

International Journal of Childbirth Education



Open Focus

The official publication of the International Childbirth Education Association

VOLUME 31 NUMBER 4 OCTOBER 2016

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The official publication of the
International Childbirth Education Association

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Columns

The Editor's Perspective – Being vs. Doing

by Debra Rose Wilson, PhD MSN RN IBCLC AHN-BC CHT 4

Across the President's Desk – What Has Changed

by Connie Livingston, RN BS FACCE LCCE ICCE 5

Features

Putting Focal Points into Focus

by Renece Waller-Wise, MSN RNC-OB CNS CLC CNL LCCE FACCE 6

Protecting the Pelvic Floor during Pregnancy

by Christine Childers, PT MS GCS CEEAA 10

Reducing Stress in Infants: Kangaroo Care

by Meredith Baker-Rush, MS CCC-SLP/L 14

Sensory-Based Calming Strategies for Infants

by Lee Stadtlander, PhD 18

Addressing the Risk of Postpartum Depression in Female Veterans

by Sara L. Schroeder, RN BSN 21

In Practice

Korean Forest Taegyo for Reducing Stress and Emotional Instability during Pregnancy

by Yuna Lee, Jiyoung Lee, and Ninez B. Tulo 24

Understanding Our Role in Bereavement

by Lindsay Carter 28

Compliance with Keeping Appointments

by Beverly M. Brown, EdD RN MSN APRN/GCNS BC 31

Expectation Setting during the Prenatal Period: A Key to Satisfaction

by Richard C Meeks, DNP RN COI 33

Can't Catch Her Breath: Peripartum Cardiomyopathy

by Caitlin Bruner, RN BSN 37

If It's Natural, Why Does it Hurt? Examining the Reasons Mom May Feel Pain with Breastfeeding

by Elizabeth Smith, MPH ICCE IBCLC RLC 40

Book Reviews

New Baby 101: A Midwife's Guide for New Parents

reviewed by Sarah L. Marshall, MSN RN ICCE CCE CBC CLC 44

Reviving Your Sex Life after Childbirth

reviewed by Jean Rother, MS RN 45

Expecting Kindness

reviewed by Shaunna Parker, MSN RN WHNP-BC 46

Four Little Books – The Bump Book of Lists for Pregnancy and Baby; Expecting You;

From Pea to Pumpkin; and Welcome Baby
reviewed by MaryAlice Sawaya, PhD RN CNE 47

Hypnobirth: Theories and Practices for Healthcare Professionals

reviewed by Debra Rose Wilson, PhD MSN RN IBCLC AHN-BC CHT 48

Finding Your Way with Your Baby: The Emotional Life of Parents and Babies

reviewed by Carol Clarke-Campbell, MSN RN 49

Being vs. Doing

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

As humans we have a holistic nature. A physical and a spiritual side that ideally is balanced, interacting, and aware. We have an outside that reacts actively and passively with the environment and those within it. There is an inside that experiences, analyzes, and remembers those interactions. Do you believe we are spiritual beings here temporarily living in a physical world to educate, grow, and nurture our spirit?

We are caught up in a material world busy with our tasks and chores required of life and careers. Rewards of today's culture are given to those who are productive and get things done. We can easily become too focused on the perceived permanence of the physical world and workaholics can have all their energy consumed in doing. The new technology interconnects us but expands our world of *doing*. Alternatively, we can become too focused in our spirituality, live on an ethereal plane or focus on the afterlife rather than being grateful and living in the now. There must be a balance between doing and being.

Many of us in practice understand the difference of *being with* as opposed to *doing to*. Those of us who are *truly with* a patient as they experience the magic of birth are connected to the patient, the experience, and the moment. Our role is to be totally attentive to their experience, especially when there is nothing to do. As a nurse sometimes we are so overwhelmed with what

needs to *be done*, we can't *be with* the mother. We do want to ensure there is one person who has nothing else to do but *be with* the mother, giving her full attention.

A *doing* state might be comfortable. It keeps us occupied, and we are gratified by the products when we are done. But *being* isn't about being lazy or nonproductive, rather it provides rich life experiences and moments worth living. In a state of *being* there is awareness, calmness, and stillness. We are more of our authentic selves. We need a balance of both *being* and *doing*. Reflect on balancing *doing-to* with *being-with* yourself and your childbearing families. Balance the doing and being in your own life. Are you a human being or a human doing? ☺

Welcome to this open focus edition of the journal; we have a variety of topics for those who work with the childbearing family. Consider writing for our journal – contact me so I can help you prepare a manuscript. Happy reading.

Peace,
Debra

editor@icea.org



Debra Rose Wilson

Brief Writer's Guidelines for the ICEA Journal

Articles should express an opinion, share evidence-based practice, disseminate original research, provide a literature review, share a teaching technique, or describe an experience.

Articles should be in APA format and include an abstract of less than 100 words. The cover page should list the name of the article, full name and credentials of the authors and a two to three sentence biography for each author, postal mailing addresses for each author, and 3 to 5 keywords. Accompanying photographs of people and activities involved will be considered if you have secured permission from the subjects and photographer.

In Practice Articles – These shorter articles (minimum 500 words) express an opinion, share a teaching technique,

describe personal learning of readers, or describe a birth experience. Keep the content relevant to practitioners and make suggestions for best practice. Current references support evidence-based thinking or practice.

Feature Articles – Authors are asked to focus on the application of research findings to practice. Both original data-driven research and literature reviews (disseminating published research and providing suggestions for application) will be considered. Articles should be double spaced, four to twelve pages in length (not including title page, abstract, or references).

For more information for authors please see our website at www.icea.org.

What Has Changed

by Connie Livingston, RN BS FACCE LCCE ICCE

Maya Angelou once said, "Stepping onto a brand-new path is difficult, but not more difficult than remaining in a situation, which is not nurturing to the whole woman."

When I stepped onto the ICEA Presidential Path on January 1, 2015, I knew that there would be significant challenges and difficulties. Yet as the contractions of labor are challenging and bring new life, the challenges and difficulties of the past two years have brought incredible progress and joys. With the talents and dedication of the ICEA Board of Directors, ICEA has seen the following:

- Heightened our collaboration with other like-minded professional organizations such as ACNM (American College of Nurse Midwives), ILCA (International Lactation Consultant Association), APPPAH (The Association for Prenatal and Perinatal Psychology and Health), USBC (United States Breastfeeding Committee) and NAPPSS (National Action Partnership to Promote Safe Sleep) - and relationships with companies such as Injoy Birth and Parenting and GOLD Family of Online Conferences. We are also incredibly proud of the ICEA/ICAN and VBAC.com collaboration: The VBAC Education Project.
- Creation or updating of fifteen Position Papers and seventeen Teaching Sheets.
- Streamlining and updating of the PCBE, Birth Doula and PPD Programs.
- Creation of the Early Lactation Care Workshop.
- Updating the ICEA/CIMS Mother-Friendly Labor Support Skills Workshop for Nurses
- Streamlining and updating the IAT Process
- Expansion of ICEA's International Outreach, including PCBE exams translated in Spanish and Chinese.
- Creation and updating of free handouts for members.
- Streamlining the ICEA Contact Hour and Alternate CE Program.

- Expansion of our social media presence including Facebook, Twitter, a new website, new e-newsletter (ICEA Connection), and a new blog "Birth: People, Places and Perspectives" (www.birthperspectives.com).
- Creation of a significant childbirth education history collection, shared at the ICEA Annual Conference.



Connie Livingston

Partnering with the ICEA Board

through much of this amazing journey has been the team of professionals from IMI Association Executives. I personally wish to thank Linda Owens, Jessica Lytle, Sarah Carlton, Kimber Williams and Allison Winter for their guidance, expertise and support. I firmly believe that without *their* team becoming part of *our* team, many of our accomplishments would still be on the drawing board.

ICEA has embraced the words of Tony Robbins, "If you do what you've always done, you'll get what you've always gotten." Together we have stepped outside of our comfort zone, thought outside of every box, and dared to dream big. Many of our dreams have become reality, but there is still much to do. To take ICEA to the next level of excellence, I am proud to say that most of the ICEA Board will be returning to continue this important work. At the helm for 2017-2018 is the incredible Debra Tolson.

The foundation of ICEA is firm and the future is brighter than ever. Get some sun glasses because as Oprah Winfrey said, "When I look into the future, it's so bright it burns my eyes!"

In your service,

Connie Livingston RN, BS, FACCE, LCCE, ICCE

ICEA President

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If you have tidbits of teaching wisdom to share, an inspirational birth story, or a short article that you would like published in our *eBirth*, submit them for consideration to communications@icea.org.

Putting Focal Points into Focus

by Renece Waller-Wise, MSN RNC-OB CNS CLC CNL LCCE FACCE

Abstract: *In 2001, Simpkin, Walley, and Keppler discussed attention focusing that includes internal and external focus. External focus is broken down into focus that utilizes the senses—visual, auditory, tactile, and olfactory. This article seeks to expand on these simple concepts, and offer childbirth educators an in-depth view of each focal point. Focal points are still a pain intervention that should be taught in contemporary childbirth education classes in a form to include both internal and external focus, along with focus that includes the senses and both hemispheres of the brain.*

Keywords: *focal points, childbirth, concentration, pain management, labor*

There are numerous pain theories that can be used to explain why the use of attention focusing activities during labor is helpful to decrease pain sensation. One of those is the Cognitive Control Theory, which describes how one focuses on mental activities to divert mental attention from pain sensation. Another pain theory is the Dissociation Theory, whereby one focuses on some aspect of a non-painful sensation rather than focusing on the painful stimuli. Using these theories during labor could take many forms, such as, focusing on a visualization of the process of labor—the work of labor in effacing and dilating the cervix, the progression of the baby through the pelvis, or even focusing on the rhythmic quality of the contractions themselves. There are many attention focusing activities that can be utilized that require mental focus, that could be used as a distraction (Jimenez, 2000). In the first of edition of *Pregnancy, Childbirth, and the Newborn: The Complete Guide* (2001) Simpkin, Walley, and

Keppler discuss attention focusing that includes internal focus, external focus or visual focus, auditory focus and tactile focus. This article seeks to expand on these concepts, and offer childbirth educators and nurses an in-depth view.

Internal Focus

The internal focus or focal point can be utilized by women in labor in different forms. One form of an internal focus is to focus on the physical mechanisms of the labor and birthing process (Simpkin, 2001). A woman's focus turns to the inner working in her body in the processes that her body is undertaking. She concentrates on the six mechanisms of labor progress and focuses her attention on visualizing those processes. She visualizes the cervix moving forward, softening, dilating, and effacing. While at the same time she focuses on the movements of her baby as the baby descends and rotates through the pelvis (Lothian, 2010). This is a form of an internal focus using the techniques of visualization where the focal point becomes internalized. This form of focal point adds to a greater sense of being connected and in-tune with the baby. It promotes calmness, thus lowering the mother's blood pressure, and rejuvenates her through the process of labor (Weatherspoon, 2011).

Another internal focal point for some women in labor is to focus on their respirations. This shifts the internal focus to the sensation of breathing. Concentration rests with each inhalation and exhalation (International Childbirth Education Association, 2011). The woman actively breathes, while focusing her attention away from the contractions and onto the sensations of breathing. With each in-breath she contemplates the feeling of air entering her nose, filling her lungs as her chest expands, then she concentrates on the air as it exits her body in a deliberate fashion. She then begins this rhythmic process over again with the next breath (Lothian, 2010). She may ponder her respirations as coming from her diaphragm. She may consider if they are shallow from her chest or deep from her abdomen (Frazer, 2015). In using this intervention for pain control a woman utilizes her

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Putting Focal Points into Focus

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whole brain. Women use the right hemisphere of the brain to consider the rhythmic nature of breathing and the left hemisphere of the brain to engage in listening to the sound of the breathing (Hilbers, 2016). Foremost, women should breathe, and should not hold their breath during labor, thus turning one's inner focal point to breathing ensures that this does not occur (Waller-Wise, 2013).

Yet another type of visualization takes on the form of imagining oneself to be in another location. Some might describe it as an intense “daydream,” as the woman lets a new location become her focus (Steffes, 2000). An example might be the woman who is in labor ruminates on being at the beach. She thinks of the sights at the beach, such as the ocean waves, the sand, the sun, etc. She would consider the smells of the beach – the salty ocean breeze, suntan lotion, grilling food, etc. She would ponder the sounds of the beach, such as the sound of the waves, laughter of other beachgoers, seagulls, etc. She would muse on the feeling of being at the beach, examples like sand under her feet and sunshine on her shoulders. She would allow her imagination of all of the senses to become her internal focus (Weatherspoon, 2011).

For some women the internal focal point may turn toward the spiritual. Reflection on their god and the creation of life that is in process may be a central focus. Praying or reciting scripture may meet the cultural and spiritual needs of some women. Focusing on the unseen divine presence may give comfort and strength to allow the process of labor to unfold (McClure, 2012). Spiritual beliefs and rituals can be effective means of coping with numerous stressors including labor contractions (Fuller, 2012). Thus, for some the internal focal point of spirituality, faith, and hope can be a very powerful source of strength and comfort during labor (Waller-Wise, 2013).

For some women this internal focal point may take on a transcendence not unlike a hypnotic state. In this state the woman's mind would become separated from her physical being. It is a state of being where rather than being unconscious the woman would have a sharper sense of awareness and internal focus (Wilson, 2012). In a self-induced or practitioner-guided hypnosis, the woman is able to escape the painful experience of labor and keenly be conscious of the powerful work going on within her body. This type of intervention decreases the need for pharmacological involvement, and is not harmful to mother or baby (Sullivan, 2015).



External Focus

An external focal point is when the woman's focus turns away from herself to the external environment. Most often this is thought of as a single visual point. This external focus or focal point can be any number of singular points to any number of women. For some it could be the partner—their eyes or their face. For others it could be the photo of a beloved pet. Still others may choose to focus on an ultrasound photograph of the yet unborn child or pictures of older siblings to this child. She could choose some other reminder of the coming baby such as a baby toy, clothing, or a crib in the room. More still, she could pick an external focal point within the room in which they are laboring; such as a ceiling tile, a picture on the wall, a flower, the view from the window, or any other object in the room. Some women may want to focus on a single object throughout labor while others will want to change focal points often during labor. Women can use the focal point object until it no longer works to help lessen their pain sensation. It might be that a woman would concentrate on a line of objects or series of

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Putting Focal Points into Focus

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objects that are in her environment. For example, counting the ceiling tiles or following the edge of a window frame with her eyes. Other points of external focus are auditory, tactile (Simpkin, 2001), and olfactory (Sullivan, 2015).

An auditory focal point is a sound that the woman listens to while she is in labor. This sound might be the sound of her partner's voice (Simpkin, 2001). It could be the sound of her own voice as she repeats affirmations, recites rhymes or verses, sings, sighs, prays, moans, or chants (International Childbirth Education Association, 2011). Often such vocalization by the laboring woman is advantageous, as it releases tension and helps the laboring woman preserve a perception of powerfulness. An auditory focal point could be a white-noise sound. Many people find the sound of blowing wind, ocean waves, roaring engines, or rain showers to be soothing (Simpkin, 2001).

Music is an example of an auditory focus. Music therapy is thought to affect the limbic system of the brain, generating a release of endorphins from the right brain, thus producing a sensation of pleasure or pain relief (Talley, 2013). Research indicates that music therapy is an effective addition to assist in pain control. Music therapy is a safe, low cost, easy to provide intervention without known risks (Cole & LoBiondo-Wood, 2014). Again, this modality utilizes both sides of the brain. Auditory focus stimulates the left hemisphere of the brain to listen and count the beat of the music, while stimulating the right side of the brain to follow the melody (Hilbers, 2016).

