developmental theory on the origins of disease and health indicates that maternal factors such as body composition, stress levels, and nutrition influence the phenotype of the developing fetus, thereby elevating the potential risk of that child developing chronic disease later in life (Bruce & Hanson, 2010). Bruce and Hanson (2010) also suggested that maternal obesity or gestational diabetes may play a role in the continuation of metabolic disease across generations. As such, Bruce and Hanson (2010) posited that poor maternal nutrition could be viewed as a fountainhead of the current global obesity epidemic.

Recent interest in the epigenetic factors affecting phenotypic alterations suggests that many chronic diseases are an unnecessary outcome of modern life (Barker, 2012). Along these theoretical lines, the physical and nutritional health of the mother can have significant effects on childhood and adolescent obesity (Lillicrop & Burdge, 2011). One example can be seen with maternal consumption of high fructose products such as sugar-sweetened beverages, fruit juice, and packages sweets. Studies show higher levels of fructose in the blood of the fetus than in the maternal blood suggesting an active transport across the placenta (Goran et al., 2013). Exposure to high levels of fructose in utero may affect energy regulation development in the hypothalamus, increase fat mass and fat cell numbers, and potentially alter satiety hormones and taste preferences in post-natal life (Goran et al., 2013). This pathway has the potential to result in increased risk for obesity and DM2 in childhood and adulthood (Muhlhausler, Gugusheff, Ong, & Vithayathil, 2013).

Barker (2012) indicated that the present paradigm of diverse causations for chronic adult diseases is limiting and has not produced successful outcomes in prevention. Barker's theory regarding the developmental origins of chronic disease posited that the intrauterine environment can be seen as the cornerstone for the health of a population making the health and nutrition of females of all ages paramount for communities and public health organizations. We need to shift from treating obesity to preventing obesity (Wang et al., 2013).

The epigenetic shifts that occur in utero may addition-



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ally predispose an individual to food addiction tendencies in childhood and adolescence, making healthy food choices more difficult, and may potentially affect neurological development (Lee & Gibbs, 2013). This moves the basis for obesity away from the assumption that the disease is a direct result of lifestyle choices and posits that obesity has a biological basis that needs attending (Gluckman et al., 2011). Apart from the role of nutrition in the developmental process of tissues and organs, the diet consumed by the mother during pregnancy and throughout breast feeding has been posited to influence food preferences throughout the life of the child (Portella et al., 2012).

Obesity is a modifiable risk factor for many of the most chronic diseases yet one that defies long-term solutions with the current paradigm (Herrera et al., 2011). Therefore, it is important to investigate new pathways to improve the global health of the planet. One strategy would be to educate childbearing women and families on the potentially significant long-term impact of the maternal environment on the fetus, growing child, and the future adult (Bruce & Hanson, *continued on next page*)

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2010). This education should go beyond current programs and involve “the complex cultural, sociological, spiritual, and emotional forces that surround food and eating” (Gluckman et al., 2011, p. 1). Health psychologists, obstetricians, nurses, pediatricians, and maternal educators are in a grassroots position to effect long-lasting change in the health and future wellbeing of the world’s populations.

## *We need to shift from treating obesity to preventing obesity*

### Obesity

The proximal factors contributing to global obesity include complex biopsychosocial influences. Some of these influences include a mismatch of our evolutionary biology and the modern lifestyle and environmental influences, or an obesogenic environment (Gluckman et al., 2011). This includes the modern industrial diet, which is made up of highly palatable, energy-dense foods that are nutritionally poor in quality and lends itself to over-consumption. Another influence lies in the discrepancy between the prenatally encoded environment of the womb and the actual post-natal environment an individual lives and grows in (Hanson, Godfrey, Lillycrop, Burdge, & Gluckman, 2011). Maternal health is an important factor as it relates to the intrauterine environment and the ways in which an offspring’s development may be influenced (Gluckman et al., 2011; Laitinen et al., 2012). Pontzer et al. (2012) and King (2013), investigating the traditional ancestral lifestyle and diet, have shown that a pivotal factor related to obesity is less related to energy expenditure but instead related to the quality and quantity of dietary intake controlled by the evolutionary brain-reward circuitry, and these neurological pathways operate on the subconscious level (Cohen, 2008).

Prenatal nutrition can be viewed as a significant factor in the potential for developing obesity later in life. Abnormal birth weight has been indicated in as much as a 50% increase in overweight children and is also indicated in outcomes of adults with high central obesity (Wang et al., 2013). Excessive maternal weight gain during pregnancy and gestational diabetes is positively associated with early childhood obesity (Lillycrop & Burdge, 2011). Micronutrient intake, carbohydrate and fat consumption, and inclusion of fresh fruits and

vegetables during pregnancy may have important significance during critical fetal developmental periods and may have future consequences for food preferences and disease risk (Portella et al., 2012). Hanson et al. (2011) stated the “phenotypic mismatch from inaccurate nutritional cues may lead to greater likelihood of developing metabolic dysfunction, cardiovascular, and noncommunicable disease” (p. 278). Malnutrition during fetal development through the ingestion of foods containing high concentrations of fructose and fat has been shown in some studies to have negative effects on infant metabolism potentially leading to metabolic dysfunction in adulthood (Goran et al., 2013). High consumption of fructose in the maternal diet has been seen mechanistically to pass readily through the placenta and to concentrate in the fetal system ultimately predisposing the fetus and neonate to insulin resistance (Goran et al., 2013).

### Maternal Health and Nutrition

Excessive maternal weight gain during pregnancy is associated with early childhood obesity as is gestational diabetes, even when prepregnancy weight is within the normal range (Herrera et al., 2011; Lillycrop & Burdge, 2011). There is a four times greater risk of over-weight or obesity at adolescence if the mother was obese prior to conception than in children of mothers within a healthy weight range (Laitinen et al., 2012). The mechanisms by which these epigenetic changes occur from one generation to the next are complex and vary from individual to individual. These mechanisms include DNA methylation, histone modifications, and tissue specificity (Herrera et al., 2011).

### Interrelated Factors

The human biology (genetics) inherited from ancient ancestors has not changed appreciably with the advent of the mass production and over-abundance of food in the developed world; however, the developmental mechanisms (epigenetics) aimed at improving chances of survival in a harsh environment become maladaptive when there is a mismatch of pre- and post-natal environments (Calkins & Devaskar, 2011; King, 2013). It is clear that the obesity epidemic has its roots in the industrialization of food production that created palatable, calorie-dense, nutrient-poor products that are readily available, easy to prepare, and inexpensive (Gluckman et al., 2011; Swinburn et al., 2011). The role of maternal health and nutrition has significant outcomes for the health of the fetus well into adulthood. Many studies link pregravid weight, maternal obesity, and gestational diabetes with

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higher risk of negative health outcomes in various life stages of the offspring (Barker, 2012; Bruce & Hanson, 2010; Lillycrop & Burdge, 2011; Patti, 2013; Rooney & Ozanne, 2011). Maternal dietary preferences may be conveyed to the child in utero through the placenta and may continue to influence taste preferences in the infant through breast milk, ultimately creating the dietary patterns of adulthood (Portella et al., 2012). The modern lifestyle leads many more people to be potentially less active at an earlier age than prehistoric ancestors, whether that is from spending long periods with technology (televisions, computers, video games), working too many hours at a job or in school, or eating many more calories than activity levels warrant or physiology requires (Gluckman et al., 2011).

### Health Education

Health education in its current form has not been successful in conveying the importance of nutrition to the future health of children, nor is it making the connection between diet and chronic disease risks in adults across the globe. However, health education is an especially important intervention for females of all ages in order to create the best first environment for the future populations of the world (Barker, 2012). Prenatal nutrition is a critical factor in the obesity epidemic (Wang et al., 2013), and excessive maternal weight gain, gestational diabetes, and pregravid obesity are critical factors in future cardio-metabolic disease risk in the offspring of these women (Hanson et al., 2011). Improving the health and nutrition of women before and during their reproductive years and creating optimal nutrition environments for babies and young children are the most important intervention individuals, communities, and governments can enact to reduce the burgeoning levels of obesity and chronic diseases in the world today, as well as supporting better health for generations in the future (Barker, 2012). Resolutions to the obesity epidemic are as complex and interrelated as the etiology of obesity is; however, the greatest impact from women's health education could be seen in pre-pregnancy counseling emphasizing the importance of lifelong nutrition and in interventions for those women who begin their pregnancy overweight or obese.

Childbirth educators can provide invaluable services to women of childbearing age by identifying nutritional habits through encouraging and reviewing food journals; teaching about the differences between processed food nutrition

and whole food nutrition for the mother and developing child; encouraging reduction in sugar-sweetened beverage consumption; and providing community support through group women's health classes. Encouraging individuals to create better health at home by cooking more meals, making food preparation a time for family interaction, and having wholesome ready-to-eat foods in their refrigerators for their children and themselves can support behavior change.

Many educational materials focus on the nutrients of specific foods and the importance of maintaining a healthy weight; however, emphasis is lacking on the role of maternal influence on the palate of the fetus and the baby as he or she begins to experience new foods. Expectant mothers may be more responsive to lifestyle change interventions during this period of life transition. Helping women to understand that the food consumption preferences of the mother may affect the food preferences and future health of the child in utero and through breast milk can help encourage women to eat a varied and nutritious diet before, during, and after pregnancy. In this way health care professionals could be effective agents of change.

Nurses, doulas, midwives and others who care for women in their childbearing years and their children can play a foundational role in educating this population on the developmental effects and future feeding preferences of their offspring due to the quality of maternal nutrition before, during, and after pregnancy. Optimizing the intrauterine environment one woman at a time for the future benefit of the next generation may alter the bioecology of obesity and shift the cultural paradigm from disease care to disease prevention.

Estimates from 2010 suggested that one-third of women in the United States of childbearing age were obese (Bruce & Hanson, 2010). Weight reduction and improved diet reduces the effects of malnourishment on the developing fetus (Patti, 2013; Rooney & Ozanne, 2011). However, the long-term effects of a varied, whole foods diet compared to an industrial or processed foods diet on the health of future generations still needs empirical investigation.

### Conclusion

The etiology of obesity is multifactorial, and a coordinated effort is needed to alter the global obesity trajectory (Gluckman et al., 2011; Lee & Gibbs, 2013). A cultural shift is needed to provide the support for long-term change in the environment of health, the examination of which is beyond the scope of this paper. Specifically, those professionals who are in contact with children and women of child-bearing age

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may affect future generations by engaging these populations in conversations and educating them about the long-term outcomes of healthy eating.

New long-term investigations should focus on the potential for optimal maternal diets to influence the dietary preferences of the offspring and the disease risk of future generations. Shifting the paradigm to focus on prevention in the next generation by optimizing the fetal environment and childhood nutrition is an important area of study establishing a future forward approach in addition to the current paradigm of disease management.

Finally, all professionals who are in contact with women of childbearing age would do well to seek further education in the mechanisms and potential benefits of diet and nutrition before and during pregnancy in order to better translate the current knowledge to their clients.

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# A Practice Guideline to Prevent Ectopic Pregnancy Rupture

by Hope Szypulski, DNP RN WHCNP Lt. Col. (Ret) USAF

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**Abstract:** Ectopic pregnancy is a major health concern for women of reproductive age and is the primary cause of maternal death during the first trimester of pregnancy in the United States. To improve early diagnosis and detection of ectopic pregnancy within a large health maintenance organization (HMO), a standard of care was developed by a Guideline Committee and released to all healthcare providers within the organization. Childbirth educators would benefit from knowing these standards of practice and teaching the early signs of this health concern to the childbearing family.

*Keywords:* ectopic, pregnancy, guidelines, nurses, triage, health maintenance organization

Ectopic pregnancy is a major health problem for women of reproductive age and is the primary cause of pregnancy-related death during the first trimester of pregnancy in the United States (ACOG Practice Bulletin, 2008). The prevalence of ectopic pregnancy within the United States has been on a steady incline for the past 30 years. Diagnosis and treatment before the tubes rupture decreases the risk of death (ACOG Practice Bulletin, 2008). For this reason it is imperative for childbirth educators to educate the public about this diagnosis in an effort to increase early symptom recognition. Our goal should be early diagnosis to protect

women from tubal rupture. Childbirth educators, including nurses, doctors, doulas and childbirth class instructors, are in an excellent position to assess for early signs and symptoms and to educate the patient. This article explores the incidence of ruptured ectopic pregnancy within a large health-care maintenance organization (HMO) and the impact it has on medical personnel and childbirth educators.

Ectopic pregnancy is a condition in which a fertilized egg settles and grows in any location other than within the uterus. The major health risks of ectopic pregnancy are the rupture of the fallopian tube, internal bleeding, loss of fertility, and possible death. Early diagnosis promotes better outcomes and less invasive treatment options such as medical management with Methotrexate. Eighteen percent of women reporting to ER with first-trimester vaginal bleeding, abdominal pain, or both are diagnosed with ectopic pregnancy (ACOG Practice Bulletin, 2008). All sexually active women of childbearing age are at risk for an ectopic pregnancy which is considered a medical emergency.