Some women may prefer a tactile focal point. This is where the focus of the woman's attention is drawn to physical touch. This might be hugging or slow dancing rhythmically with her partner. Or it could take the form of rhythmically stroking or massaging a single part of her body by herself or by her partner (Simpkin, 2001). For example, a woman might rhythmically stroke her abdomen, often called effleurage (Weatherspoon, 2011). This tactile focal point helps to disperse pain sensation by improving blood flow and blocking pain signals (Sullivan, 2015). This type of focal point utilizes Melzack and Wall's Gate Control Theory of Pain (1965). This theory states that sensory stimuli are transmitting to the brain on fast conducting nerve fibers, while painful stimuli travel on slower conducting nerve fibers. When both sensory and painful stimuli travel to the brain at the same time, the sensory impulse arrives first and "closes the gate" so that the sensation of the painful stimuli is blocked (Hilbers, 2016).

Another type of tactile focal point is found with acupuncture or acupressure points. Acupressure also utilizes the Gate Control Theory of Pain (Weatherspoon, 2011). With acupressure, steady, consistent pressure is applied for between ten seconds and one minute, and then released for an equal amount of time. This pressure-release cycle can be repeated between three and six times in sequence. There are two acupressure points that are particularly noteworthy during labor. One is the Hoku, located on the back of the hand between the index finger and thumb at the junction where they meet. The other one called Spleen 6 is located on the inner aspect of the leg approximately four fingerbreadths above the ankle (International Childbirth Education Association, 2011).

Olfactory focal points involve breathing in pleasant smells, as with aromatherapy. With aromatherapy essential oils are used to aid in intensifying the woman's own tranquilizing, energizing and relaxing properties (Sullivan, 2015). Smelling these essential oils also affects the limbic system of the brain, enhancing the sense of calm and invigoration (Smith, 2012). The oils may be inhaled in different ways; through use of a commercial diffuser or in a spray bottle. A simple diffuser may be constructed by placing 5 drops of essential oil in a dark bottle along with about one-quarter cup of water, then occasionally "mist" the air with this mixture (Adams, 2012). Another simple diffuser can be made by boiling water and adding a few drops of oil to the steaming water (International Childbirth Education Association, 2011). Essential oils can also be used in a bath to provide aromatherapy. No more than 8-10 drops of the essential oil in a bathtub is the recommended amount for immersion (Adams, 2012).

Aromatherapy can be used in combination with tactile focus. By using a few drops of an essential oil in a carrier oil, such as olive or vegetable oil, an aromatic massage oil is created (International Childbirth Education Association, 2011). Carrier oils are used to dilute the concentration of the essential oil to avoid skin irritation. Other suitable carrier oils include sesame, sweet almond, and grapeseed (Smith, 2012). This combination oil could then be used by the woman herself, a partner, doula, or labor nurse as a massage oil to provide two forms of focus (International Childbirth Education Association, 2011).

Implications for Practice

Teaching prospective families about focal points has long been a topic in childbirth education classes but there is much more to the topic of focal points than simply using a single focal point (Simpkin, 2001). Focal points are still a pain intervention that should continue to be taught in

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Putting Focal Points into Focus

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contemporary childbirth education classes in an expanded form to include both internal and external focus, along with focus that includes the senses and both hemispheres of the brain. In addition to being taught in childbirth education classes, midwives, perinatal nurses and doulas should utilize and teach these strategies when providing labor support to clients in labor.

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Call for Papers for the ICEA Journal

You are encouraged to write a paper for the journal. Here are some upcoming themes. The list of topics and themes for articles that are being sought to submit for peer review include:

Military Families
Caring for a Newborn
Pain Management in Labor
Delivery Options and Trends
Unexpected Outcomes
Build Your Business
Evidenced Based Practice
Folk Practices
Birthing Through Time
Common Discomforts of Pregnancy

Please consider sharing your knowledge and expertise with ICEA members. **Deadline for the January issue (Common Discomforts) is November 1, 2016.**

Email your paper to editor@icea.org

Author guidelines can be found at:
<http://icea.org/about/icea-journal/guide-for-authors/>


International Childbirth Education Association

Protecting the Pelvic Floor during Pregnancy

by Christine Childers, PT MS GCS CEEAA

Abstract: Incontinence during and after pregnancy affects up to 30% of women. Hormonal changes during pregnancy, damage to the pelvic floor during delivery, age at first pregnancy, and body mass index all increase the risk of stress urinary incontinence. Pelvic floor exercises (Kegels) have mixed success, but when taught during pregnancy, have shown a decrease in postpartum SUI. Teaching Kegels is extremely important since many women perform them incorrectly. Frequency and intensity should be based on initial strength of the muscle with consideration for compliance. Other exercises are offered for those unable to perform Kegels correctly.

Keywords: pelvic floor exercises, stress urinary incontinence, pregnancy

Pregnancy can be an exciting time for women – it can be a time for designing a nursery, choosing names, and glowing. Few young women enjoying their pregnancy would want to think about incontinence; a concept that is strongly associated with aging and adult diapers, not the tiny ones with fun pictures that they may be purchasing for their nursery. Unfortunately, incontinence during and after pregnancy is relatively common, affecting from 5% to 40% of women (Thom & Rortveit, 2010). Incontinence significantly affects quality of life and psychosocial function (Allahdin & Kambhampati, 2012). It needs to be promptly and adequately addressed. The purpose of this article is to examine the incidence and causes of incontinence as a result of pregnancy and to recommend some noninvasive interventions that can be introduced during pregnancy to promote pelvic floor health.

The most common type of incontinence during and after pregnancy is stress urinary incontinence (SUI), caused by variations in the strength of the collagen, connective tissue, and muscles of the pelvic floor (Allahdin & Kambhampati, 2012). During pregnancy, hormonal changes and increased body mass add to the pressure on the pelvic floor, and type and duration of delivery can increase risk of damage to the pelvic floor (Chuang et al., 2012). Age at first delivery appears to be a risk factor, with those over the age of 25 at first delivery reporting a 5% greater risk of incontinence than those under 25 (Allahdin & Kambhampati, 2012). Allahdin & Kambhampati (2012) added that those over 35 years old with their first delivery appeared at greatest risk for development of incontinence. Age is not the only factor influencing SUI postpartum (Allahdin & Kambhampati, 2012), older women who have never had children are also at risk for the development of urinary incontinence. Interestingly, Broström and Lose (2008) found that although older age was significant for immediate development of SUI, younger age at first delivery was more significant for the later development of SUI.

In addition to age, body mass index (BMI) pre-pregnancy is of concern, and a BMI of greater than 25 is an independent risk factor for SUI (Anders, 2006). Physiologically, the additional weight of an increased BMI with or without the weight of a pregnancy increases intraabdominal pressure, which further increases the pressure on the pelvic floor during such activities as coughing, sneezing, laughing, and exercising (Anders, 2006). Maintaining continence involves sustaining pressure within the urethra through support from the bladder neck and proximal urethra. Should the bladder pressure be greater than the counteracting pressure of the urethral closure due to weakness or damage of ligaments and muscles, urine leakage will occur (Anders, 2006). Hormonal changes during pregnancy affect connective tissue, potentially weakening the structures providing the support to the bladder, and the pressure of the developing baby can displace the bladder. This combination of weakness and structural changes increases the risks of pelvic floor dysfunction.

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Protecting the Pelvic Floor during Pregnancy

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tion (Allahdin & Kambhampati, 2012). Add to these issues a cough, sneeze, or exercise, and urinary leakage can often occur.

In addition to the changes in the body that might increase the risks of incontinence during pregnancy, the type and duration of the delivery can also be a significant risk factor for the development of postpartum incontinence (Allahdin & Kambhampati, 2012). Allahdin and Kambhampati (2012) found that mechanical trauma during childbirth can be a major factor for the development of SUI, noting that most of the damage to the pelvic floor occurs during the second stage of labour when it is stretched and distended by the descent of the fetal head. Allahdin and Kambhampati (2012) reported a significant decrease in the development of SUI for those women who had a caesarean section. Thom and Rortveit (2010) remarked that women who experience instrumental vaginal deliveries are the most likely to experience SUI, followed by vaginal delivery, and agree with Allahdin and Kambhampati (2012) that caesarian section deliveries are the least likely to develop SUI. Another significant risk factor investigated by Chuang et al. (2012) in postpartum SUI was the presence of gestational diabetes mellitus. Women diagnosed with gestational diabetes mellitus were still experiencing symptoms two years post-delivery (Chuang et al., 2012). Thom and Rortveit (2010) concluded that approximately 30% of all women developed postpartum SUI with Chuang et al. (2012) emphasizing that the risk increases with the number of children delivered.

addressing the health and recovery of the pelvic floor should be a primary concern both during and after the pregnancy

Considering the numbers, addressing the health and recovery of the pelvic floor should be a primary concern both during and after the pregnancy. Sahakian and Woodward (2012) reviewed various studies in an attempt to establish whether pelvic floor exercises taught and encouraged during the pregnancy had an impact on postpartum SUI. Four of the studies examined showed a significant improvement in SUI postpartum in those who had participated in pelvic floor training during their pregnancy (Sahakian & Woodward, 2012). Those studies that reported no significance also appeared to be the interventions with the least aggressive programs (Sahakian & Woodward, 2012). Sahakian and Woodward concluded that use of pelvic floor exercises



during pregnancy appeared promising but that motivation and adherence were primary factors in success (Sahakian & Woodward, 2012). In contrast Agur, et al (2008) found no significant difference at an eight year follow up for those women who had been trained in pelvic floor exercises during the antenatal period. Although they also agreed that short term there was a significant difference in reports of SUI in those who had been trained in pelvic floor exercises compared to those who had not.

It would seem that addressing pelvic floor strength and health in the antenatal period is of benefit but the question still remains as to whether pelvic floor exercises are the key to relieving stress urinary incontinence. Surgical interventions are common and include retropubic colposuspension, pubovaginal sling, and radiofrequency bladder neck suspension; each of which carries various levels of success and satisfaction (Carpenter & Visovsky, 2010). More conservative, nonsurgical intervention is usually the first line of treatment, but the effectiveness of nonsurgical management is under scrutiny. Brostrøm and Lose (2008) demonstrated a lack of clinical significance to support the use of pelvic floor exercises peripartum in the prevention of incontinence postpartum, although they do state that the intensity and frequency of the program may be significant. Brostrøm and Lose also confirmed that six years postpartum there was no difference between intervention and control groups. On a positive note, Allahdin and Kambhampati (2012) cited a Cochrane review that reported a decrease in incontinence for those women performing pelvic floor exercises antenatally and lower risk postpartum with exercises. Brostrøm and Lose (2008) reported no adverse events associated with pelvic floor exercises other than potential guilt or loss of self-esteem if they failed, thereby indicating that no harm is being done by trying these programs; however, they further added that many individuals are not performing pelvic floor

continued on next page

Protecting the Pelvic Floor during Pregnancy

continued from previous page

exercises correctly which may be of significance for the apparent failure of these programs.

Teaching pelvic floor exercises, commonly called Kegel exercises, needs to be done thoroughly and appropriately. Broström and Lose (2008) stated Kegel exercises were only performed correctly in one out of four women, all of whom had supposedly been taught how to do them by a medical professional. Hulme (2008), an expert in pelvic floor health, admits that many individuals feel that Kegels fail to help them, often due to lack of full understanding of the exercise and inability to know if they were performing them correctly. Hulme states that often the pelvic floor is not the only structure involved in incontinence and additional interventions should be introduced including lifestyle modification and other exercises that extend the strengthening beyond the pelvic floor. These interventions, along with use of technology, will be discussed later, but the primary issue appears to be to insure that women are taught pelvic floor exercises correctly and encouraged to work with them on a regular basis. Anders (2006) stressed the need for clear instructions and motivation and tailoring the program to each individual's need and starting point.

How should a Kegel be taught? As a physical therapist who has taught many women pelvic floor exercises, the following suggestion is a mixture of clinical experience, advice from teachers and mentors, and extensive reading.

First locate the pelvic floor. Use imagery to describe the location of the muscles: a hammock slung from the front to the back of the pelvis or a muscle shaped and located like a traditional sanitary napkin or light incontinence pad. Then ask the woman to sit upright on a firm surface at which point the muscles in question should be felt against the surface. Once located, start to describe the actual contraction.



Squeeze the muscles together as if trying to stop the flow of urine. It should feel as if the muscles are lifting off the surface on which they are sitting. Use an elevator analogy to feel the muscles lifting up to the second and third floors and then hold. Slowly release the muscles back to the ground floor.

Teach the woman how to evaluate if they are doing it correctly. Suggest any of the following options. 1) Insert two gloved or tissue wrapped fingers (their own) into the vaginal area and try the exercise. They should feel the fingers being squeezed by the muscles although initially this may be light. 2) Try and stop the flow during urination but not the first time of the day. As they try to stop the flow they will learn two things: firstly if they can stop the flow they have a good contraction, and secondly, if trying to stop the flow feels exactly the same as their exercise they are doing it correctly. This type of evaluation should only be attempted once a week as it disrupts urination and will train the bladder to not fully empty if used too often. 3) During sexual intercourse, practice the exercise and ask for feedback from their partner.

Finally, practice the exercise in two different ways. The first is slow: contract, hold for three seconds, and release. The second is rhythmic and steady: contract, release, contract, release. When teaching these exercises, the medical professional should not see any movement if the patient is seated and dressed. The buttocks and abdominal muscles should remain relaxed and not be involved.

There are conflicting reports on the optimum frequency and intensity for these exercises (Borello-France, 2012). Success has been noted with up to 200 contractions daily, or 5 of the shorter and 45 of the longer contractions, or 8-12 contractions up to three times a day, and also a combination of 60 fast and 30 slow contractions (Borello-France, 2012). The general conclusion is that the initial strength of the contraction should be considered before advising of the frequency. The number of contractions should be slowly increased to avoid muscle fatigue and be numbers appropriate to encourage adherence (Borello-France, 2012). Adherence is a big concern due to the generally slow changes, although some women will see faster improvements than others (Barbato, Wiebe, Cline, & Hellier, 2014). Adherence may be improved through the use of technology. Although not currently researched for pelvic floor exercises, mobile phone applications have proven successful for exercise adherence in other populations (Morris et al., 2010). Similarly, Barbato et al. (2014) demonstrated success with a fully online program for pelvic floor retraining. For those women for whom exercise is insufficient for success, electrical stimulation has mixed results (Borello-France, 2012). The use of vaginal cones or

continued on next page

Protecting the Pelvic Floor during Pregnancy

continued from previous page

balls has limited research but is under review (Oblasser, Christie, & McCourt, 2014). More invasive analysis of their contraction from a qualified women's health professional can confirm if the exercises are being performed adequately and correctly with additional biofeedback and electrical stimulation as needed (Hulme, 2008).

Hulme (2008) also advocates for additional exercises for strengthening the pelvic floor that include seated medial and lateral rotation exercises. Hulme also recommends that the client stand with their toes turned out in the "ten to two" position and bend the knees, thereby performing a classic ballet plie. This is an excellent additional strengthening exercise for the pelvic floor and one often more easily understood. Overall the consensus appears to be to teach conservative exercises first, but this must be with clear instructions, tailored to the individual, and taught in a positive and encouraging manner to promote adherence (Anders, 2006).

In conclusion, potentially one in three women will experience incontinence during their pregnancy or postpartum. Pelvic floor exercises have been shown to assist with prevention and improvement of SUI, although compliance and correctness of the exercises are issues that can result in less than optimal results. Teaching pelvic floor exercises, or Kegels, during pregnancy regardless of the presence of incontinence, has been shown to decrease the risk of incontinence both during the pregnancy and postpartum. Correct, accurate teaching at a time when the woman is able to focus and participate fully, not distracted by their newborn, cannot do harm and can provide extensive improvement in both quality of life and psychosocial function. Medical professionals working with women during their pregnancy should be educating and accurately teaching pelvic floor exercises and encouraging compliance. If a simple exercise can decrease the risks of incontinence with its significant psychosocial impact, it is worth the time of all the professionals to assist with teaching.