Early diagnosis of ectopic pregnancy is the crucial element in management. With the use of ultrasound technology, medical history, physical exam, and laboratory findings, management of ectopic pregnancy has improved immensely in recent years (Hajenius et al., 2009). Fortunately, with the advancements in technology, the incidence of fatalities have declined from 1.15 deaths (per 100,000 live births) in 1980-1984 to 0.50 in 2003-2007 (Creanga et al., 2011). Prompt ultrasound evaluation is instrumental in diagnosing ectopic pregnancy (Hajenius et al., 2009). Same-day appointments and the immediate evaluation via ultrasound allow early diagnosis.

This project began because detecting ectopic pregnancy within a large health maintenance organization (HMO) with 13 clinics was a concern. Within a year 17 out of 27 ectopic pregnancies advanced to rupture. The OB/GYN department began a campaign for best practices guidelines.

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The first guideline involved rapid assessment. Health-care providers were to ensure ultrasound evaluation and measurement of serum hCG (Human Chorionic Gonadotropin pregnancy hormone) the same day a woman presented with vaginal bleeding or pelvic pain.

### *It is vital to diagnose an ectopic pregnancy early to prevent further damage to the fallopian tube*

To evaluate this project, outcome measures included the rates of missed ectopic pregnancies and ruptured ectopic pregnancies.

### Background

The literature review was completed in academic libraries including Cochrane Library, CINAHL and PubMed. Numerous articles were found addressing the management of ectopic pregnancy for providers but there were no articles on efficacy of nursing guidelines.

### Methods

This QI project was aimed at developing and disseminating a best practice guideline to standardize the care of women with early pregnancy problems. The HMO institutional review board (IRB) deemed the project to be exempt as a QI project. To protect participant confidentiality and privacy no patient identifiers were documented. Included were all female HMO members of childbearing age who a)



### Signs of ectopic pregnancy:

- Menstrual like cramping
- Vaginal bleeding
- Pelvic pain
- One-sided abdominal pain
- Dizziness
- Nausea and Vomiting
- Tachycardia
- Shoulder pain
- Low Blood Pressure

called the medical office with a complaint of vaginal bleeding and/or abdominal pain, b) had a positive pregnancy test, and c) had not yet had an ultrasound to confirm placement of the pregnancy.

Guidelines were developed by the Guideline Committee which included three physicians, two nurse practitioners, two nurses, one nurse manager, and one clinical pharmacologist. The committee was charged with developing guidelines for consistent quality care. An algorithm was developed to assist with the triage process and it presented a visual, “step-by-step” plan of action for the patient. Once location of pregnancy was identified subsequent action would be implemented.

Assessment of this guideline included data from patients’ electronic medical records using search engines for the ICD 9 diagnosis codes for ectopic pregnancy, and analysis of outcomes utilized Chi Square tests to assess correlations between the use of the guideline and ruptured ectopic pregnancies, the use of the guideline and same day appointments, and same-day appointments and ruptured ectopic pregnancies. Effectiveness of the implementation of the guideline was determined by comparing recent data to data extracted prior to the introduction of the practice guideline.

### Results

Rates of ectopic pregnancy ruptures were dramatically reduced during the project period from 63% to 29%, but evaluation of the data demonstrates that most improvement occurred after initial education to all healthcare providers about the guidelines. Overall, the nursing guideline was not well utilized, documented in only about 27% of cases with patients with bleeding and/or abdominal pain with different

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levels of use at the various clinics. Utilization of the guideline was correlated with increased rates of same-day appointments scheduled,  $OR = 10.5$  and  $\Phi = .48$ ,  $p = .6$  and rates of ectopic pregnancy ruptures were 10% lower among nurses who used the guideline  $OR = 0.90$  and  $\Phi = .02$ ,  $p = .99$ .

### Discussion

Ineffective dissemination of the guideline is speculated to be the cause of its underutilization. Despite lack of universal guideline utilization a significant decrease in ruptured ectopic pregnancies within the HMO was noted during the project period. The ruptured pregnancy rate decreased from 63% to 29% exceeding the expected outcome of 50% or less. This finding is likely a result of the concurrent development and dissemination of a healthcare provider guideline with clinic-based discussions of the importance of same-day appointments in preventing ectopic pregnancy ruptures. It seems that, whether or not the guideline was used, the patient was still referred for a same-day appointment. Same-day appointments in this study were not found to prevent ectopic rupture but this is likely due to the inadequacy of the sample size to demonstrate a significant change. The literature suggests this is an effective strategy for the prevention of morbidity and mortality and it was, in fact, the impetus for the development of the guideline (ACOG Practice Bulletin, 2008).

As a result of a series of meetings conducted within the organization to disseminate findings of this project, a plan for initiation of a video conference program for healthcare providers was developed. The conference reviewed current guidelines and correct utilization of the guidelines. The video conference programs were aimed at adult learners and designed to be interactive to help learners convert their knowledge into practical skills. Through this program, medical staff and nurses continue to be educated on the correct step-by-step process for each guideline and the importance of consistently using these guidelines for all triage calls.

A final strategy to enhance guideline utilization will involve the introduction of a web-based training site for new childbirth educators and existing employees which will require a pass/fail test to be completed.



### Conclusion

Health maintenance organizations and childbirth educators are committed to providing safe, current care to their patients. Practice guidelines are credible resources for execution of appropriate care and improving practice as well as enhancing patient outcomes. This project provided insights into dissemination and utilization of guidelines within the organization. The ectopic pregnancy guideline is still being utilized, and additional projects should focus on the dissemination process and sustained utilization.

### Limitations

There are inherent limitations to the QI project, namely, the fact that there were few ectopic pregnancies within the HMO during the project period and the limited time allocated for the project. More time is needed to increase the number of patients available for evaluation. Large organizations present unique challenges to change projects. Changing the culture of these large organizations can be challenging and widespread dissemination of new information is a daunting task.

*Ectopic pregnancy is the primary cause of early pregnancy death.*

### Relevance to Practice

Childbirth educators, including doctors, nurses, doulas and other health care professionals in contact with this population are crucial players in determining the need for a same-day appointment. Ultrasound assessment that day is

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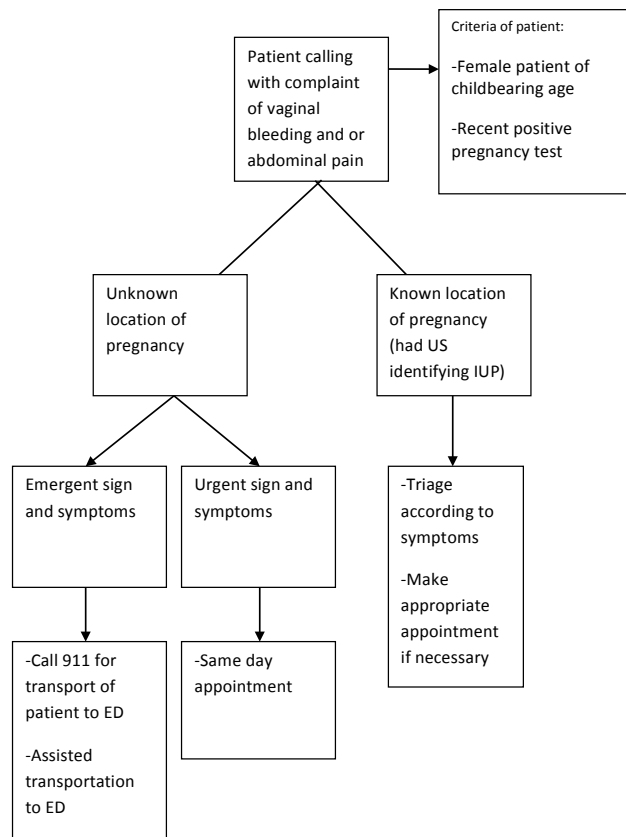
## A Practice Guideline to Prevent Ectopic Pregnancy Rupture continued from previous page

a key strategy in preventing ectopic pregnancy-induced fallopian tube rupture. Practice guidelines may help to increase scheduling of same-day appointments for women with symptoms consistent with possible ectopic rupture. It is important for childbirth educators to recognize the signs and symptoms of ectopic pregnancy and referring for immediate care. Early diagnosis and prevention of a ruptured ectopic pregnancy is a key strategy in saving lives among women.

Since childbirth educators are in a valuable position, interacting with the patient and their families routinely, often early in pregnancy, it is imperative that they are knowledgeable of the signs and symptoms of an ectopic pregnancy and can refer for fast diagnosis and intervention. Refer for same day treatment.



## Ectopic Pregnancy Algorithm for Triage



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# The Importance of Humor for a Healthy Pregnancy

by Jacqueline Shirley, PhD MSN RN CPNP

**Abstract:** *The purpose of this paper is to describe what current research shows regarding humor impacts on stress and its related outcomes. This paper also aims to explain some humor coping strategies that can be used to help pregnant women who may be experiencing stress. Stress is of particular concern in pregnancy because of the additional potential for effects on the fetus. Positive humor styles, self-enhancing and affiliative humor, have been linked with desirable health effects. Applied humor has also resulted in beneficial health outcomes. Humor coping abilities can be attained and perfected using several strategies to build skills.*

*Keywords:* humor, stress, coping, health

The transactional theory of stress and coping explains how stress develops in the absence of perceived coping efficacy (Lazarus & Folkman, 1987); this theory further links unresolved stress, from ineffective coping, to physiological and psychological problems. In pregnancy, psychological stress has been linked with multiple health issues (Cardwell, 2013; Crosson, 2012). The serious health risks that can be comorbid with pregnancy highlight the importance of finding ways to mitigate the occurrence of psychological stress. Humor may help to decrease or eliminate stress-related negative consequences (Besser, Luyten, & Mayes, 2012; Falkenberg, Buchkremer, Bartels, & Wild, 2011; Freeman & Ventis, 2010; Kuiper & McHale, 2009; Lebowitz, Suh, Diaz, & Emery, 2011; Strick, Holland, Van Baaren, & Van Knippenberg,

2009; Stuber, et al., 2009; Williams, 2009). The purpose of this paper is to discuss what the research shows in terms of the effects of humor on stress and its related consequences. Further, this paper aims to describe some humor coping strategies that can be used to assist pregnant women who are experiencing psychological stress.

Martin, Puhlik-Doris, Larsen, Gray, and Weir (2003) provided the first descriptions of two beneficial and two potentially harmful forms of humor. Research evaluating positive humor styles (Besser, Luyten, & Mayes, 2012; Freeman & Ventis, 2010; Kuiper & McHale, 2009) and humor application (video, picture, and dialectical) studies (Falkenberg, Buchkremer, Bartels, & Wild, 2011; Lebowitz, Suh, Diaz, & Emery, 2011; Strick, Holland, Van Baaren, & Van Knippenberg, 2009; Stuber, et al., 2009; Williams, 2009) have yielded results that show humor can initiate improvements in physical and emotional/psychological health and well-being. Consistent with this research, stress-busting humor coping skills may be attained and perfected (McGhee, 2010). The transactional theory of stress and coping explains how psychological stress develops and describes the resulting implications involved with unresolved stress (Lazarus & Folkman, 1987).

## The Transactional Theory of Stress and Coping

Lazarus and Folkman (1987) developed the transactional theory of stress and coping, which may help explain the possible effects of humor on health. In essence, this theory posits that psychological stress arises from perceptions that skills needed to deal with a threat are inadequate. This process begins when change is detected which prompts an initial appraisal to see if there may be a threat to well-being. If it is determined that well-being is threatened, another appraisal is conducted to evaluate for available coping strategies.

If the appraisal results in the perception that available coping mechanisms will not be effective in dealing with

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the threat, psychological stress develops (Lazarus & Folkman, 1987). Short-term impacts of unresolved stress include increases in negative affect, decreases in positive affect, and physical problems such as hypertension and rapid heart rate. Long-term impacts include poor psychological well-being and physiological illnesses. Several studies have supported key stress to illness associations identified by the transactional theory. Psychological stress has been found to have significant positive relationships with hypertension and rapid heart rate (Phillips, Der, & Carroll, 2009) and psychological well-being has been compromised by ongoing exposure to stressful situations (Bayram, Gursakal, & Bilgel, 2010; Brackett, Palomera, Mojsa-Kaja, Reyes, & Salovey, 2010). Humor may provide a powerful coping option to mitigate or eliminate threat, and consequently stress.

## Psychological Stress in Pregnancy

Pregnancy may be a time when psychological stress is particularly worrisome (Cardwell, 2013; Crosson, 2012). Several stressors have been identified by pregnant women (Cardwell, 2013; Crosson, 2012). These include lack of access to prenatal services, housing disruptions, poor nutrition, unexpected pregnancy, communication problems, and domestic violence (Cardwell, 2013). Racial discrimination has also been established as a stressor in pregnancy (Crosson, 2012). Further, hormonal changes in the pregnant woman may be making her more sensitive to the stressors she encounters which may magnify both her and her fetus' future risk for emotional/psychological and physical health problems. These pregnancy-related stressors only serve to illustrate the importance of finding ways to effectively cope with threats to well-being. Certain forms of humor have been linked with fewer stress-related impacts (Besser et al., 2012; Freeman & Ventis, 2010; Kuiper & McHale, 2009).

## Humor Coping

Martin et al. (2003) first described four different categories of humor content, or humor styles. Specifically, two positive and two negative humor forms are presented. The positive categories include self-enhancing and affiliative humor styles and the negative categories include self-defeating and aggressive humor styles. Self-enhancing humor is illustrated by humor content that reflects benevolence directed

at self and others. Affiliative humor is illustrated by content that enhances positive social and interpersonal relationships. Self-defeating humor is reflected by content that is typically disparaging and made at the sender's expense in the effort to be accepted. Aggressive humor content is identified by content that is hostile and sent at the expense of others in the effort to be accepted. In general, positive humor styles have been associated with beneficial health effects; negative forms have been linked with undesirable health effects (Besser et al., 2012; Freeman & Ventis, 2010; Kuiper & McHale, 2009).

Besser et al. (2012) found that adaptive humor styles had significant inverse relationships with distress and interpersonal conflict. Freeman and Ventis (2010) reported that self-enhancing humor was linked with lower levels of pain and higher levels of general health; affiliative humor was linked to higher levels of emotional well-being. Kuiper and McHale (2009) found that self-enhancing humor styles had significant positive relationships with low levels of depression and anxiety. This research supports the beneficial relationships between humor and lowered stress-related health problems but it does not reflect humor that is actually put into practice. Studies that have focused on the application of humor have also yielded positive results (Falkenberg et al., 2011; Lebowitz et al., 2011; Riolli & Savicki, 2010; Stuber et al., 2009).

## *watching humorous videos can improve physical and emotional/psychological health*

### Application of Humor Using Videos

Several study results indicate that watching humorous videos can improve physical and emotional/psychological health (Falkenberg et al., 2011; Lebowitz et al., 2011; Stuber et al., 2009; Riolli & Savicki, 2010). Falkenberg et al. (2011) conducted a study with hospitalized patients suffering with depression. The patients were given 1 hour humor education interventions that included watching comedy videos and practicing humor coping skills over 8 weeks. The results showed that depression levels decreased. Humorous video effects were reported by Lebowitz, et al. (2011) after their participants watched a humorous video in a one-time intervention. They reported significantly lower levels of depression and anxiety and higher levels of quality of life as compared to their counterparts who watched a neutral video.

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Rizzolo, Zipp, Stiskal, and Simpkins (2009) gave some of their study participants a 30-minute session of humor from a choice of three Saturday Night Live video options. Findings indicated that humor was effective in decreasing stress, heart rate, and blood pressure. Stuber et al. (2009) reported that the children participants in their study who viewed humorous videos as part of an intervention had a significantly higher tolerance to pain. Humor effects were not limited to video presentations. In fact, benefits have also been reported by reading/observing humorous pictures (Strick et al., 2009) and through spontaneous dialect (Williams, 2009).

## Application of Humor Using Pictures and Dialect

Strick et al. (2009) found that participants who viewed humorous pictures in an intervention had significantly lower levels of negative affect compared to participants who viewed non-humorous pictures. Short-term effects were also reported by Williams (2009) who discovered through two semi-structured interviews that male participants effectively used spontaneous dialectical humor to decrease tension associated with talking about health problems with other men. This research helps support the premise that long or short-term use of humor via video, pictures, or dialectical presentation can exert positive impacts on physical and emotional/psychological health. These humor modalities can be useful in attaining and perfecting humor coping skills (McGhee, 2010).

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**Table 1. Stressors in Pregnancy, Humor, and Direct Problem Solving Applications**

Stressors Experienced in Pregnancy	Stressors That May be Out of an Individual's Immediate or Direct Control		Stressors that May be Within an Individual's Immediate or Indirect Control
	Positive Humor Styles		
	Affiliative Humor	Self-accepting Humor	Direct Problem Solving Actions
Lowered Access to Prenatal Services	Delivered via Humorous Videos, Pictures, and Dialect	Delivered via Humorous Videos, Pictures, and Dialect	Community Prenatal Services (Department of Health and Human Services, n.d.)
Housing Disruptions	Delivered via Humorous Videos, Pictures, and Dialect	Delivered via Humorous Videos, Pictures, and Dialect	U.S. Department of Housing and Urban Development: (2014, August 3)
Poor Nutrition	Delivered via Humorous Videos, Pictures, and Dialect	Delivered via Humorous Videos, Pictures, and Dialect	Nutrition.GOV (2014, July 15)
Unexpected Pregnancy	Delivered via Humorous Videos, Pictures, and Dialect	Delivered via Humorous Videos, Pictures, and Dialect	Community Pregnancy Counseling Centers
Communication Problems	Delivered via Humorous Videos, Pictures, and Dialect	Delivered via Humorous Videos, Pictures, and Dialect	Medical Interpreter Services
Domestic Violence	Delivered via Humorous Videos, Pictures, and Dialect	Delivered via Humorous Videos, Pictures, and Dialect	The National Resource Center on Domestic Violence (n.d.)
Racial Discrimination	Delivered via Humorous Videos, Pictures, and Dialect	Delivered via Humorous Videos, Pictures, and Dialect	US Department of Health and Human Services: Office of Civil Rights (n.d.)

## Improving Humor Coping Skills

As suggested by Lazarus and Folkman (1987) and as illustrated in table 1, when possible, direct problem solving coping strategies may be the best course to take for stressors that can be controlled by the affected individual. However, if the issue is not under the individual's complete control or if the issue takes time to resolve--e.g., lack of access to needed services, housing instability, malnutrition, unplanned pregnancy, communication challenges, racial discrimination, and domestic violence (Cardwell, 2013; Crosson, 2012), less direct or emotion focused coping (such as humor) may help relieve the stress until the threatening issue can be dealt with directly (Lazarus & Folkman, 1987).

Humor coping skills can be attained and perfected (McGhee, 2010). One way to begin the process of building these skills is to increase exposure to humorous materials using videos, pictures, and dialect for at least 30 minutes two times per week. With increasing humor exposure, an individual will eventually be able to recognize what types of humor are personally appealing with an emphasis on positive humor styles (Martin et al., 2003). Writing down the jokes or humorous scenarios that are perceived as the funniest in a humor log may help this process. Reviewing what has been written may help reveal common features that contribute to perceptions of funniness. The humor log can also be read when the individual feels more stressed.

Another step in the process of building humor coping skills involves heightening sensitivities to humorous stimuli in the surrounding environment (McGhee, 2010). Humorous activities and events that happen throughout the day often go unnoticed. Consistently recognizing humor when it happens reinforces lighter, less serious attitudes and creativity. Such experiences can also be included in the humor log book for evaluation of recurring comical themes that can be used in times of stress.

Often the offending stressor is not viewed as having any potential humorous connections that contribute to perceptions that the stressor and humor are mutually exclusive (McGhee, 2010). However, individuals may be able to recall other instances when faced with a threat that in itself was not funny, yet had humorous effects or contributing factors. Re-evaluation of the current stressor's contributing factors or potential outcomes may prompt revision of threat percep-

tions. This re-assessment process may begin by thoroughly evaluating the stressor, its contributing factors, and potential outcomes. Then, creatively applying personal favorite humor themes to the contributing factors, the stressor or the potential outcomes could minimize original perceptions of threat.

In summary, the transactional theory of stress and coping indicates that coping efficacy is integral to mitigate or eliminate perceptions of psychological stress (Lazarus & Folkman, 1987). Unresolved stress is predicted to have unwanted impacts on physiological and emotional/psychological health. This may be of particular concern in pregnancy where the risk for negative, stress-related outcomes is not only a concern for the pregnant woman, but also for her offspring (Cardwell, 2013; Crosson, 2012). Humor may help to relieve stress and its negative consequences. Indeed, self-enhancing and affiliative humor styles have been linked with beneficial emotional/psychological and physiological health (Besser et al., 2012; Freeman & Ventis, 2010; Kuiper & McHale, 2009).

Application has yielded similar health benefits (Falkenberg et al., 2011; Lebowitz et al., 2011; Riolli & Savicki, 2010; Strick et al., 2009; Stuber et al., 2009; Williams, 2009). Humor coping can be attained and perfected to help stressed pregnant women deal with perceived threats which may mitigate or eliminate unwanted health consequences of unresolved stress (Lazarus & Folkman, 1987). Childbirth educators could incorporate humor coping information in health promotion content areas. Learners could be given assignments to think about stressors that are challenging them and asked to evaluate for possible humorous effects or contributing factors. Learners could then be asked to use their assessments of humorous contributing factors or potential outcomes to reassess the perceived levels of threat connected with the stressor and compare their before and after humor threat perceptions.

These suggestions may be offered to pregnancy and childbirth practitioners who may provide their first trimester clients with a handout that explains how to begin building such humor coping skills (identifying their stressors, assessing for possible humorous contributing factors or outcomes and reevaluating threat perceptions); practitioners may want to check-in with their clients during each prenatal visit to see how they are progressing in building and perfecting these coping abilities and decreasing their perceived stress. Both educators and practitioners can utilize humor as part of the nursing plan of care with clients who have a diagnosis of risk for disruption of symbiotic maternal/fetal dyad as a result

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of co-morbid or pregnancy related complications (NANDA, 2009). Humor is an accessible, enjoyable resource that can be used spontaneously when needed. What other health promotion activities can match that?

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# *Interconnectedness:* The Grandparents Role in Childbearing and Parenting

by Adriane Burgess, MSN RNC-OB CCE

*Abstract: Grandparents play a vital role in the lives of expectant mothers as well their grandchildren. The interconnected nature of generations may affect parenting styles, feeding preferences, safety of infant as well as maternal role attainment. Geographical distance, culture, maternal and paternal relationship with parents and in-laws, as well as age of the grandparent, may alter the role that grandparents play and subsequently the influence they have over childbearing and parenting. It is important for childbirth educators to acknowledge the role of the grandparent and work to assess their knowledge of current childcare and safety practices, including their role in infant caretaking responsibilities. A thorough assessment will allow educators to provide educational and support interventions and resources as appropriate to both women and grandparents.*

*Keywords: grandparents, childbirth education, social support, interconnectedness*

## Introduction

A holistic approach to the care of women and their families promotes the importance of the interconnectedness of mind, body, and spirit, and the significance that relationships hold on the health and wellness of families (American Holistic Nurses Association, 2014). Familial and social support is of particular importance in relation to childbearing and parenting roles. Childbirth educators should consider including the extended family of the childbearing woman in their care and education. When extended family is not present, an understanding of the social support systems women call on during pregnancy and in the childbearing year may be helpful when assessing the educational and support needs of the expectant mother.

As societal views of family change, such as the increase in single parent families as well as maternal role in the work force, traditional roles within the family may be blurred (Winefield & Air, 2012). Wright and Leahey (2013) stated that family is not always defined solely by biologic ties, but rather by whom individuals identify with for support. Extended families may be traditional in nature and include biologic maternal and paternal parents. With that said, it may also be important to assess the role of step family members or support persons functioning in a role of grandparent that may not have biologic ties to the family (Wright & Leahey, 2013). Family systems in the 21st century are often structured differently than in the past due to financial and societal stressors that may not have been present years ago. As extended families are separated by geographical distance it may be important to recognize the effect this lack of intergenerational interaction may have on maternal role attainment and infant development.

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Stelle, Fruhauf, Orel, and Landry-Meyer (2010) stated that there are no defined norms as to what delineates the role of the grandparent. Many factors may affect the role grandparents hold in their grandchild's life. Geographical distance, culture, maternal and paternal relationship with parents and in-laws, as well as age of the grandparent, may alter the role grandparents play and subsequently the influence they have over childbearing and parenting (Davey, Salva, Janke, & Anderson, 2012; Reid, Schmied, & Beale, 2010; Winefield & Air, 2010). Since 1970, the number of grandchildren raised in the same household as their grandparents has doubled and many of these grandparents are considered the primary caregivers of their grandchildren (Arnold, Lewis, Maximovich, Ickovics, & Kershaw, 2011). It is integral for the childbirth educator to assess what role the extended family plays in terms of support and influence on the mother, as this can have significant implications in regards to parenting and in the development of the maternal role.