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Reducing Stress in Infants: *Kangaroo Care*

by Meredith Baker-Rush, MS CCC-SLP/L

Abstract: Labor, delivery, and the care immediately following birth create stress on infants. Kangaroo Care (KC), or skin-to-skin contact between the parent and infant, aids in parental bonding and infant calming. Biological and psychological benefits for the infant using KC include, yet are not limited to, regulation of temperature, heart rate, oxygen, sleep-wake cycles, and a reduction in pain and crying time. Doulas and midwives can educate mothers of the benefits of KC, utilize KC to calm infants, and increase the social bond between parent and infant.

Keywords: infant, baby, Kangaroo Care, sensory, touch, sound, calming, midwife, doula

Stress can be defined as a biological and psychological response to a given action or situation (Contrada, 2011). Many factors may produce a biological or psychological response and the presence of ongoing stress may result in disease or illness (Cohen, Kessler, & Gordon, 1997). However, most empirical literature emphasizes that stress is when an action or situation exceeds the ability to adapt to or to find balance (Contrada, 2011). In the matter of labor, delivery, and post-delivery, infants are exposed to many different types of stressors including but are not limited to the burden of labor, environment (internal or external), and/or medical needs. The burden of labor includes length and intensity of the labor, the mother's physical abilities or limitations, and the fetal development of the baby. The environment may include the mother's physical changes in labor (e.g., contractions), pushing, visceral changes (e.g., blood pressure, heart rate, oxygenation), or stress hormone changes. After delivery, the environment may include medical procedures im-

mediately performed on the infant, lights and sounds in the room, or the separation from the mother. These factors occur in healthy "normal" births as well as in births with complications or illness. Stress on the infant will be present in all situations regardless of the health of the infant. In matters of premature, ill, or complicated deliveries, the stressors will exceed the "average." It is important to incorporate anti-stress methods in efforts to calm an infant, one such natural method, and the subject of this article, is known as Kangaroo Care (KC).

KC is a technique in which the clothing of the infant is removed (except the diaper) allowing their body, legs, arms, and face to have direct skin contact to the parent's bare chest or torso.

KC is a technique in which the clothing of the infant is removed (except the diaper) allowing their body, legs, arms, and face to have direct skin contact to the parent's bare chest or torso. The term "parent" regarding direct skin contact refers to maternal, paternal, and surrogate (Ludington-Hoe, 2011). The skin-to-skin contact of chest to chest has been found to increase the release of oxytocin, a neuronal hormone that reduces stress, increases bonding, and trust (Gianaros & O'Connor, 2011; Uvnäs-Moberg, 1998) and has been reported to have pain-relieving effects in infants (Ludington-Hoe & Hosseini, 2005). In addition, oxytocin has been found to decrease the stress hormone cortisol, and stimulate the vagus nerve, which connects with various organs and muscles in the body.

KC incorporates multisensory aspects including but not limited to touch and proprioception (the body's ability to feel the parent holding the infant), hearing (exposure to the sound of the parent's heartbeat), positioning (laying against the chest and skin of the parent), movement or vestibular (feel of the rhythmic breathing of the parent), and thermal or

continued on next page

Reducing Stress in Infants: Kangaroo Care

continued from previous page

temperature (Cong, Ludington-Hoe, & Walsh, 2011). KC is a natural behavioral technique (e.g., placing the infant on the parent via skin-to-skin), found to aid in parent bonding and infant calming rather than administering medicine or the need for invasive procedures.

History of KC

KC was originally studied in 1970 (Ludington-Hoe, 2011). The initial research included the mother and full-term infant, focusing on the mother's behaviors toward the infant and parent-child attachment (Barnett, Leiderman, Grobstein, & Klaus, 1970). The research resulted in a positive change in healthcare by creating rooming-in (i.e., the infant sleeping in the same room as the parent) with the focus on child-parent attachment, however the element and potential benefits of skin-to-skin were initially disregarded (Ludington-Hoe, 2011). In 1983, researchers from Colombia began investigating skin-to-skin contact between pre-term infants and maternal parents which resulted in an increase in research by European and Scandinavian neonatal specialists (Ludington-Hoe, 2011). Through this expanded research, by 2011, KC was endorsed by the American Academy of Pediatrics, American Heart Association, American College of Obstetricians and Gynecologists, Association of Women's Health, Obstetric and Neonatal Nurses, as well as the United States Centers of Disease Control for full term infants (Ludington-Hoe, 2011).

Benefits of KC

The benefits of KC include biological and psychological elements for both the parent and infant. For the parent, gains center on eight themes in the research literature: confidence, physical effects on the parent and infant, bonding, constructing parental role, information and communication between parents and nurses, support of family/partner, parents' physical needs, and the NICU environment (Gabriels, Brouwer, Maat, & van den Hoogen, 2015). Ultimately, the primary gains were identified as increased parent involvement in the care of the infant, increased confidence of the parent, a sense of purpose and role as a primary caregiver, and "special" connections between the parent and infant (Gabriels et al., 2015).

More striking are the benefits for the infant. These are noted in the physiological and biological changes such as temperature, heart rate, sleep-wake cycles, reduction of pain,

and oxytocin release (Bystrova et al., 2003; Cong et al., 2011; Feldman, Gordon, Schneiderman, Weisman, & Zagoory-Sharon, 2010; Ludington-Hoe, 2011; McCain, Ludington-Hoe, Swinth, & Hadeed, 2005).

Temperature

Bystrova et al. (2003) evaluated full term infants maintaining or increasing body temperature given either KC (skin-to-skin), mother's arms (infant clothed but in the mother's arms), or in the nursery (clothed and in a bassinet or swaddled in a bassinet). The infants who were in the skin-to-skin group demonstrated a higher temperature rectally as well as in the feet. The feet temperatures remained throughout the hospitalization in the skin-to-skin group while in other groups, temperatures were lower (Bystrova et al., 2003). The authors speculated that the sensory system was activated by the skin-to-skin contact through the proprioceptive aspects of KC, which resulted in temperature regulation (Bystrova et al., 2003). In other words, the way the infant's body interpreted the sensations in KC created a neurological chain reaction resulting in benefits of regulating and maintaining the infant's body temperature. Even with preterm infants (e.g., birth prior to 36 weeks), skin-to-skin contact resulted in temperature elevation (Bauer et al., 1997). In addition, Bauer et al. (1997) noted that the change in air temperature during the transition from the nursery to the skin-to-skin contact did not affect the rise in the infant's temperature elevation when skin-to-skin on the parent. In both full-term and preterm infants, the use of skin-to-skin contact resulted in a rise in the infant's body temperature, maintenance of the temperature, and positively influenced distal blood flow to the extremities (i.e., arms and legs).

Heart Rate, Sleep-Wake Cycle, and Oxygenation

The measurement of the heart rate provides the healthcare team with information related to the heart contraction rate over a set period of time (e.g., a minute). Physiologically, with each breath, a neurological signal is sent to the heart to increase or decrease the rate of contraction (i.e., pumping). The nervous system is regulated by two competing systems, one that excites (i.e., speeds up) and one that depresses (i.e., slows) activity. The heart works together with the respiratory system through the nervous system signals by means of the excitation system (i.e., sympathetic) and depressive (i.e., parasympathetic) system (Feld & Eidelman, 2003; McCain et al., 2005). Few studies have looked at the benefits of KC on heart rate variability (HRV), yet the results are consistent. Infants who used KC demonstrated better neurodevelopmental growth as demonstrated by improved HRV (Feld & Eidelman, 2003; McCain et al., 2005). Additional study is

continued on next page

Reducing Stress in Infants: Kangaroo Care

continued from previous page

warranted, however; current results of KC research indicate significant positive outcomes as it relates to decreasing stress and improving HRV.

Infants have a series of “states,” or levels of consciousness (Gottesman, 1999; White, Simon, & Bryan, 2002). These include quiet sleep, active sleep, drowsiness, quiet alert, active alert, and crying (Gottesman, 1999). The sleep states, including quiet and active sleep, typically last 60 minutes in length and transition to drowsiness prior to the infant awakening (Gottesman, 1999; White et al., 2002). A conscious/awake infant can also move through the alert states (e.g., quiet alert, active alert, and crying) and transition to drowsiness then into the sleep states. These states and the progression between states is normal infant behavior. However, environmental stimuli can alter or rapidly change an infant’s state (e.g., heel stick, bright lights, and loud sounds) which can create additional stress and a disruption in the infant’s ability to regulate sleep-wake cycles as they relate to state.

Several studies have found that the use of skin-to-skin contact aided in calming a crying or excited infant (Bohnhorst, Heyne, Peter, & Poets, 2001; Feldman et al., 2010; Feldman et al., 2002; McCain et al., 2005). For example, a stressed infant in a crying state was placed skin-to-skin to the mother resulting in a change in the infant’s respiratory and heart rate (within 30 seconds) and the infant was able to maintain a calm resting state for 40 minutes (McCain et al., 2005). Feldman et al. (2002) assessed premature infants and the impact of KC on the sleep-wake cycle. Results found those infants who utilized KC demonstrated an improved rhythm of sleep wake cycle and those with a medical risk showed a greater benefit overall in which the infant was able to stay awake and rest in the normal sleep wake patterns. These findings support the infant’s ability to improve his or her regulation of sleep and periods of wakefulness. In contrast to many studies related to heart rate, oxygen consumption, and temperature, Bohnhorst et al. (2001) noted that in preterm infants (e.g., ages 24–31 weeks), bradycardia (i.e., slow heart rate) and hypoxemia (i.e., low oxygen intake) with less regular breathing was noted. Considerations of infant head positioning and placement on the parent was a noted limitation, however, for purposes of infant safety, heart rates and oxygen saturations are recommended to be monitored on preterm infants when engaging in KC.

Reduction of Pain and Crying Time

Infants are likely to undergo various procedures to ensure health after birth and while in the hospital. The most common is a heel stick for purposes of obtaining blood. The use of KC for pain regulation or remediation was studied in both preterm and full-term infants. Ludington-Hoe and Hosseini (2005) assessed the impact of KC on preterm infants (aged 37 weeks) during heel sticks. Heart rates, states of alertness and duration of crying was noted throughout the study (Ludington-Hoe & Hosseini, 2005). Results indicated that given the use of KC, infants demonstrated reduced heart rates and crying duration (Ludington-Hoe & Hosseini, 2005). In addition, several infants in a deep sleep state did not cry at all despite the needle stick (Ludington-Hoe & Hosseini, 2005). However, the timing of the KC prior to the heel stick is important. Using KC within 30 minutes prior to the heel stick has demonstrated the greatest results in decreasing pain (Cong et al., 2011).

The theory that skin-to-skin contact between the infant and parent provides pain-relieving methods continues to be explored in infant populations with disorders, difficulties, or discomfort. Infants with colic (i.e., fussiness and crying in otherwise healthy infants) are another group in which KC may provide comfort or calming of symptoms (Rad et al., 2015). In a quasi-experimental study, infants aged 15–60 days were evaluated with KC and the potential impact on their crying duration and fussiness (Rad et al., 2015). Prior to initiating KC, colicky infants presented with an average crying duration of 2.21 ± 1.54 hours per day. After the use of KC, crying durations decreased to 1.16 ± 1.3 hours per day (Rad et al., 2015). Similar to the work of Bystrova et al. (2003), the theory of sensory system activation due to skin-to-skin contact through the proprioceptive aspects of KC, warrant ongoing study.

Summary

The impact of kangaroo care on temperature, heart rate, sleep-wake cycle, and oxygenation, and pain reduction is being universally studied. KC has consistently demonstrated positive calming effects on the full-term and preterm infant. The benefits extend far beyond the parent child bonding, and researchers have hypothesized KC may positively influence the neurological system and aid in cognitive and physical development. Additional research is needed in this area, however, based on the literature to date and the overall positive results of KC over the past 40 years of research, doulas, nurses, and midwives can quickly teach parents how to use KC and explain the general benefits with very few contraindications found in current literature.

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Reducing Stress in Infants: Kangaroo Care

continued from previous page

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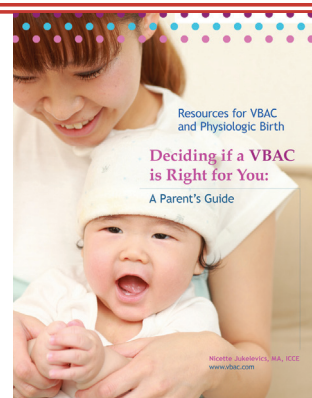
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Sensory-Based Calming Strategies for Infants

by Lee Stadtlander, PhD

Abstract: Crying in infants is a normal physiological response; however, prolonged crying can produce a great deal of frustration and stress for new parents and has been found to be related to shaken baby syndrome. Offering parents a range of calming options for their infants gives them a sense of control and connection to the infant. The process of calming their crying baby boosts parents' confidence, creates a growing sense of trust within the infant, and sets the foundation for establishing a positive parent-infant relationship. This article explores sensory-based calming techniques and provides resources for parents as well as the childbirth professional.

Keywords: calming infant, soothing infant, calming strategies, soothing strategies

Crying in infants is a normal physiological response and is a form of communication with their caregivers. Crying can be caused by different stimuli, such as hunger, discomfort, pain, or simply the baby's need to approach the caregiver for emotional comfort and safety (Halpern & Coelho, 2016). Excessive crying occurs in up to 30% of infants before the age of three months (Kim, 2011; Reijneveld, Brugman, & Hirasing, 2001) and contributes to parental stress, often leading parents to exhaustion without solving the problem. Excessive crying is defined for a newborn up to 4 months of age as crying spells and irritability for three or more hours a day, three days a week, and at least for one week, while maintaining normal child development (Halpern & Coelho, 2016). The ongoing frustration and stress of continued crying can lead parents to take dangerous measures in an attempt to calm the infant (Reijneveld, van der Wal, Brugman, Sing,

& Verloove-Vanhorick, 2004), including the indiscriminate use of painkillers and sedative medications with the child as well as smothering or slapping the infant. There are several studies showing that excessive crying without quick resolution in infants is one of the causes of shaken baby syndrome (Duhaime, Christian, Rorke, & Zimmerman, 1998; Reijneveld et al., 2004).

Being able to calm their baby reinforces parents' continued use of specific techniques that calm the infant and reduce their frustration and stress. This process boosts parents' confidence, creates a growing sense of trust within the infant, and sets the foundation for establishing a positive parent-infant relationship (Dayton, Walsh, Oh, & Volling, 2014). Parental frustration may arise when a calming technique that had been effective previously with an infant becomes ineffective. However, if parents have a wide repertoire of strategies available and if they can flexibly adapt their strategies as the infant matures, they may be less upset and frustrated in response to infant crying (Dayton et al., 2014). This article explores sensory-based calming techniques that childbirth professionals may wish to recommend to new parents as well as additional resources for parents and professionals.

The Sensory Basis for Calming Infants

Before birth, the uterus tightly surrounds the infant into the fetal position. In this position, the infant is constantly massaged and touched by the walls of the uterus and rocked through the mother's movements. There is also a constant background noise of the mother's heartbeat and shushing sounds of blood through the umbilical cord and amniotic fluid (Karp, 2015). The sensory strategies discussed in this article all help the infant move from the pre-birth environment to the post-birth environment. It is important to note that combinations of these strategies are often necessary (particularly combined with touch and movement strategies) and parents should carefully watch for their baby's preferences. In addition, it tends to be much easier to practice the methods initially while the baby is calm, rather than attempting them in the midst of crying.

continued on next page

Sensory-Based Calming Strategies for Infants

continued from previous page

Touch Calming Strategies

Massage. Infant massage (IM) is a traditional care practice particularly widespread in Africa and South Asia (Field, 2000) and over the past decades in Western countries (Underdown, Norwood, & Barlow, 2013). IM can be defined as “a systematic touch by human hands, which stimulates the tactile sense of the infant” (Abdallah, Badr, & Hawwari, 2013, p. 663). IM consists of an often standard sequence of traditional Swedish and Indian massage techniques, yoga, and reflexology, and it can be applied to the child’s arms, legs, back, chest, belly, and face, using vegetable odorless oil (e.g., see McClure, 2000).