### *Becoming a grandparent for the first time is a major transition within the structure of the family*

Becoming a grandparent for the first time is a major transition within the structure of the family (Taubmen-Ben Ari, Findlin, & Sholmo, 2013). As childbirth educators we have a unique opportunity to support families as they change and grow. Considering that with increased life expectancy, grandparents will fulfill this role within the family for often over 30 years, they may play an integral role in family life and dynamics (Stelle, et al., 2010). In addition to the relationships we build with expectant mothers, we often have the opportunity to interact with grandparents. Grandparent classes are often specifically designed to address the questions and concerns grandparents may have over their changing role within the family, as well as the changes in recommendations and practices surrounding infant care and delivery. Grandparents are often very interested to learn of changes that have taken place since the delivery of their last child. However, it is also important to assess and honor the experiences of the grandparents who attend these classes. Additionally, when interacting with grandparents, it may be

important not to impart bias related to traditional gender-based grandparenting roles and be open to roles that the grandparent will take within the individual family you are supporting (Stelle, et al., 2010).

### Importance of Social Support

Mobilizing social support often provided by those in the grandparent role has the potential to improve the health and wellness of expectant mothers and infants in the childbearing year. A holistic view of health asks practitioners and educators to take a wellness perspective and focus on health promotion. Fahey and Shenassa (2013) reported that social support has three categories – emotional support, instrumental support, and informational support. Emotional support includes making a woman feel loved and supported. Instrumental support includes giving assistance to accomplish tasks. Informational support is the provision of education and knowledge (Fahey & Shenassa, 2013; Negron, Martin, Almog, Balbierz, & Howell, 2013). Grandparents can be a significant provider of all these types of social support. Social support can help to decrease perception of stressful events and help mothers cope more successfully (Fahey & Shenassa, 2013). However, poor relationships with both maternal and paternal grandparents can be considered a psychosocial risk factor for postpartum depression (Siu, Leung Ip, Hung, & O'Hara, 2012; Reid, et al., 2012). A tumultuous relationship with the maternal grandmother, particularly in adolescent mothers where there is no involvement with the father of the baby, may increase parenting stress as well as increase the risk for child health and behavioral problems (Arnold, Lewis, Maximovich, Ickovics, & Kershaw, 2011). As providers of antenatal education, it is essential to begin to assess women for psychosocial risk factors that may influence their postpartum course and transition to motherhood. Risk factor identification may help educators to guide women towards appropriate resources for support such as case management or local new mother support groups. Additionally, it may be prudent to assess the nature of the relationship between the baby's mother and the grandmother, particularly if they co-reside (Arnold, et al., 2011). If there is noted discord between the two, educators and health care providers may want to work towards providing them with support and family interventions which could improve the family structure, as the context of this relationship seems to be directly tied to maternal and infant outcomes (Arnold, et al., 2011).

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### Culture and Grandparenting

It is also important to assess the role of the grandparent in pregnancy, birth, and childrearing within the context of culture. As educators, it is essential to provide culturally competent instruction that best addresses the families' cultural needs and norms, particularly related to childbirth and parenting (Wilson, 2012). Many cultures have customary practices that help women assimilate into motherhood by surrounding them with the support and advice of elders within the family. For instance, in Japan, women return to their parents' home towards the end of their pregnancy in order to receive support (Iseki & Ohashi, 2013). This custom has been shown to reduce the anxiety surrounding childcare, improve women's mental health, and provide a forum for women to receive parenting advice (Iseki & Ohashi, 2013). Cultural beliefs play a significant role in defining how grandparents are viewed within the family structure as well as role expectations. Grandparents may be integral in helping to develop the ethnic identity of their grandchildren (Ofahengaue Vakalahi, & Taiapa, 2013; Winefield & Air, 2010).

Ofahengaue Vakalahi, and Taiapa (2013) stated that in some cultures intergenerational living arrangements exist in order to further preserve cultural traditions and family norms, as well as provide emotional support and physical care to infants and toddlers in the home. Some cultures may place more value on the child rearing advice provided by grandparents over information sought from peers and internet sources. It is important for childbirth educators to be conscious not to negate advice provided by grandparents, but rather to empower and educate families about current childcare practices. Interestingly, in certain ethnic groups where it is expected that families play a significant role in provision of support, women may have increased anger and stress if their social support networks fail to meet their needs (Fahey & Shenassa, 2013). When assessing the family structure, it may be important to understand a woman's level of expectation of familial involvement in provision of childcare support. By doing this, educators can help clients set realistic expectations and look for alternate sources of support when family are unavailable.

### Intergenerational Parenting Styles

Parenting skills are not simply learned after the birth of the infant, but may be intergenerational in nature. Understanding an expectant mother's childhood experiences of parenting may help educators to understand perceptions about child development and behavior (O'Brien, 2010). Interestingly, children who experience harsh parenting styles tend to parent similarly to what they experienced as a child (Conger, Schofield, & Nepl, 2012). This could provide very important family assessment data for educators preparing to teach parenting and child development classes. This example illustrates how caregivers' parenting styles are influenced by their own experience of parenting, and illustrates the role the grandparent plays in parenting far before the birth of the grandchild. Grandparents seem to serve as influential moderators of parenting style, as they role model parenting behavior during their own children's childhood.

### Grandparent Role in Breastfeeding

Influential people in women's lives may sway many decisions concerning parenting, and breastfeeding is no different. Grandparents' support of infant care can serve an important role in parenting decisions, influencing maternal and infant health as well as positively affecting infant attachment (Iseki & Ohashi, 2013). Women need to rely on social support networks to help them cope with the challenges often incurred when breastfeeding for the first time (Reid, et al., 2010). Recommendations to exclusively breastfeed for six months, and to continue to breastfeed with the inclusion of supplemental foods for at least the first year of a child's life could prove difficult without the necessary social support (American Academy of Pediatrics, 2012). Studies show that maternal and paternal grandmothers exert the most influence on feeding choices and may instruct mothers on early introduction of solids and supplementation (Reid, et al., 2010). As childbirth educators, it may be important for us to question mothers about their support network; particularly their mother's breastfeeding history, so that the educational needs surrounding breastfeeding can be individualized. An intergenerational approach to teaching and learning may be helpful when providing breastfeeding education. The support of family may help women meet their goal of breastfeeding exclusivity, further promoting the long-term health of mother and infant. This approach may be particularly important when educating teen mothers (Reid, et al., 2010).

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Reid, et al. (2010) challenged educators of expectant parents to consider new ways of allowing grandparents to share their expertise, while being brought up to date on the latest recommendations on feeding practices for infants. Grassley and Eschiti (2011) advocated for allowing grandmothers to tell their own infant feedings stories. Educators can do this by prompting mothers in perinatal classes to go home and ask their own mothers about their infant feeding experiences or by allowing grandmothers to voice their own stories in Grandparents' class. Due to hospital practices surrounding childbirth in the 1960's and 70's and lack of knowledge surrounding the significant benefits of breastfeeding, many expectant grandparents may not have first-hand experience with breastfeeding (Grassley & Eschiti, 2011). Inclusion of the entire family in breastfeeding education has the possibility to improve maternal support and thus breastfeeding initiation and duration.

## Safety of the Infant

There is no question that grandparents can have significant impact on the childcare practices new mothers and fathers enact. As research has advanced the science, infant care practices have changed dramatically in the past several decades in order to improve the health and safety of infants. Grandparents may have a knowledge gap since it could possibly have been 20 or more years since they have actively provided infant care. Safe Kids Worldwide (2014) stated that over 7 million grandparents in the United States live with their grandchildren, and that over 13% of those grandparents are relied on to be caregivers. With this said, targeting grandparents for infant safety education may help provide infants with safer child care environments. Safety topics covered in these courses can include topics such as car seat safety, choking relief and infant sleep safety. Poisoning is a key topic to include in these courses as it has been noted that 38% of child poisonings involve a grandparent's medication (Medication Safety, 2014). With such a high rate of poisonings happening while children are in the care of their grandparents, it is integral to distribute this information to grandparents everywhere so that grandparents can begin to properly lock and store medications (Medication Safety, 2014).



Information on infant sleep safety is also a key topic on which to educate grandparents, particularly due to the dramatic changes that have taken place in infant sleep practices since 1992. In 1992, the American Academy of Pediatric (AAP) Task Force on Infant Positioning and SIDS first issued a statement saying that infants should be placed on their back to sleep (Flook & Vinceze, 2012). The Back to Sleep campaign was officially launched in 1994 (Flook & Vinceze, 2012). Infant safe sleep practices promoted by the Back to Sleep Campaign were in stark contrast to the prone sleep position used by parents of previous generations. Older parents who now have children of childbearing age, may not have been educated on the importance and implications of the most up to date *Safe to Sleep* recommendations. Recommendations such as: placing an infant on their back to sleep; encouraging pacifier use during all sleep times; eliminating the use of soft bedding, blankets or bumpers in sleep environments; the importance of room sharing until the infant is 6 months of age; and the provision of a smoke free environment for all infants may be important recommendations for which to inform grandparents (American Academy of Pediatrics, 2011). It may also be important to remind grandparents that bed-sharing with the infant is never appropriate as this significantly increases the infants risk of sudden infant death syndrome. Additionally, with the increase in SIDS deaths related to entrapment and asphyxia, in 2011 the AAP expanded the *Safe to Sleep* guidelines to focus on crib safety (American Academy of Pediatrics, 2011). Grandparents may need to be made aware of this change in crib guidelines and safety, as they may be apt to utilize older cribs saved from when their children were infants. These safety education topics are excellent examples of the interconnectedness of

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families. Through education and awareness, we as childbirth educators can empower families to keep infants and children safe.

### Childcare Stress and the Grandparent

In today's often stressful financial climate, grandparents are often charged with, or volunteer to, provide childcare for their grandchildren. This can be both a rewarding and stressful experience for grandparents. Increased time spent providing care to grandchildren can decrease time spent on self-care such as exercise and going to doctors' appointments (Winefield & Air, 2010). It may be important to remind grandparents who provide regular care of their grandchildren to take time out to care for themselves as well. It is integral to educate expectant parents who plan to have grandparents care for their infants to build in periods of time within the childcare schedule to support grandparents time to continue their self-care routines (Winefield & Air, 2010). Although grandparents may value their time spent with their new grandchild, the increased burdens associated with childcare may increase the grandparent's need for social support (Winefield & Air, 2010). Childbirth educators should make a conscious effort to assess the needs of grandparents who are planning to provide childcare for their grandchildren, and provide them with information and access to community resources that are available if grandparents begin to feel overburdened with childcare stress (Iseki & Ohashi, 2013).

### Implications for Practice

As childbirth educators, we have the privilege of getting to know families and garnering their trust. We have an excellent opportunity to begin to assess the learning as well as support needs of families across the lifespan. We can hold classes specific to the informational and support needs of grandparents, allowing them a forum to voice their questions and concerns surrounding the upcoming delivery of their grandchild. Although all ages of grandparents may take on the role of childcare provider for a grandchild, Winefield and Air (2010) reported that grandparents under the age of 55 have been found to have greater responsibility for discipline, care taking, and provision of advice related to childcare. This information may help to focus educational initiatives when seeking out grandparents who may be more likely to have

increased childcare responsibility. Additionally, we can assess new mothers for gaps in social support that may not be available to them due to geographical distance or lack of positive relationship with extended family members. When considering designing classes specific to the needs of grandparents, it may be prudent to allow for opportunities for them to share their own previous experiences with childbirth, parenting and infant feeding. Incorporating exercises which encourage expectant mothers to seek out and listen to the infant feeding stories and child care experiences of those who will fill the role of grandparent could be added to childbirth classes in order to help to build relationships and identify gaps in learning.

### Conclusion

Grandparenting is a dynamic process that evolves as both grandparent and child age and mature (Siu, et al., 2012). We must be conscious of incorporating family and social support assessment into our interactions with expectant parents so that we can provide resources that are targeted towards the needs of the family as a whole. Although there are many non-modifiable factors that contribute to the strength of the grandparent-grandchild relationship, frequency of contact has been shown to positively affect the relationship. As educators, we should encourage the development of the bond between the grandparent and their new grandchild regardless of geographic distance, and frequent contact should be encouraged between grandparent and grandchild (Davey, et al., 2009). Grandparents can be informed of a wide variety of technological means by which to keep up direct contact. The birth of a new baby is not an experience that is isolated only to the expectant mother, but the transition to grandparenthood and provision of support may improve self-efficacy as well as growth in the grandparents as individuals (Iseki, & Ohashi, 2013; Taubman - Ben-An, et al., 2013). As educators we should be mindful of the significance this transition may hold, and help families to embrace the interconnectedness that the birth of this new baby brings to the whole family.