IM may help to establish eye contact as well as a sensitive tone of voice and touch, which in turn may help both the development of the baby’s ability to regulate emotions (Belsky, 2001) and the parental attachment relationship (Beebe & Lachmann, 2002; Slade, 2005; Tronick, 2007). IM has been reported to help in decreasing depression in parents and aid in bonding with the infant (Gnazzo, Guerriero, Di Folco, Zavattini, & de Campora, 2015). The resource section of this article contains videos and books that go into detail on IM techniques.

Swaddling. Some degree of infant restraint, known as swaddling (also called binding or bundling), with or without the use of a cradleboard, was an almost universal childcare practice before the 18th century (Lipton, Steinschneider, & Richmond, 1965). Swaddling is still common in some countries in the Middle East and South America, and it is gaining popularity in the United Kingdom, the United States, and the Netherlands (van Sleuwen, Engelberts, Boere-Boonekamp, Kuis, Schulpfen, & L’Hoir, 2007). Swaddling infants and sleeping on the back appears to promote a better efficiency of sleep, more quiet sleep, and fewer spontaneous awakenings compared to sleeping on the back unswaddled (Franco, Seret, van Hees, Scaillet, Groswasser, & Kahn, 2005).

It is important for caregivers to accomplish a secure swaddle to ensure the blanket does not become loose and the baby remains wrapped during the sleep period. The act of swaddling does carry a risk of the baby overheating if the caregiver uses multiple blankets that are too thick or uses thick fluffy fabric that creates excessive thermal insulation (van Gestel, L’Hoir, ten Berge, Johannes, Jansen, & Plötz, 2002).

To avoid hip dysplasia risk, the swaddle should be wrapped in such a way that the baby is able to move his or her legs freely at the hip (Baby Center, 2016). This is more easily done with a large blanket that can keep the arms in place while allowing the legs flexibility, all while allowing for proper hip development.

Movement Calming Strategy

Rhythmic movements or swinging mimics the feeling of movement within the womb and is a powerful calming strategy (Karp, 2015). The use of slings and rocking chairs provide a natural motion for parents to soothe their infant; typically, jiggles or small movement calms better than larger movements. Other options for busy parents are infant swings and rocking or jiggly smart sleepers.

Visual Calming Strategies

Low light. There has been some empirical evidence from newborn intensive care units that low light calms infants (Zavgorodnii, Semenova, Chehovskaya, Piontkovska, & Besh, 2007). Low light has also been recommended in the popular press as a mechanism to calm fussy infants (Voss, 2014).

Auditory Calming Strategies

Shushing. Within the womb, infants hear a constant white noise-like sound similar to shhhh. Making this noise at a level similar to their crying level next to the baby’s ear will often calm them (Karp, 2015). Machines making a continuous low white noise (similar to the sounds of vacuum cleaners or fans) are also effective and commercially available.

Singing. The singing of infant directed songs (e.g., *Itsy Bitsy Spider*, *Frère Jacques*), with higher pitches, slower tempos, and more regular timing than adult songs, has been found to be soothing to infants (Corbeil, Trehub, & Peretz, 2015). Singing by the parent, typically also accompanied by movement, is most effective, but recordings of infant directed songs can also be used for calming.

Gustatory Calming Strategies

Pacifiers. Sucking is a basic reflex in infants and forms the basis for nutrition; however, it also provides a calming technique with pacifiers. Sucking a pacifier has been reported to lower the infant’s heart rate, blood pressure, and stress levels. The use of a pacifier has also been reported to lower the risk of sudden infant death syndrome (SIDS; Fleming et al., 1999). Pacifiers should not be introduced until breastfeeding is well established.

Implications for Childbirth Professionals

A crying infant can produce a great deal of frustration and stress for new parents. Offering parents a range of calming options for their infants gives them a sense of control and connection to the infant. There are a number of resources available to give additional advice and techniques, which are listed in the Resources section of this article.

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Sensory-Based Calming Strategies for Infants

continued from previous page

Suggested Resources

DVD

- *Infant Massage: The Power of Touch* - DVD (2003). Demonstrates the basic massage strokes and then devotes special time to massage techniques
- *Massage Practice for Infants* - DVD (2008). Step-by-step techniques that help relax the baby and relieve common physical discomforts.

Books

- Ady, M. (2008). *An infant massage guidebook: For well, premature, and special needs babies*. Bloomington, IN: AuthorHouse.
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Website

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Addressing the Risk of Postpartum Depression in Female Veterans

by Sara L. Schroeder, RN BSN

Abstract: Female Veterans are the fastest growing demographic within the Veterans Affairs. Today's female Veteran is likely younger, likely deployed multiple times and may have posttraumatic stress disorder (PTSD). Research indicates that women with PTSD are at a greater risk for experiencing postpartum depression. VA provides maternity services, but the caregivers are normally outside the VA health care system. For this reason, it is imperative that non-VA providers are aware of the increased risk of post-partum depression and tools that are available to screen and advocate for this unique population. Resources are available within the VA to assist these female heroes through a potentially difficult time.

Keywords: postpartum, depression, female, veterans, education

The face of the “typical” Veteran is changing, and there is an increasing chance that it is a female who is under 48 years old, has experienced more than one deployment and is affected by Posttraumatic Stress Disorder (PTSD) (U.S. Department of Veteran Affairs, 2015). The female population is, in fact, the fastest growing segment of the Veteran Affairs (VA), (U.S. Dept. of VA, 2013).

This growing demographic requires that additional attention be given to emerging trends and health care needs of female Veterans. One identified need is postpartum

depression (PPD) screening for female soldiers. Many factors contribute to making this a difficult problem to manage, mainly because over 80% of female Veterans do not receive primary care through the VA and virtually all maternity care in the VA is provided by non-VA providers (U.S. Dept. of VA, n.d.-3).

Increasing Female Veteran Population

The increasing female Veteran population is of great importance to the Department of Veteran Affairs, and there has been a concentrated effort to improve services for the female population in recent years. Female soldiers are affected by their service and deployments, the same as their male counterparts, but have unique needs in their care.

During the years of 2000-2014, almost 153,000 cases of PTSD were identified per the criteria established by the U.S. Army Office of the Surgeon General (Dept. of Defense, 2014) in combat/non-combat military forces. During this same period, the female population was 16.5% of the total military force (Fischer, 2014). While the PTSD cases cited above were not broken down by gender, based on the 16.5% female population, this could equate to over 25,000 female Veterans suffering from PTSD.

Postpartum Depression

The National Institute of Mental Health estimates that 15% of pregnant women experience postpartum depression (PPD) every year (U.S. Dept. of Health and Human Services, n.d.) however, that number may be higher based on differing criteria, postpartum time frame used and specific populations (O'Hara & McCabe, 2013). There is the need for more research but some studies suggest that a woman with PTSD may have a higher risk for developing postpartum depression (PPD) within one year after giving birth (Nguyen et al.,

continued on next page

Addressing the Risk of Postpartum Depression

continued from previous page

2013). This evidence gives support to the need for a practice of regular PPD screening and education for our female Veterans before birth and during the first year postpartum.

Screening Strategies

There is considerable debate as to whether screening for PPD during the prenatal or postpartum period is beneficial. Thombs et al. (2014) reported that PPD screening for all women is not cost-effective due to the incidence of false-positive screening and the subsequent follow-up referrals that are required. However, pregnant female Veterans may have diagnosed or undiagnosed PTSD, which can be a risk factor for developing maternal depression (Nguyen et al., 2013). If providers are unable or unwilling to screen all women for PPD, there should at least be a serious consideration for screening each new maternity patient for Veteran status.

If a patient is a Veteran, additional questions can be asked such as whether she experienced combat, deployments, military sexual trauma, or has been diagnosed with PTSD. An answer in the affirmative to these questions could place the Veteran at a higher risk for PPD (Nguyen et al., 2013). When a Veteran is identified as high risk for PPD, the provider can then begin a proactive educational process with the Veteran, which not only makes the Veteran aware of her heightened risk but also teaches her what symptoms to watch for and how to seek treatment if she experiences PPD. The PPD conversation should occur at each prenatal visit and particularly, when the Veteran has come to a facility to give birth. When warranted, the Edinburgh Postnatal Depression Scale (EPDS) can be used to screen pregnant and postpartum women (Siu et al., 2016).

During hospital admission for childbirth, the Veteran will likely have at least one close acquaintance, family member or significant other with her who can learn the signs and symptoms of PPD. Often, it is friends and family that are the first to notice that a woman may be having difficulty in the postpartum period (U.S. Dept. of Health and Human Services, n.d.). Educational material and resource information can be included in the baby's take-home bag.

Of greatest importance is that maternity caregivers and primary care providers consider screenings for PPD throughout the first year postpartum, for those women at high risk. Continued assessment in the first year postpartum is important because there is research that indicates some women may screen negative 4-12 weeks after childbirth but will screen positive for PPD as much as 6-12 months after

childbirth (Yawn, Bertram, Kurland, & Wollan, 2015). Some providers are concerned that once they identify PPD, there may be no help available for addressing the urgent need. However, resources are available for the Veteran and the non-VA provider.

Resources for Female Veterans at Risk

The U.S. Department of Veterans Affairs (n.d.-1) reports that every VA Medical Center has a Women Veteran Program Manager (WVPM) who is a Registered Nurse, Physician Assistant or Social Worker. This individual is responsible for overseeing the needs of female Veterans to assure there are no barriers to timely and quality health care (U.S. Department of Veteran Affairs, n.d.-1). The WVPM is an advocate for female Veterans and can be a wonderful resource for female Veterans that are already receiving VA health care and those who are interested in applying for eligibility. Another responsibility of the WVPM is to educate female Veterans on VA health care benefits for those who are not receiving care through the VA. The WVPM is typically located at the main VA health care facility but serves all female Veterans within the designated coverage area.

If a non-VA provider has a female Veteran who is identified as being at risk for PPD, a call can be placed to the WVPM for information on local services. If the Veteran is not signed up for VA health care, the WVPM can put the Veteran in touch with eligibility services to establish if qualifications are met. Once eligibility is determined, the WVPM can assist the female Veteran with coordination of care to include seeing a primary care provider as well as mental health providers. The WVPM can also assist with local resources such as support groups and other peer support networks. There are numerous handouts that the WVPM can provide to a non-VA provider, to be used for Veterans who may be interested in VA services. For example, handouts on the Women Veteran Call Center, Veteran Crisis Line, or brochures on female health care services offered through the VA, are all available simply by calling the local WVPM.

Another resource that is available to female Veterans at risk for PPD is a local Vet Center. These facilities are designed to provide readjustment counseling, free of charge, to combat Veterans and their family members (U.S. Dept. of Veteran Affairs, n.d.-2). Vet Center patient charting is separate from the VA's healthcare charting system, which can be important to Veterans who are hesitant to seek mental health care through the VA.

An additional resource for any non-VA provider who cares for female Veterans is www.va.gov. This site provides a search option for all locations and services within the VA

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Addressing the Risk of Postpartum Depression

continued from previous page

system. Under the heading of “Health,” you will also find direct links to VA programs such as PTSD, Mental Health and Women’s Health.

Conclusion

Every day there are cries in the media for the VA to provide better care for our nation’s Veterans. Unfortunately, there are some situations where the VA cannot do it alone. A possible option for identifying those females at risk for PPD may be for maternity caregivers and non-VA providers to complete screenings, provide education, and refer to resources as needed. In the case of pregnant Veterans and PPD screening, it cannot only be initiated by the VA because the majority of female Veterans receive maternity care outside the VA healthcare system.

More importantly, PPD screening cannot be a one-time effort. Our female Veterans need providers to commit to help them through a potentially troublesome time in their life. It is not enough to just identify those at risk but follow through on referrals for intervention is also needed. If untreated, PPD has the potential of negatively affecting both the Veteran and her child throughout the life span. Regular and consistent PPD screening is necessary to address our nation’s heroes’ needs and requires a concentrated effort by every provider who works with pregnant female Veterans for us to be successful.

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Korean Forest Taegyo for Reducing Stress and Emotional Instability during Pregnancy

by Yuna Lee, Jiyoung Lee, and Ninez B. Tulo

Abstract: The Korean Forest Taegyo Program is a forest retreat for pregnant couples. The intention is to educate and allow the experience of nature's peace and healing to promote a more mindful and nurturing pregnancy. Concepts from the program and benefits to the pregnancy, baby, and couple are discussed.

Keywords: Taegyo, pregnancy stress, emotional instability, Forest Taegyo

Pregnancy is a life event where physical, psychological and social changes are prominent. At the same time, this phase of life is a turning point for not only the mother but also the family as it changes and expands. Because of these components, the mother may suffer depression, stress, anxiety, or degradation of self-esteem. These released emotions of the mother influence maternal fetal attachment and her relationship to the other family members (Kim, 2014).

In the early stage of pregnancy, women may have ambivalent feelings, hyperemesis, and fatigue. In its late stage women may feel fear of delivery and pain, together with various mental, physical, and financial stressors. Pregnancy stress is known to have negative effects on a pregnant woman's physical state and mental well-being (Itsvan, 1984; Lazarus & Folkman, 1984). High stress in pregnancy has been shown to be associated with low birth weight for babies and higher chances of premature delivery (Copper et al., 1996; Hedegaard, Henriksen, Sabroe, & Secher, 1993). Pregnant women's emotional instability has been correlated to higher rates of children's aggression, anxiety, and other behavioral disorders (Jo & Kim, 2007). In Korean culture it has always been believed that the fetus can feel the mother's emotional state through the umbilical cord. The mother's hormones may affect the fetus' sensibility. Emotions are chemical-based neural reactions that could very well pass to the baby. The

fetus' autonomic nervous system receives the mother's stress, anxiety, worry, anger, and sadness (Parcells, 2010; Wadhwa, 2005). There is a need for psychological intervention programs for reducing stress and increasing physical relaxation in pregnant women.

Forest Taegyo Program is a childbirth education program based on the Korean traditional taegyo. Forest Taegyo Program is a nature-friendly approach that includes various taegyo activities in a physical forest environment. These activities include forest sensory experience, meditation, wisdom from the forest, nature mobile arts and crafts, forest concert, wind shower, and childbirth education for the couple. It is a green cradle which helps protect health and a sanitarium which recovers health (Kim, 2006).

Through communing with nature, pregnant women induce positive sensitivity. This communicates to the growing baby. Pregnant women learn to co-exist with other living things. They participate in nature mobile arts and crafts activities. They will be at ease in forest meditation and raise friendly feelings with their babies. Meditation in the forest allows pregnant women to relax their minds and bodies, and there is increased intimacy in the mother-fetus relationship.

Korean Forest Taegyo Program

According to Pungipssong, there are seven attitudes which could be taken as seven virtues for pregnant women. Pregnant women must try to listen to the sound of the wind as it makes the pine trees sway. Nature's sound, which includes the sound of the forest, is a music that purifies a pregnant woman's mind and body. At the same time it gives positivity to the fetus' mind and body as well. The energy in the forest is received by the fetus in the womb (Park, 2010). Forest energy becomes a source of positive power. The forest has lots of positive energies, especially phytoncide, which is good for respiratory diseases and for oxygen supply. Nature Taegyo communes the fetus in the forest with fresh air. The

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Korean Forest Taegyo
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Korean Forest Service launched a couple's camp, Taegyo Forest, as the first step of a forest welfare system in life circle. This emphasizes the importance of nature Taegyo.