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# Electronic Cigarettes: Implications for Pregnancy

by Marie Peoples, PhD MPH

***Abstract: Electronic cigarettes are marketed as a safe method to smoke without the associated health risks of traditional cigarettes, which may increase uptake by pregnant and early parenting women. Because electronic cigarettes are a new technology and are largely unregulated research on health effects is undeveloped. The evidence on adverse developmental health effects that nicotine has across the life span, regardless of the delivery system, is well documented and can be applied to electronic cigarette usage. Health practitioners must stay abreast of emerging health issues and should integrate education on the danger of nicotine delivered through electronic cigarettes into client encounters.***

*Keywords: electronic cigarette, tobacco, pregnancy, harm reduction, smoking*

## Introduction

Electronic cigarettes (e-cigarettes) have exploded on the market and have reintroduced smoking as trendy, hip, and fashionable with the added allure of being harmless. Revenues from e-cigarettes surpassed one billion dollars in 2013 and are on track to exceed the 80 billion dollar market of traditional cigarettes by the year 2047 (Forbes, 2013). E-cigarettes were first produced in China in 2004 (World Health Organization [WHO], 2008) and have quickly become a globally popular product marketed as a safe method to inhale nicotine without the toxic risks of traditional cigarettes (Polosa, Rodu, Caponnetto, Maglia & Raciti,

2013). Marketing e-cigarettes as a safe alternative to smoking provides a vehicle to recruit young first-time smokers and may reduce the inhibitions of those previously reluctant to engage in tobacco use, including pregnant, post-partum, and parenting women. Because e-cigarettes are a relatively new phenomenon, the available body of research on short and long-term health effects is immature. On the other hand, the promise of harm reduction cannot be ignored until longitudinal studies are available.

Harm reduction methods are intended to reduce the consequences of a behavior when a person cannot immediately stop the behavior. The application of harm reduction has mostly been applied to illicit drug addiction. Harm reduction methodologies could potentially reduce morbidity and mortality from tobacco use without automatically removing exposure to all tobacco or nicotine (Parascandola, 2011). Early harm reduction attempts in the 1960s and 1970s to research the efficacy of modified tobacco products (low-tar and low-nicotine) were unsuccessful due to the limited scientific understanding of nicotine addiction (Parascandola, 2012). At that time in history tobacco usage was primarily viewed as a psychological problem (Parascandola, 2011), today nicotine dependence is recognized as a medical condition in the Diagnostic and Statistical Manual of the American Psychiatric Association (Baker, Breslau, Covey & Shiffman, 2012). In recent years there has been a renewed interest for public health to engage in tobacco harm reduction strategies (Parascandola, 2011). In the future, e-cigarettes may provide a harm reduction avenue. Because the research and knowledge on the benefits and risks of e-cigarettes is sparse, for now, any potential benefits must be considered in tandem with potential adverse health and societal implications. In the future, if harm reduction claims are validated, it could benefit pregnant and parenting women battling nicotine addiction. Until longitudinal research is available, health practitioners should be cautious and must engage women of childbearing age in discussions about the potential risks

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of e-cigarettes. The statistics on e-cigarette uptake clearly indicate that health practitioners must aggressively educate and offer clients information reflecting current knowledge on the safety of e-cigarettes.

### Technical Description of E-cigarettes

The WHO (2008) categorizes e-cigarettes as Electronic Nicotine Delivery Systems (ENDS). The devices are manufactured and sold by numerous companies and are simplistic in design. E-cigarette devices are comprised of a lithium battery, electronic workings, an atomizer, cartridge that holds a liquid mixture of water, propylene glycol, flavor, and nicotine (Polosa et al., 2013). Brody (2014, p. 379) further explains the devices by stating, “E-cigarettes create a vapor that provides a dose of nicotine that varies with the vigor of inhalation and depends on the nicotine content of the cartridge, which is often not listed.” It is important to note that because e-cigarettes are not regulated there is not a mandate to list the content and ingredients comprising the device. In short, the purpose of the device is to electronically deliver nicotine into the respiratory system without the use of tobacco.

### The Burden of Traditional Tobacco

Traditional tobacco use (cigarettes, chew, snuff, etc.) is an epidemic. Tobacco use kills an estimated 440,000 Americans annually (NIDA, 2012). Further, tobacco use contributes to disease and disability for an estimated 16 million Americans annually (CDC, 2014). The Centers for Disease Control and Prevention (CDC) estimate that 41 million adults in the United States use tobacco products (CDC, 2014). Of the 41 million adults, an estimated 16% are women (CDC, 2014). The introduction and rapid popularity of e-cigarettes creates a quandary for health professionals and policy makers. It is currently unknown if e-cigarettes will further burden morbidity and mortality related to nicotine uptake or if the promise of offering harm reduction and hope to longtime smokers will come to fruition. Perhaps both ends of the spectrum will be true. Regardless, health professionals must begin incorporating discussions on e-cigarettes with pregnant, parenting women and their families.

Data from the 2011 Pregnancy Risk Assessment and Monitoring System (PRAMS) indicated that approximately

10% of women reported smoking during the last 3 months of pregnancy (CDC, 2014). Additionally, of women who smoked three months prior to becoming pregnant, 55% were able to quit during pregnancy (CDC, 2014). Of the women that quit smoking during pregnancy, 40% relapsed within six months after having the baby (CDC, 2014). There is a wealth of research highlighting adverse health outcomes related to smoking while pregnant, including increased risk of miscarriage, premature delivery, low birth weight, and birth defects (CDC, 2014). The damage caused by smoking is not limited to in utero. Research has uncovered the equally adverse health effects for secondhand smoke for people of all ages. Most concerning is the adverse impact secondhand smoke has on children over the life-course. Children exposed to secondhand smoke experience increased incidence of ear infections, more frequent and severe asthma and other respiratory illnesses (coughing, sneezing, bronchitis, pneumonia) and are at greater risk of sudden infant death syndrome (CDC, 2014).

Awareness about the health risks related to smoking traditional cigarettes and the health risks of secondhand smoke exposure may not be enough to compel abstinence. Childbirth educators and other helping professionals must remember that nicotine, the primary component in tobacco, is highly addictive (National Institute of Drug Abuse, 2012). Countless individuals, including pregnant and parenting women, have difficulty achieving short-term and long-term smoking cessation. While smoking tobacco products has long been recognized as addictive and difficult to achieve abstinence from, there is a societal stigma attached to smoking, which may be amplified for pregnant women. Real and perceived social stigmas and negative judgments may create additional barriers for women struggling with nicotine addiction to candidly share smoking habits with health providers and childbirth educators. Compounding the difficulty of nicotine addiction, abstaining from smoking and minimizing exposure to secondhand smoke is the reality of income. Women who live in poverty or on the fringe of poverty are rarely in a position to make autonomous and self-determined choices about living conditions including exposure to secondhand smoke.

### Summary for Practice

Because health care professionals and childbirth educators recognize the long-term health effects of nicotine addiction and exposure to secondhand smoke, the preference may

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be to transition pregnant and post-partum women directly to abstinence. Instead, practitioners should assess the level of addiction, and determine if a harm reduction approach would be more advantageous. Undoubtedly instantaneous abstinence is ideal; yet, the value of harm reduction and stepped approaches to cessation may result in long-term abstinence, which produces better health outcomes than relapse. While reduced harm is not perfect, health professionals and childbirth educators must consider this option as progress towards the optimal goal of increasing favorable healthy maternal child outcomes.

During encounters with pregnancy and early parenting, women health practitioners and childbirth educators have an opportunity to establish safe and nonjudgmental discussions while promoting healthy living practices (Thrower & Peoples 2014). These encounters provide a foundation to address current and emerging trends such as e-cigarettes. Pregnant and parenting women should be informed that smokeless tobacco products contain *nicotine*, including e-hookahs, vape pens and other types of smokeless devices (CDC, 2014). Professionals should not assume that knowledge on the dangers of nicotine is obvious. Marketing of smokeless products is creative and uses branding to attract specific populations. Marketing of smokeless products incorporates appealing fun flavors and socially appealing situations, which suggest the impression of being distant and separate from traditional tobacco use.

The vast body of evidence that has firmly established nicotine as an addictive and harmful substance presents a sound platform for health professionals to warn women and their support systems about the potential risk of e-cigarette usage. Pregnant women and all women of reproductive age should be made aware that the effects of using e-cigarettes prior to pregnancy or during pregnancy has not been studied (CDC, 2014), therefore the risks are unknown. However, adverse effects of nicotine before and after pregnancy are well documented, and smokeless devices contain nicotine (CDC, 2014). Most importantly, if a pregnant or parenting woman is struggling with nicotine addiction it must be conveyed that e-cigarettes are not regulated and are not scientifically shown to be an effective and safe method for cessation efforts.

In short, when pregnant or postpartum women struggle with nicotine addiction and achieving sustained abstinence

is not probable, practitioners should recommend a Food and Drug (FDA) approved NRT aid. E-cigarettes as a smoking cessation method may indeed have a place in future practice. However, until validated through scientific research, the safety and harm reduction claims of e-cigarette cannot be considered as anything more than smoke and vapors.

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# Helping Parents Make Informed Decisions Regarding Bed-Sharing

by Natosha L. Matlock-Carr, MSN FNP-C and Karen S. Ward, PhD RN COI

**Abstract:** *Child birth educators assist expectant parents in many ways. They teach about pregnancy, the birthing process and are resources for the decision making that is part of planning for a new baby. Bed-sharing is among the “hot-topics” for today’s young families. Controversy abounds for this issue. Although some professional associations have taken a stand against the practice, actual research has been inconclusive on whether it is harmful or beneficial to children. It is important that child birth educators are informed on the issue so that they may effectively discuss the pros and cons and help parents reach satisfying conclusions.*

*Keywords:* bed-sharing, co-sleeping, sleep-sharing, SIDS

## Introduction

Bed-sharing is defined as parents and children sleeping in the same bed, or on the same surface (Sobralke & Gruber, 2009). Although bed-sharing is a practice that is deeply rooted in some cultures, there is significant controversy over the advisability of bed-sharing (Homer, Armari, & Fowler, 2012). In 2005, the American Academy of Pediatrics (AAP) released a policy statement that did not recommend bed-sharing (Blabley & Gessner, 2009). This policy statement was in response to a high rate of sudden infant death syndrome (SIDS) and the alleged relationship between SIDS and bed-sharing (Blabley & Gessner, 2009). However, there are many

parents who choose to bed-share for reasons of bonding, promoting breastfeeding, parental monitoring of the infant, and decreasing infant arousals (Sobralke & Gruber, 2009). Because parents often seek advice in making decisions regarding whether to bed-share or not, it is crucial that child birth educators become knowledgeable about the pros and cons of this “hot issue.”

Historically, bed-sharing was commonplace and well accepted, with both infants and young children. In today’s modern societies, the practice is not routine and is something parents and health care personnel consider an option. This change came about as a result of medical recommendations as well as a variety of cultural and personal beliefs (Lujik, et al., 2013). From Dr. Spock’s (1976) admonitions that bed-sharing “spoiled” a child to the AAP’s warnings that SIDS deaths could be attributed to bed-sharing, acceptability of the practice decreased dramatically. Lately, however, many parents have voiced interest and participation in bed-sharing in light of perceived benefits and little hard evidence to limit it. Western societies, which are typically considered non bed-sharing nations, have shown an increase in bed-sharing in recent years. While an earlier study (Lozoff, Wolf, & Davis, 1984) reported rates of bed-sharing as high as 70% in African American families, others (Luijk et al., 2013) found that 13% of families in the United States were bed sharing as compared to 6% in 1993. All figures are thought to be low as a result of the generally negative feelings regarding bed sharing.

Child birth educators are seen as valuable resources for all issues related to birthing and raising children. They are instrumental in providing education and recommendations to parents based on knowledge acquired from evidence based practice guidelines. While parents clearly make their own

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final decisions, they seek advice from trusted sources. Child birth educators need to stay informed and include all the facts about bed sharing to give objective points for the individual family to consider, particularly with this controversial topic.

### Background

There are many pros and cons to the practice of bed-sharing. Issues of safety, health, psychological security, cultural values and financial considerations are all factors that enter into a decision to bed share or not. Each factor can have a different impact depending on the age of the child and whether or not the decision to bed share has been a deliberate one (usually based on parental preferences) or happens because the child initiated the practice. There are also different implications based on how often and under what circumstances the bed sharing occurs. Familiarity with all aspects of the topic helps child birth educators discuss bed sharing in an informed manner with interested parents.

### Safety

Safety of the child is (and should be) the most important consideration when making any decision about child rearing practices. One of the most significant issues surrounding bed-sharing is whether or not it contributes to higher rates of SIDS, which some professionals propose. Others, including many parents, claim that bed-sharing can actually decrease the incidence of SIDS because the child is closer and any difficulty with breathing or sleep is more noticeable.

The American Academy of Pediatrics has discouraged bed sharing since 1992 due to the belief that bed sharing increases the risk of SIDS (Sobralnske & Gruber, 2009). The potential risks include: an infant being overlain by the parent, the infant turning into a prone position, the infant becoming entrapped by soft bedding, the infant getting overheated, and the infant being asphyxiated by the clothing of a parent, particularly one who smokes (Sobralnske & Gruber, 2009). In 2005, the American Academy of Pediatrics (AAP) Taskforce revised its 'Safe Bedding Practices for Infants' of 2000. The AAP recommended that 'infants (should) not bed-share during sleep' (Norton & Grellner, 2011, p. 507). The recommendations from the AAP are from a scientific, medical standpoint aimed to reduce the risk of SIDS.