One study examined eight sessions of Forest Taegyo Program. Each session lasted for three days and was held at the National Natural Recreation Forest. Participants were 101 pregnant women who were in their 24th – 38th week of a healthy pregnancy without complications. It was revealed that Forest Taegyo Program had a positive effect in reducing pregnant women's stress and it helped also in improving emotional stability. The couples who participated in the program and tried all the various activities established strengthened relationships (Jang, 2015).

The activities of Forest Taegyo Program aimed at reducing stress and emotional instability of the mother and her fetus are listed in Table 1.

Here and Now is the orientation of the participants. The participants are asked to greet one another for fellowship and tension reduction. This is also the time where they give and call the babies inside their womb nicknames. Sensory Experience in the Forest is the activity that keeps the couples' mind calm through watching the trees, blue sky, sunrise and sunsets. Couples can smell fresh and delicate scents like



phytoncide from the plants, flowers, grass, and soil. They can recover sense of hearing through the sound of chirping of the birds, running water, bugs, and wind in the calm forest. Also they can recover sense of touch through touching bark on a tree, leaves, and soil. This fresh and healthy stimulation give sensitivity and emotion stability to couples and fetus. Wisdom from the Forest is an activity for learning the wisdom of life from a forest that exists in survival and competition with various creatures and features changing for growth. Besides communication with the forest, the activity also opens the sensation of communicating with couple and fetus. Medita-

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Table 1. Practical Forest Taegyo Program

Day	Program	Activities
Day 1	Orientation (Pre-test)	<ul style="list-style-type: none">• Informing the participants on what to expect from the program
Day 1	Here & Now	<ul style="list-style-type: none">• Bonding with participants• Adjusting to their new environment
Day 1	Sensory Experience in the Forest	<ul style="list-style-type: none">• Helping in the development of the fetus through sensory stimulation• Emotional stability
Day 1	Happily, Healthily Waiting (childbirth education for couple)	<ul style="list-style-type: none">• Managing stress and establishing better communication of the couple• Strengthening the support of the spouse
Day 2	Meditation in the Forest	<ul style="list-style-type: none">• Emotional stability and reducing stress• Fetus's development of intelligence and personality
Day 2	Wisdom from the Forest	<ul style="list-style-type: none">• Learning attitude as a parents as watching various living things in the forest
Day 2	Nature Mobile Craft	<ul style="list-style-type: none">• Emotional development of fetus through sensory stimulation
Day 2	Musical Concert in the Forest	<ul style="list-style-type: none">• Emotional stability of pregnant women and brain development of fetus
Day 3	Wind Shower in the Forest	<ul style="list-style-type: none">• Helping brain development of fetus through increased oxygen capacity
Day 3	Nature Frame Craft	<ul style="list-style-type: none">• Building intimacy with fetus
Day 3	Photo Story (Post-test)	<ul style="list-style-type: none">• Participants sharing their experiences in the program

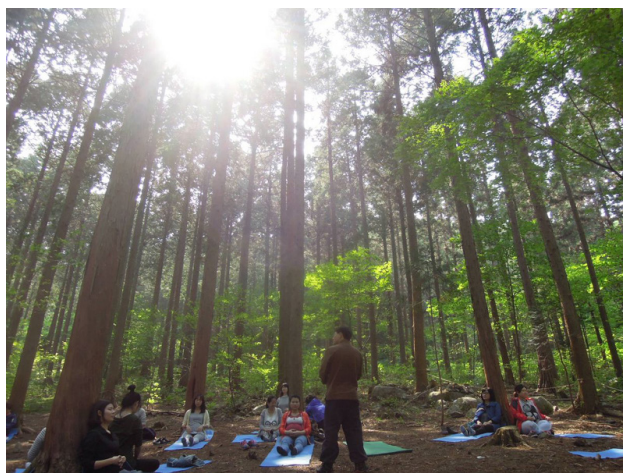
Korean Forest Taegyo

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tion in the Forest is a couple's activity that relaxes the body, deters negative thoughts, and focuses on breath. Couples sit opposite each other, or the partner puts a hand on the pregnant woman's stomach. This activity reduces pregnant woman's stress and improves emotional stability by building intimacy with fetus. Wind Shower in the Forest is deep-breathing clean and fresh air. It helps fetal brain development. Nature Mobile Arts and Crafts and Nature Frame Craft are nature art activities for couples. While they make crafts, they feel accomplishment and happiness, and this also improves maternal-fetal attachment. Musical Concert in the Forest is a musical activity. When parents listen to music and sing a song joyfully, they experience intimacy with the fetus. Photo Story is an activity of sharing memories of the camp. Couples watch the video of their experiences and share their happy moments.

Conclusion

Anyone can experience depression or anxiety during pregnancy, and many pregnant women feel stress (Park, 2011). Wells and Evans (2003) showed that nature increases positive emotions and buffers the impact of life's stresses. Being in nature improves recovering feelings and psychological well-being (Kaplan, 1984, 2001). Tsunetsugu et al. (2007) reported that watching scenery or talking and walking in the forest leads to psychological and physiological relaxation. There is measured effectiveness of the Forest Taegyo Program, with results demonstrating that the program had a positive effect on pregnant women's emotional stability and maternal identity (Kim, Lim, Choi, Kim, & Park, 2012; Park, Lim, Kwon, Lee, & Kim, 2011). Kim et al. (2003) stated that



fragrant substances from the trees of the forest stimulate the olfactory nerves that helped in the decrease of anxiety and depression. Shin, Kwon, Hammitt, and Kim (2005) mentioned that mystique of the forest enhances optimistic changes to mental stability and makes human senses and emotions more delicate and sensitive.

The Forest Taegyo Program effectively comforts pregnant women psychologically. The five senses communed well with the environment through various activities (watching, touching, and listening to nature, natural view, birdcall, sounds of a valley, the sound of bugs, fragrance of forest, clean and fresh air, and warmth of the sunlight. Korean Forest Taegyo Program has the potential to be a popular prenatal environment. This program is considered as a nature friendly childbirth education and could be used throughout the world.

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The ICEA Board of Directors is extremely pleased to announce two new evidence-based Position Papers that will soon be available on the ICEA website.

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to make informed decisions about where their babies will sleep.

Education of Pregnant Families on Harmful Environmental Substances: The International Childbirth Education Association recognizes the need to provide evidence-based education to expectant and new parents on strategies to minimize the harmful effects of harmful environmental chemicals and toxins to the developing fetus, the pregnant woman and the family.

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International Childbirth Education Association

Understanding Our Role in Bereavement

by Lindsay Carter

Abstract: Pregnancy loss upon delivery of a stillborn infant can be a traumatic time for the family involved. The aim of this literature review is to explore the relationship between the childbirth educator and the mother of the stillborn infant in the period following delivery, and to identify what can be applied in practice. Studying the influence of a healthcare team on grieving mothers may have positive outcomes for future families and nurse-patient relations. The feelings following a stillbirth can be a health factor in grieving mothers and indicates a clear need for insights.

Keywords: nurse-patient relations, grieving, bereavement, perinatal

Pregnancy loss upon delivery of a stillborn infant can be a traumatic and painful time for the family involved. Stillbirth is defined as the intrauterine death and subsequent delivery of a developing infant that occurs beyond 20 completed week's gestation (Stadtlander, 2012). Statistics Canada (2013) reports that the fetal death rate was 0.7% in 2011, accounting for 2,818 stillborn infants across the United States. Butler, Hall, Willetts, and Copnell (2015) point out that the parent's experiences and subsequent journey through grief are directly influenced by the actions of doulas, nurses, midwives, and others that are caring for the family.

Background

The delivery of a stillborn infant can affect both parents profoundly, and the sense of loss can radiate to the friends and family of the couple. The term perinatal bereavement encompasses "a complex phenomenon and while its chief

manifestation is grief, it is influenced by multiple variables that may not be captured in a single measurement tool nor conceptualized as only the experience of grief" (Fenstermacher & Hupcey, 2013, p. 2392).

Grief

Mothers and their families will experience grief following infant loss. Losing a child is a painful crisis for parents – they need many types of informal and professional support in which to cope (Nikkola, Kaunonen, & Aho, 2013). Grief is a natural reaction to separation, bereavement, or loss of a loved one (McGuinness et al., 2014). This experience manifests physically, psychologically, socially, and behaviorally, accompanied by a subjective, individual experience. Additionally, the quality of care offered during this period may relieve or aggravate the distress experienced by a bereaved mother.

Interventions

Post-delivery, the aim is to support the grieving process of mother and her family. Despite interventions for bereaved parents being developed and tested to some extent, demonstrating their effect and helpfulness had received less attention (Nikkola, Kaunonen, & Aho, 2013). The postpartum period is particularly difficult for bereaved women, as it involves progressing through many changes, both emotionally and physically (McGuinness, Coughlan, & Power, 2014). The death of a newborn baby can be a significant tragedy as it breaks an existing attachment that has developed between the developing fetus and mother.

The feelings following a stillbirth can influence health in grieving mothers

The Need to Understand Psychosocial Aspects

The feelings following a stillbirth can influence health in grieving mothers. "Bereaved mothers may have thoughts of self-harm, feelings of regret, guilt, despair and symptoms of

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Understanding Our Role in Bereavement

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physical distress, however mothers may also have experiences of personal growth, such as greater forgiveness, empathy and hope after their child's death" (Nikkola et al., 2013, p. 1152). It is therefore critical to develop an understanding of the psychosocial aspects surrounding infant stillbirth and nurse-patient relationships.

Types of Intervention/Phenomenon of Interest

The literature studying parental experiences following a stillborn delivery showcases multiple interventions attempted or recommended in which positive results were yielded. The involvement of the healthcare team is a positive opportunity to provide education and compassion. Johnson and Langford (2015) researched a protocol which provided:

- a. Early identification and labelling of the participants' room and chart for acknowledgement of the loss;
- b. The offer of chaplain services or notification of the women's spiritual leader;
- c. Honor of any special request such as baptism, special ceremony, or prayer;
- d. A packet of flower seeds or a tree of remembrance to be planted at home;
- e. A soft plush care bear;
- f. Other physical mementos such as the blanket the baby was wrapped, foot prints, and a lock of hair;
- g. Participation in a naming ceremony; and
- h. Completion of self-addressed sympathy card.

The opportunity for a memento or ritual for the child is routinely explored throughout the literature. Parents appreciate acts of kindness and commemoration by staff such as flowers, cards, telephone follow-up, or attending memorial services (Kobler & Kavanaugh, 2007, p. 293). When possible the family's wishes for the delivery could be explored before the birth of the infant and should be respected by the healthcare team when possible (Cholette & Gephart, 2012).

Aspects of a palliative care approach could include an interdisciplinary consult team to facilitate healthy attachment and grieving (Bennett & Synders, 2011). This team would provide suggestions for talking with family members, provide opportunity for family to be with, hold, bathe, and dress the infant, and integrate family cultural and religious rituals.

Research compiled from a questionnaire concluded that mothers who receive support from healthcare teams in addition to family members experience lower levels of both anxiety and depression (Cacciatore, Schnebly, & Froen,



2008). Bereaved mothers reported less depressive symptoms overall when perceiving that social support was available to them. This stress relief was achieved by providing information, warmth, and hope, which has an essential role in lessening severe bio-psychological distress such as neuronal changes, depression, post-traumatic stress disorder and other pathogenic factors. Women who received bereavement care with caring interventions reported lesser levels of overall grieving (Johnson & Langford, 2015). Cholette and Gephart (2012) remind us to refer to the child by first name. When the family's wishes regarding the stillborn infant were known to the healthcare professionals, an environment of openness and safety was created (Bennett & Synders, 2011).

Bereaved parents indicated an overwhelming appreciation for continued contact from health professionals as it helps them feel cared for, supported, and less isolated (MacConnell, Aston, Randel, & Zwaagstra, 2012). Mothers experienced distress when they felt hurried to say a final goodbye to their infant (McGuinness et al., 2014). The nurse or doula's response to the grief is relevant and it is important to reflect on our feelings. The mother's shock, anxiety, sadness, and vulnerability can limit the mother's ability to comprehend teaching she receives during the early postnatal period. Overall, considerate and professional interjection was a beneficial aspect to parental grieving. Social support generally is recognised as any action or relationship that has some positive benefit for another person

A mother may grieve not only for the loss of her child but also for the loss of the future (Kobler & Kavanaugh, 2007). This mother may be predisposed for extended or delayed bereavement. Mothers and their families often experience a variety of physical, mental, and social maladies following the birth of a stillborn infant (Cacciatore et al., 2008). These effects can include suicidal ideation, increased maternal mortality, somatisation, family disorganization,

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Understanding Our Role in Bereavement

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economic deprivation, social isolation, depression, anxiety, and mental illness. When a baby is stillborn, the social support system of many bereaved mothers falters (Cacciatore et al., 2008). Stillbirth is often an isolating, marginalizing experiencing for a woman. A social discrepancy exists in the legitimising of grief after the death of a stillborn child versus the death of a live-born child.

Our Role

The health care professional's role immediately following delivery represents an opportunity to validate the infant in the eyes of the parent. We may be approached by grieving families because we are seen as a safe haven. Parents respect the knowledge and experience of those of us who have been working with them as childbirth educators, nurses, and doulas (Cholette & Gephart, 2012).

Developing a care plan with the mother can identify what is important to her, her child, and her family, while also outlining a strategy for healthcare providers (Bennett & Synners, 2011). To support families through their bereavement, we have to address negative social norms regarding death. It takes a large amount of energy and emotion to support grieving families. There are inherent rewards and positive feedback that we receive from families. It is beneficial and mutually rewarding for the nurse and mother to have a relationship during the immediate post-partum period, yet it is also challenging (MacConnell et al., 2012).

It is commonly thought that there are gender differences in grieving. Fathers need support as well. It is suggested that we look beyond gender to understand different patterns or styles of grief. These patterns could be related to gender but are not determined by them. The gender literature reinforces the concept of subjectivity in grief, and that although there may be similarities and presumptions present, each case is unique (Avelin, Radestad, Saflund, Wredling, & Erlandsson, 2012).

While working with the family we must remember self-care (Stadtlander, 2012). Recognizing that stress and burnout can be a result of a caring profession allows for prevention and management before the grief of caring causes irreparable harm for the healthcare provider. Developing a structure in which nurses can perform their job competently and safely for themselves and the client is paramount.

Conclusion

Delivering a stillborn infant can be a sad and life-altering event. The presence of the caring health care professional at the bedside is an opportunity to support the family in effective coping practices, and to memorialise the experience for future memories and bonding.

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Compliance with Keeping Appointments

by Beverly M. Brown, EdD RN MSN APRN/GCNS BC

Abstract: The clients in this case client review were from a clinic and outreach program staffed by volunteer health care providers in the Southeastern United States. Of the 60 patients reviewed who met the criteria, 97.5% of clients kept scheduled appointments after the birth of a healthy baby after a position dedicated to appointment compliance was put in place. Compliance was enhanced by calling and making scheduled visits to the client's home. Treating patients with respect was another reinforcement intentionally utilized and helped to facilitate compliance with mother-baby after care, compliance with prescribed medications, and follow-up appointments.

Keywords: compliance, medications, appointments

This article covers lessons learned from strategies utilized to ensure compliance for mothers to keep their follow-up care appointments for themselves and their babies. The same strategies helped to create compliance with patient/clients taking their prescribed medications and contraception until they were ready for another child. The services offered to these clients are provided by volunteer health care providers at a clinic/outreach program in the United States.

The other area that contributed to compliance in keeping their follow-up appointments was scheduling comprehensive care service visits in the community where the clients live. The individuals designated to do this follow-up calling included the receptionist, the health provider, their assigned care giver, and a volunteer who served as an appointment compliance officer. This was particularly beneficial to moth-

ers with 1-5 children. It is helpful if residents receive services from health professionals who live in their own community.

Literature Review

The literature suggests that a combination approach is necessary to promote compliance in follow-up care, treatments recommended, treatments implemented, and preventive care. According to the theoretical article by Marcharia, Leon, Brian, Stephenson, Haynes, and Haynes (1992), asking a patient about their follow-through on teaching and care in a manner that is not judgmental or threatening is the simplest and quickest way to promote compliance. Compliance with clinic appointments can be defined as whether the client followed the plan of treatment suggested by the health care provider(s) (Marcharia et al., 1992). It is relevant to point out that different types of appointments are linked to varied rates of compliance (Rodriquez, et al., 2007).

Physician reminders via mail and telephone, orienting the client to the clinic, and completing a contract with the patient, are effective methods which facilitated patients to keep their follow-up appointments (Marcharia et al., 1992). Patient education and computerized practice based information has caused changes in medical practice; but, just having guidelines in practice alone was not beneficial nor was it sufficient enough in facilitating patient's compliance in keeping their follow-up appointments.

Phillips (2008) found that vulnerable populations with low income and no insurance are less likely to be compliant and to keep their appointments. Phone calls, mailing reminders, and texting contributes to patients/clients having a greater compliance in keeping their scheduled appointments.

A compliance appointment officer was very beneficial in assisting and guiding volunteer health care professionals at an outreach (minorities and AIDS) community clinic in the SE United States. Information was collected from non-profit and for profit community-based organizations. Informed consent was obtained. Compliance for this program was defined as when the client kept a scheduled appointment, even if they arrived late.

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Compliance with Keeping Appointments

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Care was aimed at mothers and children in minority groups. A worker dedicated to assisting compliance with teaching and follow-up appointments helped ensure care. Compliance was enhanced by calling and making scheduled visits to the client's home. Treating patients with respect was another reinforcement which helped to facilitate compliance with mother-baby after care, as well as compliance with prescribed medications, and follow-up appointments. Of the 60 patients reviewed who met the criteria for assistance with the compliance officer, the compliance rate was 97.5%. These clients were keeping scheduled appointments after the birth of a healthy baby.

Health care professional staff assisted with compliance, followed-up regularly, and treated patients with dignity and respect. All of these factors made a difference in compliance outcomes.

Recommendations for Childbirth Educators

Below are some suggestions to help higher-risk clients to keep their appointments and follow through with teaching.

- Bring in more services for clients at each visit, such as WIC Consultants, immunizations, mobile midwife, mobile pediatric nurse practitioners, and other support services that are available.
- Hire health care persons and seek health professionals in and from the community in which you are providing services.
- Be casual, approachable, engaged, and respectful in each encounter with a client.
- Encourage and include clients in decision-making.
- Talk and listen to the client, not at client and ensure the outcomes are realistic rather than idealist depending on the environment in which therapeutic measures will be implemented.
- Follow-up instructions should be written at a level of understanding for the client. They should include contact information for emergencies, activities allowed, date, time, and location of next appointment, side effects of medication, or other teaching (Ricci, Kyle, & Carman, 2013).
- Follow-up after discharge could include a visit by OB and pediatric experienced registered nurse, a midwife, doula, and/or other health care professionals. This will assist with rapid assessment of complications and needed interventions in the home ensuring safety of the mother and newborn (Perry, Hockenberry, Lowdermilk, & Wilson, 2011).

Conclusion

This review of client's records and literature revealed that clients who are made to feel special and treated with dignity and respect are more likely to keep their scheduled appointments. They are more compliant in following the plan of treatment. Unplanned pregnancy rates are reduced allowing their bodies to heal and empowering them to decide when they want their next pregnancy. Taking the extra time to call, text, and send a reminder to patients contributes to a patient being compliant in keeping their follow-up care.

Knowing what is expected from the provider and having someone to listen to the client or patient before the plan of care is actualized helped to ensure the plan treatment will be followed by the client/patient. They will keep their follow-up appointments for after-care. More beneficial services can be offered and compliance with care and follow-up is enhanced. Another evidenced-based practice care issue discovered is that there is no one approach that work in any particular case; it takes a combination of strategies, approaches, and techniques in this modern day society and culture. Finally, this organization providing services passes on the knowledge that there is a direct link to their success associated with their many wonderful volunteers on their health care team.

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Expectation Setting during the Prenatal Period: A Key to Satisfaction

by Richard C Meeks, DNP RN COI

Abstract: The birth of a child is often filled with many emotions. A healthy baby and satisfied parents are the ultimate outcome of the birth experience. Parents who are satisfied with care communicate the experience with others and likely return to the facility for additional services. Ensuring parent satisfaction is an ongoing task. Satisfaction begins with education and expectations encouraged at the prenatal hospital visit. Childbirth educators contribute to a couple's birth experience by working with hospital regarding setting of expectations and how to incorporate aspects of communication, clinical alarm awareness, and pain management strategies during the prenatal hospital visit.

Keywords: prenatal, expectations, satisfaction, communication, pain, alarms

The birth of a child is often an experience filled with many emotions. Parents are excited, anxious, and potentially fearful about the entire experience. An expected outcome of a positive birth experience is not just a healthy baby. Parents also expect timely communication, appropriate customer service, skilled caregivers, and adequate discharge instruction (Fowles, 1998). Where the birth will occur is usually a considerable decision for parents, taking large amounts of time, research, and thought. Messina, Scotti, Driscoll, Ganey, and Genevieve (2009) indicated choice of facility often depends

on a previous experience, word of mouth, or proximity to the home. Parents who have a poor birthing experience are not likely to return to the facility for future deliveries or other services (Ross, Frommelt, Hazelwood, & Chang, 1987). Expecting parents ask family and friends about experiences with a facility and seek information regarding its reputation, quality of care and, most of all, overall satisfaction with the encounter. This feedback from others helps form a positive or negative perception about the upcoming birth (Coye, 2004).

Background

Perception is a determining factor in patient satisfaction. Often, satisfaction results from a comparison between expectations and parent's perceptions about what actually happened (Coye, 2004). Patients' perceptions and their opinion of an experience can be positive or negative. This opinion is based on personal interactions with others, preconceived notions of the experience, internet research and past experiences. Perception can also be based in fiction due to lack of understanding or inadequate knowledge of a situation. In the clinical environment, this misunderstanding leads to mismatched care goals or unexpected outcomes producing patient anxiety and an unpleasant experience.

Patient satisfaction is a subjective determinant of quality care (Ross et al., 1987). Satisfied patients are more likely to be active participants in medical treatment, which increases positive outcomes. In return, positive outcomes produce satisfied patients who would return for further treatment (Ross et al., 1987). Satisfaction is defined as the patients' subjective evaluation of cognitive and emotional response resulting from interaction with the nurse (Erikson, 1995). This measure is a formal benchmark of patient experience often determined by a post discharge survey, phone call or interview. This review of satisfaction determines patient

continued on next page

Expectation Setting during the Prenatal Period

continued from previous page

perception of the overall experience, nursing care, physician care and other items such as cleanliness, food quality and timeliness of prescribed treatments or medications. The satisfaction score is based on patient experience and ultimately patient perception of the hospital stay.

Patient satisfaction is often seen as a mediator between a perception of quality and plans to return for future services and/or likelihood of recommending the facility to others. While the formal measure of satisfaction often occurs after discharge, a more timely approach is needed to capture current experiences and resolve any ongoing quality issues during the care episode. Also, in order to consistently achieve a patient's satisfaction, the nurse must match expectations from the patient with actual reality of what the event will be like. A patient's satisfaction of an experience can be fostered by setting appropriate expectations prior to the experience (Ross et al., 1987). Those patients educated on what to expect during the birth process often experience increased satisfaction, offered fewer complaints about care and, ultimately, reported a more pleasant birth experience.

Patient participation in care delivery is necessary

Patient participation in care delivery is necessary and improves communication and overall quality of the birth experience. While patients are often eager to participate, lack of knowledge or current understanding of the birth process is prohibitive. In order to engage parents lacking sufficient knowledge of the birth experience, clinicians must assess and clarify patient thoughts and beliefs of what the experience will be like beforehand.



An expectation is defined as a belief about a future experience (Zysberg & Zysberg, 2008). Expectations play an important role in service and quality of an experience (Coye, 2004). Setting appropriate expectations with parents prior to the birth experience is helpful in promoting a positive outcome. When expectations are not clarified prior to the birth, parents are more likely to be unhappy and complain about aspects of care. This leads to the perception of a poor birth experience.

Clinical Application

Patient satisfaction during the birth experience is difficult to confirm (Fowles, 1998). Couples strive to solidify the birth experience into their self-image as parents. Couples expect education about the birth process during the prenatal period (Clark, Beatty & Reibel, 2015; Sabatine, 2012). It is imperative that clinicians incorporate time into the educational process to set expectations of the birth experience during prenatal care. This time spent with parents will strengthen what is expected during the labor process and counter any false or negative impressions about the birth of their child. Talking with expecting parents about communication, clinical alarms and post-partum pain management encourages a positive birth experience.

Communication

One of the most important tasks during the delivery of a child is communication (Sabatine, 2012). Inadequate communication during this experience is often a frustration for parents (Fowles, 1998). This frustration is fueled by vague responses, inaccurate information, and untimely responses. Incomplete, rushed or delayed communication leaves patients and families confused, anxious and questions about trust of the healthcare team. Lack of communication often leaves parents unsatisfied with care, and with a negative perception about the birth experience (Fowles, 1998). In order to minimize this frustration, all communication with parents should be timely, complete and as accurate as possible.

The concept of time is a simple approach to strengthen communication efforts. Each attempt to communicate with expecting parents establishes alignment of priorities and expectations regarding sequences of events, the return of the clinician with necessary medications or treatment, and even discharge. Time, as an aspect of communication, is measurable and provides the patient and family a benchmark for care, testing or other responses from the healthcare team.

In order to incorporate the aspect of time into each communication attempt, the clinician must consciously engage parents with active responses including timing of

continued on next page

Expectation Setting during the Prenatal Period
continued from previous page

treatment, next availability of pain medications, or even the next return to the patient’s room (Table 1). This will give parents an idea of the next steps in care, and what to expect in the next hours or days of the birth experience.

Caution should be taken when incorporating the aspect of time in communication with parents. Strengthening this area of communication sets expectations that the nurse will return to do a certain task, give a medication, or meet other needs. When a defined timeline for care is given, the nurse should make sure to meet the timeline if at all possible. When situations arise that cause the timeline impossible to follow, the patient should be given an explanation and a new timeline. Timely, accurate communication, including the aspect of time, helps produce a favorable overall experience.

Clinical Alarms

The labor environment is filled with ringing bells, high-pitched sounds and beeps. This noise potentially creates a level of anxiety, fear and undue panic for expecting parents (Honan, et al., 2015). During the labor process, maternal and fetal monitoring equipment is used to provide clinical updates of mother and baby. Often, this equipment provides a sound in the patient room as well as the nurse’s station. These sounds alert nurses to changes in the condition of mother and baby and are necessary during the birth of a child (Yoder & Phillips, 2013). Nurses must identify these alarms and prioritize in order of urgency. While alarms are considered a safety net for mother and baby, the sounds

and interruption provide a possible reason for a decrease in satisfaction. Providing information on what the alarms mean can help alleviate some of the parents’ concerns.

The use of clinical alarms in high risk areas such as during the labor experience is mandatory (Jo & Paul, 2012). Each alarm must be analyzed by the nurse to determine significance and any necessary action by the nurse. This action could include adjusting the in room alarm parameter, titrating a medication according to vital signs, or securing a device. While many alarms do require action from the nurse, some do not. Nuisance alarms can occur as often as 85% in the labor environment (Joe & Paul, 2012). While these alarms do not require a nurse’s attention, the sound of the alarm is a potential irritant for expected parents.

In order to minimize patient and family irritation and anxiety from clinical alarms, education regarding clinical alarm management should be incorporated into the prenatal hospital visit. Expecting parents should be educated regarding how the mother and baby will be monitored, associated alarms during the monitoring period and how nurses will manage clinical alarms as these occur. As much as possible, parents should be given more control of the birth experience (Fowles, 1998). During the prenatal visit, parents should be empowered to ask questions about ringing alarms and participate in the labor experience by ensuring monitoring equipment is secure and located as instructed by the nurse. This empowerment and baseline understanding regarding clinical alarms in the labor process will alleviate potential frustrations and facilitate a satisfactory birth experience.

continued on next page

Table 1. The Concept of Time as a Communication Strategy

Non-Specific Communication	Specific Communication including Time
Call if you need anything.	Call if you need anything. I will be back in 30 minutes.
Your lunch will be here in a few minutes.	Your lunch should arrive at approximately 12 noon.
Your pain medication is not due for a few hours.	Your pain medication is not due until 2pm.
Let me gather some supplies, I’ll be right back.	Let me gather some supplies, I’ll be back in 15 minutes to start your IV.
I’ll be right back to change your dressing.	I’ll be back in 10 minutes to change your dressing.
Transport will be here soon to take you to the procedure.	Transport will be here in 20 minutes to take you to the procedure.
The doctor is on the unit. He will stop by.	The doctor is on the unit. He will stop by in approximately 45 minutes.
I will call the doctor if your pain does not improve.	I will call the doctor if your pain does not improve by 11pm.
Your family can visit soon.	Your family can visit at approximately 10:30 am.

Expectation Setting during the Prenatal Period

continued from previous page

Pain Management

Pain is inevitable during the birth of a child. Women, anxious about pain during the prenatal period, were less likely to be satisfied with the birth experience (Hodnett, 2002). The mother experiences pain during the post-partum period and up to several weeks after discharge. While pain is expected, lack of understanding regarding management of pain, and pain control issues are frustrations of parents during the birth process (Fowles, 1998).

Pain is subjective. Patients are responsible for communicating with nurses about pain. While nurses ask about pain during the assessment and reassessment phases of the birth experience, women must communicate intensity, duration, aggravating and alleviating factors of pain during the entire experience. Often, patients are asked to rate pain on a predetermined scale. This rating should be a true assessment of what the patient is experiencing regarding pain management efforts.

In order to minimize frustration and anxiety around pain, education regarding pain management during the birth experience should be incorporated into the prenatal care. Expecting parents should be educated regarding the subjectivity of pain, use of the pain rating scale and various nursing interventions to alleviate pain during the experience (Hodnett, 2002). Early education regarding pain management will alleviate fear and clarify uncertain or unrealistic expectations parents have about pain management. This education and understanding regarding pain management will facilitate a satisfactory experience with pain management during birth.

Advice for Nurse Educators

The birth experience is an exciting and stressful time for parents. Setting expectations with parents during the prenatal period is a best practice to increase satisfaction with the experience. Parents who are satisfied with the service and nursing care during the birth of a child are likely to communicate this satisfaction with friends and family, return to the organization for future services, and appreciate the skill and communication of caregivers.

When communicating with parents, including the concept of time enhances success of the interaction. Training staff regarding this concept by providing role-play opportunities to engage staff in modeling this behavior will address potential problems and allow staff members to become familiar with this communication technique. Education regarding the concept of time should include an interactive training component.

Childbirth educators should also provide a framework for the prenatal hospital visit. This framework should include aspects of communication, clinical alarm management and pain management topics. Sufficient time should be allotted for questions and concerns to be discussed. Online or printed materials for families to review, prior to the actual birth, reinforce what is taught during the visit. Parents receiving such education before the birth of a child will feel more knowledgeable and, ultimately, more pleased with care, the facility, and the overall encounter. Their expectations will be realistic, more likely to match their actual experience, and result in the perception of a highly satisfactory birth event.