"The bed-sharing discussion began in earnest when

anthropologists proposed that SIDS was a phenomenon of solitary infant sleep and that infants benefitted from the sensory stimulation of sleeping in close proximity to their parents ..." (Ball & Volpe, 2013, p. 85).

Other research suggests that bed-sharing alone does not increase the risk of SIDS and that this recommendation is not valid for all parents or infants. Many parents believe that sleeping with their infant actually reduces the risk of an external threat affecting the child (Chianese, Ploof, Trovato, & Chang, 2009). Parents claim that sleeping with their infant helps them to sense what is happening and more easily monitor the situation (Baddock, Galland, Bolton, Williams, & Taylor, 2006; Chianese et al., 2009; Lozoff, et al., 1984). Parents report feeling they would immediately know if their child was in danger or needed them during the night if they bed-share. Thus, bed-sharing might reduce the risk of SIDS for their child "because the parents would immediately know if the baby stopped breathing" (Chianese et al., 2009, p. 29). Parents choose to sleep with their infants because they feel close to them and want to better protect them.

### Health

Good sleep habits and nutrition are both desired for every child by parents and health care workers alike. Getting a good night's sleep has shown to be important for individuals of every age. Breast feeding is the best choice for infants, offering advantages other than simple nutrition. Exploration of how bed-sharing influences these needs is an important consideration when deciding whether or not to bed share.

An infant's inability to self-soothe is highly associated with night waking and difficulty falling asleep. If an infant can self-soothe, then he is more likely to have better sleep and to sleep throughout the night. Self-soothing is a learned trait. The issue becomes, do infants learn this better alone or with their parents? One study concluded "Overall, children who sleep in a separate room obtain more sleep, wake less at night, have less difficulty at bedtime, fall asleep faster, and are perceived as having fewer sleep problems" (Mindell, Sadeh, Kohyama, & How, 2010, p. 396), but this has not been universally supported.

### *Parents choose to co-sleep reporting they feel closer to the child.*

Evidence indicates that sleep problems are a reason for initiating bed sharing in school age children (Jain, Romack, & Jain, 2011). One problem is sleep onset associations. This

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is defined as the need to reproduce the exact conditions/routine that occur at bedtime, when the child first falls asleep. This means that if the child first falls asleep with the parents present, when she awakes during the night hours without the parents she will not be able to return to sleep without the parents present (Jain et al., 2011). This can initiate the beginning of bed-sharing.

Breastfeeding is a healthier source of nutrition for the infant and beneficial to the mother. Breastfeeding reduces the risk of SIDS. Women who breastfeed are more likely to bed-share with their infant, and they tend to breastfeed for a longer period of time (Ball & Volpe, 2013). Parents report that it is much more convenient if the infant sleeps with them to breastfeed. The parents or baby do not have to fully wake in order to respond to feeding cues (Baddock et al., 2006; Chianese et al., 2009).

### Psychological Security

Some parents bed-share for emotional reasons. Parents describe feeling pleasure, closeness, and comfort when bed sharing with their infant (Baddock et al., 2006; Chianese, et al., 2009). Maternal bonding and maternal sleep are also associated with bed-sharing in a positive manner (Krouse, Craig, Watson, Matthews, Kolski, & Isola, 2012). Skin-to-skin contact between the infant and mother can moderate crying and cortisol stress levels in infants (Homer et al., 2012). Bed-sharing allows parents to bond with their child during sleep when they are not able to spend much time with them while awake. This can be true for parents who have to spend a lot of time away from their child due to work, divorce, or other factors. Parents of more than one child may report not having adequate bonding time with each individual child during waking hours.

Short-term observational studies have shown that infants “experience more touching and looking, increased breastfeeding, with faster and frequent maternal response” (Jain et al., 2011, p. 187). Jain et al. (2011) reviewed several studies looking at a variety of psychological factors. Overall very little was concluded from their literature survey. “The results indicated neither positive nor negative consequences for bed-sharing children at any age.” (Jain et al., 2011, p. 187). Studies explored behavioral problems, overall mood, persistence, cognitive abilities, social, emotional and developmental maturity, sleep problems and creativity. Although

individual studies resulted in different findings, no consistent pattern emerged that supported or did not support bed-sharing. Parents, and children alike, may feel the sleeping environment is a safe and comfortable place. As the family practices sleeping in the same bed the child may feel like she is receiving more attention from the parent and this could make her feel more at ease and secure. On the other hand, it could be argued that bed-sharing might cause the child to be more insecure because he cannot sleep alone. Again, the evidence, to date, indicates no specific positive or negative effects on child development.

The emotional life of parents is significantly altered by the birth of a child. A myriad of feelings are part of the new experience; there is generally overwhelming joy as well as some degree of negative thoughts due to the inevitable disruption in the household. The issue of bed-sharing is one that a couple must discuss and come to agreement on so as not to create additional stress and strain due to the arrival of a new member of the family. Both fathers and mothers need to consider the advantages and disadvantages to bed-sharing in the context of their marriage relationship.

Messmer, Miller, and Yu (2012), examined the degree of marital satisfaction for mothers that are intentional (parent initiated) versus reactive (child initiated) bed-sharers. The results of the study indicate that “the relationship between time spent bed-sharing and marital satisfaction would be moderated by classification as an intentional or reactive bed sharer” (Messmer et al., 2012, p. 806). In other words, reactive bed-sharers have a significant decrease in their marital satisfaction, while intentional bed-sharers did not experience this decrease in marital satisfaction.

### Cultural Values

Sleeping patterns are strongly influenced by culture. A study that examined the sleeping patterns of Japanese and American families found that Japanese families shared their beds at least three nights a week, while the American families participated in bed-sharing less than three nights per week (Sobralse & Gruber, 2009). Bed-sharing “is common and seen as a healthy bonding experience in many cultures worldwide; warmth, protection, and a sense of well-being are factors suspected as being incentives to co-sleep” (Sobralse & Gruber, 2009, p. 474). “Beyond Western post-industrial settings with medicalized infant-care, mother-infant sleep contact remains the cultural norm, and babies sleep in contact with a care-giver night and day” (Ball & Volpe, 2013, p. 86). “For many groups of parents, bed-sharing forms part of

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their cultural or personal identities, so the message to desist is unacceptable and rejected” (Ball & Volpe, 2013, p. 89). These cultural values should be respected, even if out of the norm in one’s own beliefs.

Overall bed-sharing is less prevalent in cultures that consider autonomy and individualism to be valuable attributes. Parents in western cultures want to instill independence early on in the life of their child thus resulting in solitary infant sleep patterns (Luijk et al., 2013). The United States is a multi-cultural country with many different viewpoints regarding bed-sharing. Jain, et al.(2011) report significant differences in the incidence of bed-sharing among African Americans (27.9%), Asians (20.9%), and Caucasian families (7.2%). As stated earlier, there has been an increase overall in the rate of bed sharing in the United States in recent years. This could be due to the diverse cultures that make up the United States or it could be that Americans in general are beginning to favor bed-sharing.

### Financial Considerations

“Among the widely reported factors associated with a greater prevalence of bed-sharing are socioeconomic factors like lower family income...” (Luijk et al., 2013, p.1093). Parents without the financial ability to have access to safe cribs tend to sleep with their infants. Other financial factors that can influence bed-sharing in all ages include the lack of sleeping areas and the lack of heat in the home. With a limited number of bedrooms, the entire family may practice sleeping together in one area or on the same surface. If there is no heat, they are also more likely to bed-share for maximizing warmth.

### Role of the Child Birth Educator

Child birth educators may be consulted on the topic of bed-sharing. Even if the parents do not ask, it can be helpful to open the subject for discussion and provide information to help have a plan in mind. If parents are electing to bed-share then providing them with research results promotes the safest method to engage in the practice.

Children’s Medical Center in Dallas, Texas developed safety guidelines to give to parents if they are going to co-sleep with an infant. According to the safety guidelines the sleeping should take place on a firm mattress, beds should not have railings or headboards, beds should not be placed directly against a wall, heavy blankets should not be used

during sleep, and never sleep on a sofa with an infant (Sobralke & Gruber, 2009). These guidelines should be shared with parents to help them create a safe environment for the infant. Armed with information, parents can more easily make the informed decision which will work best for their family.

Thorough sleep assessments should be done and should include the family’s routine, cultural beliefs, sleep hygiene practices, economic status, environmental factors, and parental work patterns (Sobralke & Gruber, 2009). If bed-sharing is in practice, it should be determined whether the parents are doing so intentionally or reactively and whether it is because of perceived sleeping problems or real sleeping problems (Sobralke & Gruber, 2009). If the parents report the infant does not have a regular sleeping pattern or sleep hygiene is not in place, this is an indicator that education regarding sleep hygiene should occur. Lastly a physical examination can assess for any illness that might affect the infant’s sleep, such as respiratory, cardiac, or neurological problems (Sobralke & Gruber, 2009).

Healthy sleep hygiene can be established by implementing the following: sleeping in a dark, quiet, cool area; having a regular sleep schedule, including naps and the infant’s bed time; engaging in quiet activities before bedtime; putting infants in bed to sleep when they are drowsy, but not asleep, in order to promote self-soothing; using a transition object for infants 3 months of age and older, such as a blanket, or soft toy; and planning when to move the infant to a crib (Sobralke & Gruber, 2009).

Families should be educated that bed-sharing should never occur when a parent smokes, consumes alcohol, or uses sedating medications (Vennemann et al., 2012). Parents should be reminded that sleeping on an inappropriate sleeping surface, such as a sofa, the risk of Sudden Infant Death Syndrome is highly increased (Vennemann et al., 2012). As with any teaching-learning situation, the child birth educator should make sure that the parent is able to summarize the information back to ensure that the education was understood correctly.

## Conclusion

Literature has shown that there are few definitive answers regarding the benefits or risks of bed-sharing. It remains a controversial topic. Research exists indicating it can be both potentially beneficial and harmful to an infant or child. The idea that bed-sharing is harmful comes mainly

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from a possible increased risk of SIDS in infants that bed-share. However, research indicates that the bed-sharing alone cannot be named the one specific cause of SIDS. “Despite a strong position against parent/child co-sleeping taken by the American Academy of Pediatrics (AAP, 2005), there is little scientific evidence to demonstrate the ill-effects of children sleeping with their parents when done in a safe environment” (Sobralnske et al., 2009, p. 474). Likewise bed-sharing is also indicated to be beneficial. Planned bed-sharing can promote breastfeeding, encourage a non-prone sleeping position for infants, increase maternal bonding, and provide more infant arousal (Sobralnske et al., 2009).

Bed-sharing is also becoming a more common practice among families in the United States. “In one U.S. study, over 35% ( $n = 615$ ) of families reported frequent co-sleeping and 76% ( $n = 1,335$ ) at least sometimes” (Sobralnske et al., 2009, p. 475). Some research reports that the actual practice of bed-sharing is more prevalent in the United States than is reported. This is based on the assumption that U.S. families do not always report they actually do bed-share because of the societal pressure against bed-sharing (Sobralnske et al., 2009).

Further research is indicated to provide a clearer understanding of the risks and benefits associated with bed-sharing. The available literature essentially leaves the decision of whether bed-sharing is a good or bad practice up to the reader. Although the AAP does provide a recommendation against bed-sharing there has been an increase in the number of bed-sharing families in the United States. This seems to indicate that even though the recommendation exists families are beneficially reinforced in other ways.

Childbirth educators can help the family to consider the infant's safety above everything else when discussing sleep arrangements. Presenting information will promote a better understanding of bed-sharing. Until more is known on this “hot issue,” guiding families to their own conclusions regarding the desirability of bed-sharing for their family, based on existing evidence, is a service that can easily be provided.

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# A Unique Grief

by Janice Harris, RN MSN EdS

**Abstract: Loss of a baby by miscarriage during the perinatal period is a profound life-changing event for the parents. It is a unique grief that is often misunderstood. This paper discusses some of the special considerations of the miscarriage and the grieving that follows. The nursing care of this special group of parents is different and requires nurses, midwives and doulas to intervene allowing the grieving process to begin.**

*Keywords: miscarriage, grief, loss, perinatal loss*

## Introduction

Mrs. B arrives in the office four days before her scheduled appointment. She is crying softly and her husband has a look of concern. He tells you she started bleeding about an hour ago and complaining of abdominal cramping. He states she started spotting about two hours before the bleeding. She suddenly bends over holding her abdomen and moans. Taking her back to an exam room, you are telling her she may be having a miscarriage or the pregnancy is terminating. Upon exam, there is evidence of a complete miscarriage. Mrs. B asks, “what is wrong with me if I can’t carry a baby? I don’t know anyone who has lost their baby. My baby!”