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Can't Catch Her Breath: Peripartum Cardiomyopathy

by Caitlin Bruner, RN BSN

Abstract: Peripartum cardiomyopathy is one of the most severe cardiovascular complications in previously healthy women during pregnancy. Unfortunately, many of the normal stresses of pregnancy mask the presenting symptoms of peripartum cardiomyopathy. The purpose of this article is to summarize the definition, symptoms, treatments, and implications associated with peripartum cardiomyopathy. Childbirth educators who are well informed on peripartum cardiomyopathy will be able assist these higher risk mothers have through their pregnancies.

Keywords: peripartum, cardiomyopathy, best practice, differential diagnoses, childbirth educator

Peripartum Cardiomyopathy

Those who teach childbirth education classes may be serving those with peripartum cardiomyopathy. Because many symptoms of cardiomyopathy are similar to other pregnancy related conditions, these mothers often experience a delay in diagnosis. Those who teach childbirth education classes may be referred for further care.

What is Peripartum Cardiomyopathy?

You may have a client diagnosed with this heart condition. Most expecting mothers are unaware of what peripartum cardiomyopathy is and childbirth education providers can empower women with information about the disease including the symptoms, how it is diagnosed and treatments. Peripartum cardiomyopathy is “defined as development of heart failure secondary to left ventricle systolic dysfunction towards the end of pregnancy or in the months following

delivery, without other identifiable causes for dysfunction of the heart” (Biteker, Kayatas, Duman, Turkmen, & Bozkurt, 2014, p. 317). This disease develops because of the pregnancy, and is not the same as other cardiomyopathies (Hilfiker-Kleiner, Haghighi, Nonhoff, & Bauersachs, 2015). Peripartum cardiomyopathy is a potentially life-threatening cardiovascular complication.

Once thought to be idiopathic, the disease is often related to chronic hypertension, undiagnosed mitral stenosis, obesity, preeclampsia, anemia, and other complications (Akpınar, Ipekci, Gulen, & Ikizceli, 2015). The condition was formerly referred to as “postpartum cardiomyopathy” but new research shows symptoms can occur during pregnancy as well. It is not uncommon to have early diagnosis between the 17th and 36th week of gestation (Biteker et al., 2014). A mother may experience symptoms in the last month of pregnancy or earlier, or as late as five months after delivery.

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Can't Catch Her Breath: Peripartum Cardiomyopathy

continued from previous page

What are the Signs and Symptoms?

Signs and symptoms of peripartum cardiomyopathy may present as early as the 17th week of gestation and a practitioner may review these with her patient early in her pregnancy. These symptoms can include the following: dyspnea, dizziness, chest pain, cough, fatigue, and peripheral edema. Shortness of breath is the most common presenting symptom with patients stating they are having a hard time catching their breath (Patel, Berg, Barasa, Begley, & Schaufelberger, 2015). A mother is more likely to develop these symptoms if she has also been diagnosed with risk factors such as hypertension and pre-eclampsia during her pregnancy (Fett, 2014).

Because the symptoms associated with peripartum cardiomyopathy overlap with other diagnoses and normal complaints during pregnancy, her health care practitioner has to rule out other diagnoses as well. These differential diagnoses include:

- myocardial infarction
- severe pre-eclampsia
- myocarditis
- pericarditis
- amniotic fluid embolism
- pulmonary thrombo-embolism
- sepsis
- drug toxicity and others (Okeke, Ezenyeaku, & Ikeako, 2013)

How is Peripartum Cardiomyopathy Diagnosed?

The practitioner will begin with a thorough history and physical exam including when the symptoms began, the duration, severity, and what alleviates them. Some of the tests used to diagnose peripartum cardiomyopathy include the following: ECHO, ECG, chest X-Ray, BNP and cardiac MRI. An ECHO is used to assess overall cardiac function, and shows the ejection fraction, which indicates heart failure. The BNP, a bloodwork test, is a marker for acute heart failure and its severity. Performing an ECG measures and gives a picture of the electrical function of the heart. A chest X-Ray can show if there is increased cardiac size, and if there are any pleural effusions, or fluid in the lungs. The cardiac MRI is used to determine myocardial contraction (Okeke et al., 2013). Criteria for diagnosing peripartum cardiomyopathy include a positive physical exam and history, a BNP of greater than 200, cardiac damage noted on the MRI, cardiac enlargement or pleural effusions seen on X-ray, and an EF less than 45% (Hilfiker-Kleiner et al., 2015). These tools in conjunction with a physical assessment assist the practitioner to make an accurate clinical diagnosis.

Some cardiac and BP drugs are contraindicated during pregnancy.

What are the Treatment Options?

Once the diagnosis is made treatment options will be considered with the patient. Treatment will vary depending on whether the patient is still pregnant. Overall, treatment of peripartum cardiomyopathy follows a similar plan to conventional heart failure treatment. Depending on the severity of the disease, the patient may be admitted to the hospital for close cardiac monitoring and supplemental oxygen. Untreated peripartum cardiomyopathy may lead to congestive heart failure, arrhythmias, clots, and sudden death (Akpınar et al., 2015). The patient will be placed on dietary sodium restriction and medications immediately. Pharmacological

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Can't Catch Her Breath: Peripartum Cardiomyopathy

continued from previous page

therapy should include diuretics, vasodilators, and digoxin (Akpınar et al., 2015). ACE inhibitors and spironolactone are contraindicated during pregnancy. Because patients with this disease are at high risk for development of thrombosis and thromboembolism due to pregnancy-related hyper-coagulation as well as blood stasis associated with severe systolic dysfunction, anticoagulants must be considered (Akpınar et al., 2015). The recommended anticoagulant use varies depending on pregnancy. Heparin should be used during pregnancy and warfarin can be started postpartum. (Okeke et al., 2013).

Implications for Future Pregnancies

Once a patient has been diagnosed with peripartum cardiomyopathy, recommendations for future pregnancies should be made. The recommendation will differ depending on recovery. If the mother has made a full recovery with normal heart function, future pregnancy is not contraindicated. However, if the ECHO shows there is an incomplete recovery of cardiac function after treatment, future pregnancy should be deferred while further treatment is attempted (Fett, 2014). However, any “consecutive pregnancy carries a recurrence risk of 30-50%” (Akpınar et al., 2015, p.1282). Even if a patient's EF has returned to normal she should still be given consultation regarding the reoccurrence risk in future pregnancies.

Considerations for Childbirth Educators

Childbirth educators may have mothers diagnosed with peripartum cardiomyopathy. Because these moms may tire faster, childbirth educators should consider teaching more classes that are shorter in length. Home visits might be offered and private classes may better facilitate learning. Classes during pregnancy and postpartum provide an opportunity to present, discuss, and empower expecting mothers with information on common signs and symptoms. Educators may direct mothers to online resources such as cardiomyopathy.org and <http://www.hopkinsmedicine.org>



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If It's Natural, Why Does it Hurt?

Examining the Reasons Mom May Feel Pain with Breastfeeding

by Elizabeth Smith, MPH ICCE IBCLC RLC

Abstract: Frequently women will hear that breastfeeding should be pain free and if there is pain something is wrong. Latch is not always the problem and other causes and resolutions of breastfeeding pain are examined in this article.

Keywords: breastfeeding, pain, nipple pain, latch

Frequently women will hear that breastfeeding should be pain free and if there is pain something is wrong. The first thing most IBCLC's, LE's CLE's and nurses will examine is the latch. The assumption is that if baby is latched on correctly there will be no pain. This however, is not always correct and we need to look at the whole picture to make breastfeeding a good experience for mom so that she will have the desire and ability to achieve her goals (Academy of Breastfeeding Medicine, 2016; Walker, 2015).

Pain Assessment

The first place to start is pain assessment. If the nipple is intact, with no bruising, bleeding, cracks, redness, soreness or other signs of breakdown, what could be the problem? Most first-time moms are surprised at the sensation of breastfeeding. The suckle of a newborn is strong and generally the first experience may be unexpected. The role of the care provider is to determine if the sensation she is feeling is truly pathological pain or the normal physiological experience of breastfeeding. It is important to assess and educate about the sensations that are felt when a baby is feeding at the breast (Walker, 2015). Remind her that she will experience the sensation of the suckle, let down, involution

contractions and possibly post-birth fatigue; all of which can contribute to the perception of pain. Start with making her more comfortable; adjust pillows and help with supporting the baby. Remind her of her breathing for labor. Teach her how to be mindful of what she is experiencing. Once these adjustments have been made, then a more complete assessment can be done (US LCA, 2015).

LATCH

Latch is the most common term used to determine if the baby is suckling at the breast correctly. The LATCH Breastfeeding Assessment Tool has been used in clinical practice since 1994 (Jenson, Wallace, & Kelsay). It is a scoring system used to evaluate breastfeeding success.

Each of the five letters is given a score of 0, 1 or 2 and then they are added up with 10 being a perfect score. The "L" stands for latch or rather how well the baby goes onto the breast. The person evaluating looks to see if it appears that the lips are flanged, the tongue is under the nipple and extends over the gum line, and the baby is sucking behind the nipple on the areola.

Often the baby has one or both lips tucked causing friction and pain to the nipple. A simple adjustment of the baby's position or lips could solve this issue. Many moms are afraid they will suffocate their baby so they worry a lot about the nose, thus causing a shallow latch by holding baby away from their body. By bringing baby closer to mom, he or she will move the head to breathe, thus solving the shallow latch as baby tilts the head back to the correct position. An assessment of the baby's mouth should be done to make sure that the suckle is good, the palate is not too high or low, and that the tongue can protrude past the gums. Very often, a minor adjustment to the position of the baby and the way mom is

continued on next page

If It's Natural, Why Does it Hurt?

continued from previous page

supporting the baby will make a huge difference in how well baby is latched.

The “A” stands for amount. The observer or mom should be watching for the suck-swallow-breathe pattern to be sure baby is getting milk from the breast. Listening for audible swallows is also done to assess the transfer of milk. Once full milk is established the softness or emptying of the breast after a feeding can be another way to determine transfer.

Babies are sleepy after birth. They have gone through an intense physiologic process and transition to extra-uterine life. It is important to consider that in the first 24 hours, feeding attempts should be made, but as long as baby is healthy and full term, short bursts of sucking and frequent sleeping are to be expected. After 24 hours, more concern should be taken to assure that baby is following the suck-swallow-breathe pattern and is able to stay awake longer during feeds.

The “T” denotes the type of nipple. The nipple should be adequate for baby to hold onto and should become erect with sensation. If the type of nipple is a concern, further evaluation needs to be done by a lactation professional.

Nipple type can be a challenge. It is possible for babies to suckle on a flat or inverted nipple but it may be difficult and require practice (Newman, 2016). The most important part of counseling a woman with a flat or inverted nipple is to not make her feel abnormal or defective. It is better to make statements such as “with this type of nipple” rather than “your nipples are flat/inverted/small.” By making the first type of statement you clarify the problem without making it seem like it is her fault or a problem with her body. Nipple shells or shields can be good tools, but should never be given without counseling on the benefits and risks.

The “C” assesses the mother’s comfort with breastfeeding. Her report along with a visual look at the nipple will determine how to score this area. Any bleeding, cracking or breakdown of the nipple must be assessed to determine if there is an underlying issue that is contributing to the tissue breakdown.

A mother’s comfort with breastfeeding is the number one consideration. Regardless of what the care provider sees, it’s mom’s experience that determines if she will continue breastfeeding or not. Study after study looking at intention to breastfeed and reasons for quitting conclude that the number one reason women quit breastfeeding is due to pain, regardless of intention to exclusively breastfeed (Dennis, Jackson, & Watson, 2014). It is important to provide education and tools to reduce pain and sensation to increase long term breastfeeding.



“H” stands for help. This is where it is determined if the mom is able to get baby to breast on her own or if she needs additional help. How well is mom doing on her own? In a hospital setting, the birth itself is often times an indicator of how well she does on her own. Cesarean, IVs, medications, hospital beds, disruptions, and fatigue can all influence how well mom is able to get baby to breast. Initially she may need full assistance to get baby positioned and onto the breast. Many times moms worry about how they will do this on their own when they go home. This is why it is so important to be a passive observer and help verbally guide her with minimal assistance when possible. There are times when full assistance is needed but the overall goal is to get to the point where she is capable of doing it on her own (Kendall-Tackett, 2007).

The Latch Score is a very useful tool but it cannot be the only criterion for breastfeeding success (Tornese et al., 2012). Giving her the skills to be successful alone, or guiding her support person to assist, empowers them to feel confident when they are on their own. There are many other considerations besides latch that can cause pain or discomfort with breastfeeding. When teaching, avoid overwhelming new parents with everything that could go wrong, yet you also want them to be prepared for some of the challenges. These are common issues that could be taught during pregnancy and will give parents some tools to assist them when they experience difficulties (Kendall-Tackett, 2007; Post-Partum Support International, 2016).

Fluid in the Breast or Nipple

With the high rates of IV fluids given during labor, fluid retention should always be assessed when helping a mom experiencing pain during breastfeeding. A quick assessment is to look at her feet; if she has edema in the feet, she most

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If It's Natural, Why Does it Hurt?

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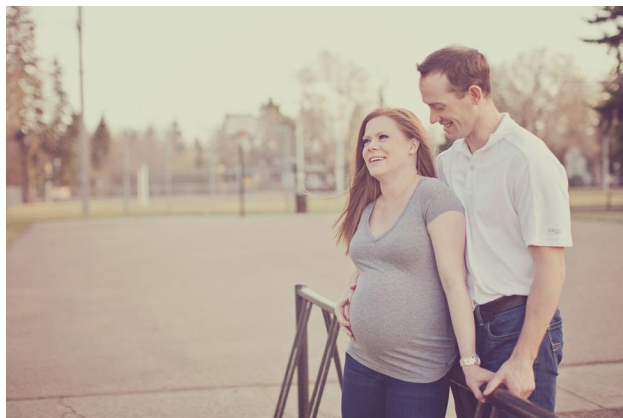
likely has it in the breast tissue. Reverse pressure softening is the general advice given to help baby to obtain a deeper latch and reduce the sensation from the pressure on the nipple and areola. By gently pushing back with fingers on the areola and working around the nipple most of the fluid can be pushed out and provide relief (La Leche League.org, 2016).

A less common technique is to use lymphatic massage to reduce swelling in the breast (Witt & Bolman, 2016). This technique is done by doing firm massage with the hands, starting at the areola and massaging back towards the wall of the chest to push additional fluids out of the breast tissue and alleviating pain. A more thorough description and video can be found at www.bfmedneo.com (Academy of Breastfeeding and Medicine, 2016).

Engorgement, Mastitis and Plugged Ducts

Engorgement can begin once the milk “comes in.” By using this traditional term of milk coming in, some women perceive that previous to this event they don't have milk or don't have enough milk. A good way to counsel is to advise them that in a few days they will have increased milk volume as the baby's belly begins to expand and that during this time they may feel engorged. Standard care for engorgement is to feed often, use ice packs as well as Ibuprofen for pain and to reduce swelling, warm compresses to help the milk to flow, and to pump/hand express minimally to remove more milk. These practices will usually work to relieve the discomfort of engorgement. Remind mom that overfilling of the breast is usually resolved within a few weeks, as her body regulates the amount of milk her baby needs (US LCA, 2015).

If milk is not removed from the breast, mom may get mastitis. Mastitis is inflammation of the breast tissue that occurs from milk stasis with or without infection. This condition does require referral to a higher level care provider.



Mom should be advised to call her doctor or midwife if she experiences pain, redness, lumps and/or fever and flu-like symptoms (Lawrence 2005).

Plugged ducts occur when an area of the breast has insufficient milk removal, causing milk to back up in a duct. In general these are painful but benign. Massage and compression of the area will usually work the blockage out, and immediate relief will be experienced. If that doesn't work, warm compresses can be used along with massage to help get the milk moving.