## Perinatal Loss

Mrs. B is experiencing perinatal loss. This is not uncommon, as March of Dimes (2012) statistics demonstrates approximately 10 to 15% of all *known* pregnancies are miscarried. In the past, most women did not even know that they were pregnant when the miscarriage occurred. However, with today’s early home detection kits, more women are aware of the pregnancy within the first month (Frost, et al., 2007). The March of Dimes further notes that almost half of all pregnancies end in miscarriage. Most miscarriages occur during the first trimester (<20 weeks), some do occur during

the second trimester and a loss of the baby that occurs after 24 weeks is termed as a stillbirth (Miscarriage Association.org, 2014).

Perinatal loss is frequently glossed over as not having a major impact on the mother or father. Hutti, Armstrong and Myers (2013) note that the extent of the grief will vary for each couple depending primarily upon the level of perception by the parents of the baby assuming “personhood” (p. 698). If a relationship has developed, the grief will probably be more intense. This relationship is usually more concrete earlier in the eyes of the mother than of the father, as she goes through symptoms of pregnancy such as morning sickness, sore, full breasts and the cessation of menstruation. The loss of a baby during the first trimester is especially difficult for the parents as there is no baby to hold, no naming of the child and nothing physical to mourn (Leon, 1990). Furthermore, there are no mementos, such as hand and foot prints, locks of hair or photographs to put in a memory book, as there are when the child is a stillbirth (Fenstermacher & Hupsey, 2013, Frost, J. Bradley, Levitas, Smith, & Garcia, 2007, Hutti, et al., 2013; Leon, 1990, Woods & Woods, 1997).

## Grief

“Grief is an individual process of coping with the stressful change in relationships that is created by a death” (p. 44). It is a personal experience and is different for each individual as well as exhibiting gender differences (Moore, et al. 2010). The grief is influenced by the parents’ previous experiences such as loss of other family members, loss of previous pregnancies, and unresolved grieving from these previous experiences. This grief is also influenced by the personality of the individual, gender, and culture. Moore, et al., (2013) further states that perinatal grief may be influenced by the support of family, friends, and other social networking acquaintances. This grieving process may be further influenced by healthcare workers. In this study the healthcare workers were identified as the least supportive by the grieving parents. Frost, et al., (2007) comments that in today’s world miscarriage is not discussed openly and many women are unaware of the possibility of miscarriage, furthering affecting the *continued on next page*

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grieving process. Grief is amplified by the loss of things that will never be, as the parents had hopes and dreams of the future for the child and for themselves as parents. With the loss of these dreams, parents face challenges both at the time of the loss and potentially during future pregnancies (Woods & Woods, 1997, Frost, et al., (2007).

## Nursing Implications

In a United Kingdom statistic, it was noted that women who had a perinatal loss of a child at less than twenty weeks, nursing care was essentially missing. The statistics reports that of the women questioned: 29% stated they felt cared for; 45% felt they were not informed of what was happening to them; and 79% had no aftercare. These statistics are staggering. Frost, et al. (2013) discussed the medicalization of childbirth, where miscarriage in early pregnancy is considered insignificant, as there is not an outcome (baby) and the primary concern becomes one of infection. This leads to very little discussion with the parents regarding the miscarriage.

### At the time of crisis parents deserve:

- To be treated with dignity
- To be given simple explanations
- To be spared innocuous small talk
- To be allowed (encouraged) to cry
- To be guided through unfamiliar issues and painful decision making
- To be comforted not to be isolated

*(Leon, 1990, p.82)*

Nurses present at the time of the miscarriage may not be aware of the ramifications of statements such as, “You are young and you will have the opportunity for many more children,” or “This just happens who knows why.” These platitudes are meant to comfort, but instead the mother’s thoughts return to “Why me?” Leon (1990) points out the beginning of the pregnancy changes the mother’s sense of self as an individual identity to that of motherhood with the child bringing her to this new identity. The loss of that child is real and with it the intense grief that follows. As healthcare providers, whether nurse, midwife, or doula, it falls to each one to be aware of the potential impact of the loss on the mother,



father and other family members. Acknowledgment of the loss is the beginning point for both the parents. It is important for the nurse not to minimize the loss, but be prepared to answer the questions that the grieving parents will ask.

Questions such as, “What happened to my baby?” or “Why did I lose this baby?” have no immediate answer as there are numerous medical reasons why the baby miscarried. The most common cause is a chromosomal abnormality that is incompatible with life. This is followed by hormonal factors, endometrial and vascular factors, anatomical factors, and many others (Leon, 1997) Frost, et al. (2007) describes part of this as the ‘scientisation’ of death, and every death must have an ‘outcome’ and a ‘cause’ (p. 1004). As noted earlier, there are numerous potential causes but these are usually not identified following a miscarriage.

## Nursing Care

As the miscarriage occurs and the parents begin the grieving process, nurses, midwives and doulas are on the leading edge to provide information for the parents, letting

*continued on next page*

## A Unique Grief

continued from previous page

them know that the grief is real. This also means that the grief is allowed to continue for more than a day. Encourage the parents to talk with each other and with others including friends and family. Discuss the availability of support groups, which are available locally, and on-line resources for perinatal loss. Furthermore, if the grief becomes overwhelming and they do not feel they can cope with daily life, then seeking professional help is strongly recommended (Fenstermacher & Hupsey, 2013; Frost, et al., 2007; Moore, et al., 2013; Hutti, et al., 2013, Leon, 1990; Woods & Woods, 1997). Finally, as there are no physical mementos, encourage the parents to reflect in a journal the events and feelings of the pregnancy prior to the miscarriage. Also, recommend follow-up with the caregiver to evaluate the responses and the needs of the grieving parents (The Miscarriage Association, 2014).

The loss of a baby by miscarriage is a real phenomenon occurring to a mother and father. The grief is as real as if the death had occurred at full term pregnancy. The difference is profound and may be life-altering, presenting with nothing to follow but a unique grief.

### Resources for Perinatal Loss

- <http://www.miscarriageassociation.org.uk/about-us/media-queries/background-information/>
- <http://www.nationalshare.org/additional-resources.html>
- <http://www.marchofdimes.com/loss/from-hurt-to-healing.aspx>
- <http://www.amendgroup.com/>

(Each web site has numerous other resources listed to help you and your patient deal with perinatal loss)

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*Janice Harris, MSN, RN, EdS teaches in the Division of Nursing at Tennessee State University, Nashville, Tennessee. She has over 15 years teaching experience both in academia and hospital based education. Prior to teaching she was an Emergency Department/Trauma Nurse. She also has worked as a Home Health Nurse. In all aspects of nursing she has worked with patients who have experienced miscarriage, deaths of infants, children and adolescents, and working with adults experiencing the grief and loss of family and friends of all ages.*

# Doing the Best I Can: Fatherhood in the Inner City

by Edin, K., and Nelson, T.J.

reviewed by Karen S. Ward, PhD RN COI

The book, *Doing the Best I Can: Fatherhood in the Inner City*, by Kathryn Edin and Timothy J. Nelson does much more than report on a research study. It provides an insightful look at the lives of unwed fathers living in compromised socio-cultural circumstances. After hearing politicians, educators and celebrities (among others) attribute many of the world's woes on disinterested, disappearing fathers, the authors of this book decided to thoroughly investigate what motivates disadvantaged, unwed fathers.

The general stereotype of fathers who do not actively contribute to their children's lives is that they just do not care enough to share resources with their offspring. Characterized by the label "dead-beat Dads", these men are thought to deliberately avoid the father role and fall short of the responsibilities incurred when creating a child. Edin and Nelson found that this stereotype is far from true in most cases.

Edin and Nelson actually moved to an inner city neighborhood in order to experience the environment that shapes the lives of these men. Over several years, more than 100 men, both black and white, were interviewed multiple times in order to construct a picture of fatherhood from their perspective. The result is an engaging tale of devotion and concern for their children on the part of fathers who cannot consistently bring their dreams to reality; not from lack of care and concern, but due to the realities of life in their world.

For the majority of fathers in the group, pregnancy was neither desired nor planned. More often than not, the mother was a casual acquaintance who was not the "love of his life", but someone who happened to be there and available for sexual activity. The men involved were surprised when confronted with the fact of the pregnancy. Surprisingly, however, they were both accepting and very pleased with the news. They received the information with joy and anticipation of a son or daughter. Often they viewed it as an opportunity to be a better parent than they had had in their own childhood. They envision a life for their child greatly improved from their own circumstances. Unfortunately, very few of the men have the skills to make this hope a reality.

For many reasons, the men fail to adequately provide for their children, but not because they do not care. Many of them lack a skill set that will serve them well in the working world; they either cannot find jobs or are the first to be laid off from job markets that shrink quickly. This situation can lead to depression and despair and, all too often, criminal

activity. When they find themselves unable to assist financially in their child's upbringing, they shy away from any consistent contributions. Instead, they get satisfaction from giving their children small treats when they have "enough" money. They also justify the way they

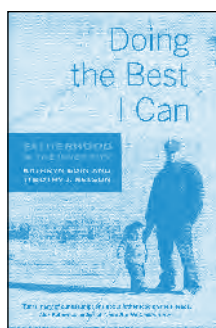
handle the lack of financial help by trying to "be there" for their child. Being able to provide personal presence and guidance is important to their sense of what being a father means. Over and over, the men reported their efforts to

spend time with their children as evidence of their parenting skill.

For childbirth educators, most parental contact is with mothers and the infants they are birthing. When fathers are involved, they are the husbands or designated "partners" of the mothers. Such fathers, who attend class with the mothers, are able to ask their own questions and represent themselves. Gaining insight about the lives of fathers who may not be attending classes can be helpful in guiding interactions with their counterparts – some of the unwed mothers.

Although this is a research report, the content and writing style make it a very readable book. The authors present their findings in an interesting and understandable manner. Like all research, the reported findings are dependent on how well the men who were available, selected and interviewed represent the population discussed. Care is taken to convey this to the reader.

This book is recommended for anyone who cares about the lives of children who are born to lower socioeconomic, unmarried parents. While other sources must be relied on for learning about the mothers, this exploration of unwed fathers is very thorough. Discovering the viewpoints and ways of thinking held by these particular fathers is valuable background for dealing with them and their families. The book allows readers to gain insight into the men who are "doing the best they can."



University of  
California Press,  
Los Angeles, CA  
2013  
284 pages  
\$29.95

*Dr. Karen S. Ward is a Professor in the School of Nursing at Middle Tennessee State University. Her doctoral degree is in Developmental Psychology and she is interested in human development and family studies.*

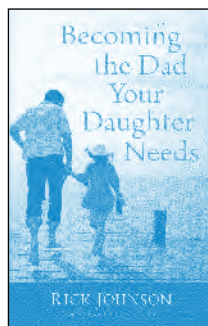
# Becoming the Dad Your Daughter Needs

by Johnson, R.

reviewed by Kathy Martin, PhD RN CNE

*Becoming the Dad Your Daughter Needs* marks the crossover of established author and founder of 'Better Dads' to focus on a father's relationship building with the female child, a daughter. While having published several prior books on the role of fathers with sons, and husbands with wives, in this book he explores the complexity of raising a daughter in today's world and progressively outlines a foundation from which to maintain an open and honest, loving relationship, built on communication and mutual respect.

The book explores the relationship between physiological and emotional development from infancy to young womanhood, and common behaviors of the developing female child. Presented from an admittedly patriarchal perspective, Johnson explores the developmental phases of



the father daughter relationship within the context of a Christian home. The strength of the book comes from a proliferation of simple strategies and interventions from which a father may promote the development of a daughter who is comfortable and confident in her own skin and from which a lifelong bond with her father may exist.

Revell Publishing,  
Grand Rapids, MI  
2012  
191 pages  
\$12.99

*Dr. Kathy Martin is a nurse educator and clinician, currently serving as the Executive Director, Division of Nursing, Tennessee State University in Nashville, Tennessee.*

# What Good Men Do

by Baxter, D.S.

reviewed by Brian S. Paramore, MA MSN RN

In this book, Baxter attempts to explain what constitutes a good man primarily by examining the lives of seven different historical figures including Jesus Christ. The intended audience for the book is fathers of the Mormon faith (the Church of Jesus Christ of Latter Day Saints). The book has nine chapters, and is written in a simple and straightforward manner.

The author provides an introductory chapter explaining the need for good men, followed by seven chapters examining the lives of different historical figures, and a chapter on how to raise sons into good men. The layout generally consists of outlining the life of the historical figures followed by two to three lessons the reader should learn from the life of the individual. Due to the layout, the book feels like a group teaching tool primarily targeted at young men and fathers. The author emphasizes



the need for men to put fatherhood above church obligations, although some of the historical examples seem to emphasize church first.

The book is recommended for new fathers of the Mormon faith who seek a simple introduction to the meaning of fatherhood within the context of the Church. This book would not be appropriate for other audiences.

Cedar Fort,  
Springville, UT  
2014  
128 pages  
\$18.95

*Mr. Paramore is an Assistant Professor of Nursing at Tennessee State University located in Nashville, TN. He has experience working in various mental health settings with pediatric populations and end-of-life care with geriatric clients.*



# Globalized Fatherhood (volume 27)

by Inhorn, M.C., Chavkin, W., and Navarroj, A., (Ed)

reviewed by Janice Harris, MSN RN EdS

In the past, fathers have been known primarily as the breadwinners for the family and the mothers stay at home and care for the children and family needs. Moving into the twenty-first century there is a definite change issuing forth in the dynamics of family. Mothers and motherhood have been extensively researched but research on the role of the father is lacking. In the book *Globalized Fatherhood* the editors have accumulated research regarding fatherhood around the world showing fathers have moved or want to move into new roles of fatherhood and family caregiving.

These changes have a direct relationship with changes in economics, changing roles of mothers, job positioning within corporations, gay marriage and changing gender norms. Through perspectives in sociology, anthropology, geography, health and medicine, public policy, political science and demography, the editors explore fatherhood from Peru to India and China. In the past most of the research has been based on the white, middle class, father which gives little insight into fatherhood of other countries or groups.

This book is divided into eight sections with two chapters in each section. The sections include corporate fatherhood, transnational fatherhood, primary care fatherhood, clinical fatherhood, infertility fatherhood, gay/surrogate fatherhood, ambivalent fatherhood, and imperiled fatherhood.

Each of the chapters discusses the changes in the role of the father in the home and childcare setting. Countries such as Denmark, United Kingdom, and Japan strive to create new policies to encourage fathers to take paternity leave following the birth of their children. Other countries such as Vietnam and Indonesia and the Philippines are dealing with changing gender roles as the mothers migrate to obtain work or the father leaves and becomes an absentee father. Many children from Peru are taken into Spain where very strict rules apply to the communication between the children and biological father. Fathers in Mexico are changing their roles as they attempt to role model new ways of fathering, unlike the methods of their fathers. Fatherhood in Gaza changes as the father becomes the major caregiver of children requiring cancer treatment in Israel. These fathers become the primary caregiver for as long as the treatment is required with no visits home for respite.

Infertility and new technology has influenced the concept of fatherhood for some men. The inability to procreate conflicts with the desire to have children through artificial

insemination. This conflict influences the role of fatherhood in many and places them in a dilemma of caring for the child of an unknown. Arab men who are infertile are also using these new technologies to reproduce. This infertility challenges the masculinities and they go to great lengths to find clinics to aid them in their fatherhood quest. In the United States, Australia and Israel gay married men desiring to become fathers are using surrogate mothers from India. These surrogates have no contact with the children once they have given birth. The laws in India are very strict regarding the contact once the adoption has taken place.



Nigerian men have strong beliefs regarding fatherhood and their role as the head of the household. With changing economics and globalized information there is a change in the ideas of masculinity and marriage; prompting a change in the role of fatherhood. Men in Iran are faced with state policies to reduce the population. With a reduced number of children in the household the Iranian fathers' concept of fatherhood is changing and ultimately may be creating more violent reactions to the children. China has strong feeling on the importance of male children and this has left many men without the ability to find a wife. This disproportionate ratio of males to females is leaving many young men without the ability to father children. The final group discussed is veterans of the Gulf War. Many of these men suffer from Gulf War Syndrome. One of the effects of this syndrome is the veteran no longer feels he is, or would be, a good father. Because of the syndrome, he may lack the ability to conceive, or there is a greater possibility of birth defects. Fatherhood, in their thought, is unattainable.

Each well-written chapter contains research on the topic of Fatherhood as lived by fathers and mothers in that country. The researchers have interviewed and collected data to give the reader and in-depth look at fatherhood as it is emerging into the 21st century. This book would be an asset for those caring for future mothers helping to understand the other side of parenting and the changing roles of fatherhood.

Janice Harris, MSN RN EdS is faculty at Tennessee State University. She has more than 20 years teaching experience.

Berghahn Books,  
New York, NY

2015

430 pages

\$104.57

# Children, Spirituality, Loss and Recovery

by Bellous, J.

reviewed by Debra Rose Wilson, PhD MSN RN IBCLC AHN-BC CHT

This academic book is authored by numerous researchers, counselors, psychiatrists, ministers, and professors and presents the child's perspective to loss and trauma and how these little people optimistically integrate negative experiences into healthy growth and development. Reading this book I was reminded that the resilience of children is more than is expected from or of adults. The authors, experienced in their fields, present practical and theoretical perspectives for those who work with children that have been exposed to trauma, loss, and grief.

The first chapter, written by a teacher, considers those affected by the HIV/AIDS pandemic and applies experience from working with children in infected/affected African countries. The work against stigma and ignorance must continue with funding, resources, and research. Whole recovery is possible. Humans are "better at being judgmental than at being compassionate." Since HIV/AIDS has a greater impact on women, the gender inequality leaves them and the children at higher risk for infection, poverty, stigma, and the burden of care-giving. To allow healing and whole recovery affected and infected children need a belonging environment free of stigma where their experience will be acknowledged.

The second chapter focuses on the resilience of children and begins with two touching case examples of trauma, discussing how responses to these experiences differs. There is a great deal of current research about resilience in psychology and social work and this ability to adapt positively to adversity is a learned skill supported by innate personality traits. Masten's work is examined where resilience is seen as building on intellectual, personality, motivation, positive self-concept, and other characteristics. This chapter offers hope and faith in resilience skills to help children adapt to adversity.

The third chapter describes the affliction of grief from a holistic perspective written from a Christian paradigm. The difficulty expressing deep anguish is not restricted to children and the author intermingles personal and professional experience ministering to grieving children offering hope and personal transformation as a positive outcome.

The fourth chapter describes the spiritual and physical suffering of children in extreme poverty in Liberia and the glimmer of hope that programs offered to the most vulner-

able. The development of goals and hope provide a heartwarming view of the reach towards stability.

The fifth chapter examines the change in how spirituality in children is viewed in light of tragedy in school environments. The consistency and normalcy of a school environment offers a healing ground for recovery. All members of the school community are involved in providing and receiving support in a safe place. A discussion of disenfranchised grief reminds us of how individuals will grieve and how this controlled place can validate loss, and restore not only the individual but the entire community.

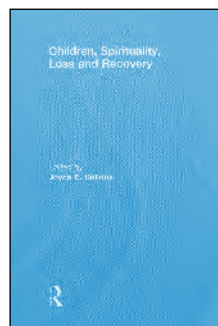
Chapter six revolves around religious faith and beliefs about the life cycle and how this feeds into a child's understanding of death, and development of spirituality. From a theological perspective, the stories of religion provide a context for meaning. The seventh chapter explores how focusing on spiritual development and a child's perspective of trauma and loss lead to healing and wholeness. This chapter presents qualitative data gathered about tragic experiences of children and how the innate spirituality and

developed resilience of children combine to allow children to thrive despite adversity.

Chapter eight presents an existential approach to tragedy experienced by children. The transformational nature of these experiences can be of benefit to healthy growth and sheltering children from loss and grief might even be considered detrimental to becoming spiritual human beings. Satre and Kierkegaard's paradoxical influences are clear in the chapter, as it is working through the paradoxes of life that we become more than we were before. Reflective dialogue, social support and interchange, and intentional focus on the grief provides context to the experience and healthy outcomes.

Chapter nine focuses on the experience of loss and recovery in children with disabilities. A case study helps the reader understand the point that spirituality development is part of the journey through trauma and the author provides

Routledge, London  
2013  
101 pages  
\$45.64



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# The Baby Bonding Book for Dads: Building a Closer Connection with Your Baby

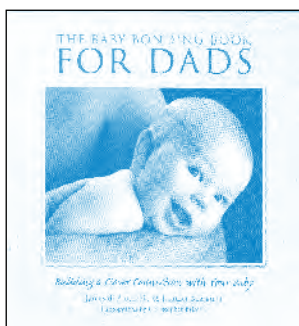
by di Properzio, J., and Margulis, J.

reviewed by Edward A. Wiltcher, EdD MSN RN

In this booklet, di Properzio and Margulis attempt to capture those special moments between newborns and toddlers and their fathers. Not all new fathers are naïve when it comes to bonding with newborns, and this booklet offers snippets of advice. The booklet is divided into 20 topics ranging from Newborn time, Skin to skin, and Dressing to impress to Writing to your baby. Within each section of the booklet, a brief explanation is provided, directed towards new dads, on what they should do at that moment to develop a special bond.

Children, for the most part, do not consciously remember how they were treated as infants. Yet bonding is crucial because memories, conscious and unconscious, are developed during the first day of life. This early bond between father and infant is extremely important, for it helps to develop not only the memories, but also leads to a healthy adulthood.

Another component of the booklet is the beautiful black and white photographs found throughout. The photos show fathers and infants in various positions. These illustrations depict the bonding action between father and infant such as skin-to-skin contact, laughter, touch, and holding. However,



the illustrations could be improved by using more culturally inclusive subjects and settings.

The recommended audience for this book consists of new fathers who want a simple, accessible introduction to basic interactions with their baby. It would best serve as

a jumping off point for more comprehensive coverage of the subject. To be sufficiently informed, new fathers will need more information on the importance of bonding, the science behind bonding, how it helps children develop into respectful teens and independent adults, and various steps towards bonding along with a rationale.

Willow Creek Press,  
Minocqua, WI  
2008  
93 pages  
\$15.95

*Dr. Wiltcher is an Assistant Professor of Nursing at Tennessee State University located in Nashville, TN. He has over twenty years of teaching and nursing experience and has co-authored books related to learning and teaching strategies.*

## Book Review: Children, Spirituality, Loss and Recovery

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useful lists of how to work with adolescents after life changing disability.

Overall this book is useful for those working with grieving children but is intended for social workers, nurses, counselors, and ministers caring for the varying age groups.

There is a Christian bias to most application, but that might be overlooked by other faiths for its usefulness in examining spirituality instead of religion. This would be a useful book of readings for a graduate course in grief, or for a grief counselor who is beginning to work with children.

*Dr. Debra Rose Wilson is on faculty at Tennessee State University in Nashville, TN. She is an accomplished writer and editor of the IJCE.*

# *The Tragedy of Fatherhood: King Laius and the Politics of Paternity in the West*

by Weineck, W.

reviewed by Pinky Noble-Britton, PhD MSN RN

This book provides a historical analysis of western theories of fatherhood. The Freudian contribution to the development or non-development of the relationship of son and father is thoroughly explored. Fatherhood is seen as a dark and tragic feat as identified by the Freudian view with contributions of the father as a political and powerful yet subject to defeat lent by Aristotle and Hobbes. The book provides a strong case for the philosophical and psychological schools of thought regarding the destruction of the paternal or fatherly role. Weineck did well in using the Laius Complex and the Oedipus Complex or Pateur to support the argument of the imminent destruction or tragedy of the father. Although, there were some strong references made of the ideal father, with the power and positive character one would embrace, the book is very well embodied with the impressions of the father on his way to destruction. Additionally, the use of the story of the dead children in the conclusion seemed somewhat cryptic and cold although slightly relevant given the book's underlying theme.

There is no apparent fit in the conventional, childbirth preparation and labor and birth classes. The best fit would be as a reference for providing existing impressions of the frailty of fatherhood and strategies to preserve new and robust examples of fatherhood. With parenting as one of the key factors of childbirth education, it would be challenging to use this book as a reference for portraying the ideal father.

The suggested audience for this book would cross several disciplines. For a start, this book would be best suited for graduate level students or students in their last year

of undergraduate studies. The language level for this text would challenge the early stage undergraduate student; a prerequisite course in psychology and theology would be

*Bloomsbury, London  
2014  
208 pages*



beneficial for easy translation of thoughts expressed in the text. Suggested disciplines therefore include psychology, theology, sociology, political science, and literature. Great historical analyses of socialization principles and the family, with emphasis on the role of the father, can be explored using this book. There is significant reference of the expected role of the father by great thinkers such as Aristotle, Plato and Kleist. However, with the strong references to the possible loss of the father's grasp of their roles the inclusion of thoughts on the paternity in a perfect city provided a fair comparison.

This book is more suited to counselors and psychologists than to childbirth educators. The book would be a great resource for ongoing debates and conversations on the importance of fatherhood and how best to ensure that there is no clear pathway that leads to the tragedy of fatherhood.

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*Pinky Noble-Britton, PhD MSN RN has twenty years experience as a registered nurse in various adult care settings. Has an educational background in Social Work, Nursing Informatics and Nursing Education. Currently serves as an Assistant Professor in nursing at Tennessee State University and Thomas Edison State Community College.*

# Welcome to the Family

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