Additionally, mom can try different breastfeeding positions to see if the baby can help remove the plug. The Australian Position is less common but very effective for removing the milk from a plugged duct. This position is done in one of two ways. First mom lays baby on the bed or floor and leans over baby having him or her suckle on the breast. In this position, gravity and alternate mouth position will help pull the milk. The alternate way to use this position is for mom to lie flat and then bring baby on top of her to feed. Again the change is suckle may resolve the issue (Morbacher 2003).

Candidiasis

Yeast infections or Candidiasis, often called thrush, are another cause of breast and nipple pain. Yeast is very common, and thrives on milk along with a warm, wet environment, and is very easy to pass from mom to baby. It is very common if mom or baby has had antibiotic treatment which can disrupt the normal flora in the body. Candidiasis can be fairly easy to determine due to the specific symptoms. The skin is often red or pink, shiny and itchy. Mom will often describe a burning sensation on the nipple or even up into the breast. Mom should consider her diet and reduce sugary foods since yeast thrives in that environment. She can also try a vinegar wash of the nipple to get rid of the yeast. Careful hygiene, including washing bras and breastfeeding tools frequently, will help get rid of the yeast. If these measures do not work then a care provider can look at prescribing medications for mom and baby that will kill the yeast (Strong & Mele, 2015).

Raynaud's Syndrome

A less commonly known but prevalent issue that can occur in breastfeeding is Raynaud's Syndrome. It is often misdiagnosed as Candidiasis. Raynaud's can be either primary or secondary and is a vasospasm of tissue that occurs before, during or after the feeding. Frequently, the spasm occurs after the feeding and causes a specific blanching of the nipple which turns white, then blue before returning to normal color. A woman experiencing this will often feel

continued on next page

If It's Natural, Why Does it Hurt?

continued from previous page

significant pain in conjunction with spasms of pain between feedings. This issue can be very distressing to moms if they don't know what they are experiencing. The cause is difficult to determine and there are not a lot of treatments. A woman experiencing this phenomenon should check with her care provider for possible supplements or medications that can ease the symptoms. General recommendations are to wear warm clothes, use dry heat on the nipple, avoid wet breast pads, and limit alcohol, caffeine, and other vasoconstrictors. With good counseling on the problem, moms are often able to work through the sensation and continue breastfeeding (Strong & Mele, 2015).

Mood and Anxiety Disorders

Post-Partum Mood and Anxiety Disorders (PMAD) can affect around 30% of women (Postpartum International, 2016). One of the frequent symptoms of PMAD is unspecified breast or nipple pain. If a mom is experiencing pain and no physiological symptom can be found, then doing a screening for PMAD would be a good route to determine the problem. If mom does have a disorder then treatment for that specific problem could alleviate the pain and allow her to meet her breastfeeding goals. With good support, breastfeeding can be successful while treating a mood or anxiety disorder (Kendal-Tackett, 2007; White & Smith 2016).

Role and Scope

As a childbirth educator or doula, it may not be within the scope of practice to diagnose or treat breastfeeding problems without additional training, licenses, or certifications. However, information and knowledge on the possible problems are important to help educate those in your classes. Having a network for referral is important to be able to help moms seek help if they are experiencing any problems with breastfeeding. Childbirth, breastfeeding, and parenting go hand in hand and are not exclusive of one another. As an educator or doula, experience and knowledge in all areas of the perinatal period will increase your ability to educate and assist the families with whom you work (Walker, 2015).

The general goal is to provide education using evidence-based sources and assist with referrals in the community. As we move forward, lactation education and support should be valued by the childbirth educator and doula. ICEA recently became a Global Partner with International Lactation Consultant Association (ILCA) as both organizations see a future of working together for the best outcomes for moms and babies.

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New Baby 101: A Midwife's Guide for New Parents

by Wattis, L.

Queensland, Australia: Complete Publishing,
2014, 104 pages, \$24.95 paperback

reviewed by Sarah L. Marshall, MSN RN ICCE CCE CBC CLC

There are times when pregnant women receive inappropriate and incorrect information through social media, well-wishing family members, friends and peers. Personal experience, cultural beliefs and myths also may affect how they care for their child during the developmental life cycles. In addition, the birthing process can create physical and emotional challenges.

Lois Wattis, Registered Nurse and midwife, International Certified Lactation Consultant, Fellow of the Australian College of Midwives, mother, and grand-mother. She is the published author of many articles and professional guidelines and is qualified to compose *New Baby 101: A Midwife Guide for New Parents*. She offers expert advice about how to care for a newborn, hopefully decrease anxiety and facilitate a smoother transition during the first three months of parenthood. The author eloquently shares some of her personal experiences and motivation which led to her writing *New Baby 101*. It is organized, easy to read, researched, and evidence-based. The fundamental care for newborn topics discussed in detail include feeding requirements and alternatives, bathing, swaddling techniques, and diapering. Other important decisions are covered, such as Hepatitis B vaccination, screening tests and schedules. First time or seasoned parents will benefit from reading *New Baby 101: A Guide for New Parents*.

New Baby 101: A Guide for new Parents should appeal to a culturally and linguistically diverse Inter-

national audience. However, the author used certain colloquial terms such as “nappy” to describe diaper change which may confuse an audience not familiar with that lingo. Nevertheless, clarity is provided through context, demonstrations, illustrations, videos, and channel access.

I recommend that childbirth educators read *New*

Baby 101: A Guide for New Parents. I further recommend that women who plan to become a parent and their supportive persons, women who attend or are not able to attend a childbirth education class also read this book before giving birth. The essentials discussed in *New Baby 101* may prevent the spread of inaccurate information, reinforce what is taught in childbirth classes, promote successful child rearing, and most importantly, offer parents the opportunity to make an informed decision about how to care for their newborn child. The book can also be used as a reference and is an asset for ICEA readers.



Sarah has served in many leadership roles such as manager, consultant and coordinator. She is currently employed as a Patient/Community Health Educator, Clinical Instructor, President, SUNY Downstate College of Nursing Honor Society at SUNY Downstate Medical Center, Brooklyn, New York. She is a member of Adelphi University, Alpha Omega Chapter STTI and is serving a second term as Non-Faculty Adviser. She is a Virginia Henderson Fellow-STTI.

Reviving Your Sex Life after Childbirth

by Wallace, K., PT BCB-PMD

reviewed by Jean Rother, MS RN

San Bernardino, CA: Self-published, 2014,
117 pages, \$19.95 paperback

Pelvic floor physical therapy is a topic that many women may find new and innovative. However, Kathe Wallace, PT, BCB-PMD has been teaching about and evaluating pelvic floor dysfunction for the past 25 years. In her latest book, *Reviving Your Sex Life after Childbirth*, Kathe shares her knowledge and expertise in helping post-partum women regain a pain free and rewarding sex life. Since childbirth alters the musculoskeletal structure of the pelvic floor and pelvic girdle resulting in muscle weakness and possible pain, there is available education, treatment, body conditioning and manual techniques for regaining normal function. Wallace provides explicit and detailed instructions with illustrations for enhancing pelvic health.

The introduction to the book begins with information concerning the bodily changes that occur due to the childbirth process. Vaginal births may result in a new awareness of musculoskeletal pain and discomfort during the time of healing. During the recommended six-week post-partum visit to a physician or midwife, it should be noted that any intense pain that interferes with normal functioning is not typical. Therefore, if the new mother is healing well, yet experiencing pain or discomfort, she could be referred to a Women's Health Pelvic Physical Therapist. These therapists receive additional training in assessment and examination techniques for pelvic floor muscle and genital issues. This unique area of physical therapy continues to grow throughout the United State and abroad.

Kathe also provides an overview of changes within the postpartum body and discusses two problems that may occur during or after a vaginal birth. The first problem is pain and restricted mobility as a result of tears or an episiotomy. The everyday activities of caring for a new infant and staying mobile can present difficulties. In addition, prolonged pushing during labor may produce spasms or generate trigger points in the pelvic region. The author demonstrates techniques and tips for addressing these trigger points, which include direct pressure and stretching. The second problem discussed is pelvic floor muscle weakness and how it can affect bowel

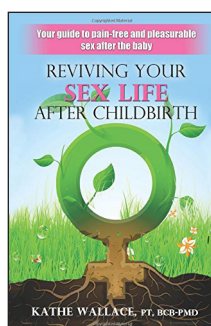
and bladder control. Once a new mother has healed, she should not experience complications with bladder and bowel control. At times women may also feel like their uterus is falling out of their vagina and describe an organ prolapse. Sexual intercourse may be impaired due to the prolapse of the uterus. Wallace discusses the various types of prolapse that may occur, and strengthening activities that can prevent the prolapse from advancing to a possibly difficult complication. Other problems may be hemorrhoids, queefing or farting, fissures, fistulas, and diastasis rectus abdominis.

Furthermore, Kathe includes 10 tips and various guides

to help new mothers understand their bodies and transition towards therapeutic healing. Recommendations deal with various topics including, but not limited to: care of the perineum, hormonal changes, relaxation techniques, internal vaginal stretching techniques, exercises for pelvic floor release, episiotomy or perineal tears, exercises for strengthening pelvic floor muscles, assessment of diastasis rectus abdominis and massage techniques for scar tissue. The helpful hints are explained with

numerous drawings and thorough instructions.

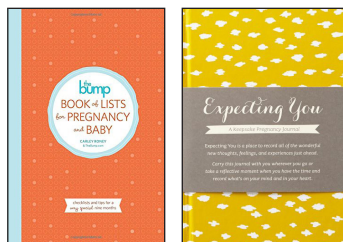
Reviving Your Sex Life after Childbirth provides new mothers additional information which can support them and enlighten them concerning very sensitive topics throughout postpartum. An instructive book that generates questions and enables women concerning pelvic health and sexual pleasure is valuable during such a stressful time. Health Care Practitioners will benefit from recommending this as an illustrative and explanatory resource for all new moms and their partners. It is a welcome addition of valuable and empowering information for women experiencing the healing process after childbirth.



Jean Rother, MS RN is an Associate Professor in the Department of Nursing at Metropolitan State University of Denver. She has 7 years of experience instructing Community Health and Mental Health Nursing in the Accelerated Nursing Program.

The Bump Book of Lists for Pregnancy and Baby

by Rowan, C., New York: Potter Style, 2015, 191 pages, \$12.74



Expecting You

by Riedler, A., Seattle Washington: Compendium Inc., 2014, 140 pages, \$14.66

From Pea to Pumpkin

by Murry, G.B., Naperville, Illinois: Sourcebooks, 2014, 84 pages, \$11.54



Welcome Baby

by Zadra, D., Seattle, Washington: Compendium, 2012, 66 pages, \$16.87

reviewed by MaryAlice Sawaya, PhD RN CNE

This article provides a review of four little books targeted toward pregnant and parenting families. Two of the books are intended for pregnant women, and two books are designed as keepsake mementos to record the bay's first year of life.

The Bump Book of Lists for Pregnancy and Baby is the most helpful book in the group. It is a paperback book which contains checklists and tips for the nine months of pregnancy and the first four months of baby's life. The forward introduces the reader to why the authors love checklists. It also extends a thoughtful message of congratulations to the prenatal reader.

Checklists contained in the book are organized in a month by month countdown from pre-pregnancy through delivery and newborn through month four of the child's life. The checklists provide examples of things to do before, during and after pregnancy. There is ample space provided in the margins to mark the book and make personal notes. The lists are well developed and thorough. This leaves the reader with the sense that pregnancy, childbirth and parenting during the first few months of life is a manageable undertaking. The checklists help to reduce anxiety about "what to do," especially for the first time parent. The book is well suited to the first time parent, or those who have experienced a significant amount of time between pregnancies and may have forgotten the typical course of the events.

A second helpful book is *Expecting You*. This book is a keepsake journal for use during pregnancy. Each section of the book contains an easy to understand prompt for the expectant mother to reflect on her pregnancy and write the child and family story. It begins with the anticipation of pregnancy and follows the typical pregnancy through delivery.

Some prompts are repeated in the journal to record how the parent is feeling or how the parent is getting ready for the baby's arrival. The intention of the journal is for the expectant woman to record and share the experience with loved ones. It can also be used as record to share with the new baby.

This hardcover journal provides ample room to write and is printed in neutral calming colors. If completed, the journal would provide a pleasant memory and provide a pregnancy history for both the parent and child.

From Pea to a Pumpkin: A Baby Journal is a soft cover memory book to record baby's first year of life. The introduction page is colorful while the remainder of the pages are printed in gray, white and black. The keepsake is organized from birth through the first twelve months of life. It contains typical prompts to record photos, height, weight, developmental tasks and baby's likes/dislikes. Overall it provides an opportunity to record a simple record of baby's first year of life.

Welcome Baby is a hardcover keepsake printed in gender neutral matte colors, with simple drawings of animals and nature. The book contains prompts for parents to capture the first year of the child's life, inclusive of developmental milestones. The book is organized chronologically from birth through twelve months and sections are separated by inspirational quotes. This keepsake provides a straightforward yet comprehensive record of the first year of life.

Dr. Sawaya is a tenured professor of nursing at Metropolitan State University of Denver, in Denver, Colorado. She is a Certified Nurse Educator (CNE) with over 35 years of experience in nursing and nursing education.

Hypnobirth: Theories and Practices for Healthcare Professionals

by Watters, Y.

New York: Rowman & Littlefield, 2015,
125 pages, \$65.00 hardcover

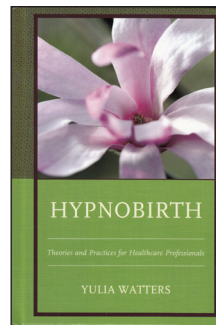
reviewed by Debra Rose Wilson, PhD MSN RN IBCLC AHN-BC CHT

The central question that the book seeks to answer is whether hypnosis can aid in achieving a comfortable, successful birth. The book is intended to increase awareness of hypnosis, explain how hypnosis can be used in childbirth, and to describe steps to be taken by the pregnant woman and her support team in order to benefit from hypnosis. The main intended audience is caregivers who work with expecting mothers. The book consists of ten chapters, with appendices summarizing techniques and foundations of hypnosis.

The Introduction to Hypnosis chapter focuses on the history, myths, and practices of hypnosis. The second chapter, *Pregnancy and Childbirth*, explains natural childbirth and hypnobirth in particular. Chapter 3, *Special Connections*, takes a systems-based view of the mind-body-spirit connections. Chapter 4, the *Hypnotic Mindset*, instructs caregivers on how to lay the groundwork for the process in the final months before birth. Chapter 5, *Hypnotic Essentials*, covers certain elements and mind-sets that facilitate hypnosis. The sixth chapter, *Hypnotic Aids*, describes how techniques such as guided imagery can help in hypnosis. Chapter 7, *Hypnobirth in Action*, focuses on practice and technique. Chapter 8, *Hypnotic Assistance in the Unexpected*, explains how hypnosis can

be of benefit when things aren't as planned. Chapter 9, *Life after Giving Birth*, explores the use of hypnosis in helping new families adjust. Chapter 10, *Conclusion*, consists of closing remarks.

As a clinical hypnotherapist I have spent many years teaching and coaching laboring women through the experience using hypnosis as a non-invasive approach to pain management and increased empowerment. This is a delightful easily read book targeted for health care professionals who want to learn more about effective, caring, gentle, and safe approaches to managing birth pain. Myths are demystified. Provided are examples of words to use, techniques for visualization, introduction of supporting research, and appendices rich in prompts. Hypnosis can better prepare a mother to face labor or the unexpected with a calm demeanor and informed choices. I encourage you to consider becoming certified in hypnosis so this can be part of your repertoire for assisting the childbearing family.



Dr. Wilson is a faculty member at the School of Nursing at Tennessee State University in Nashville and has a private practice in childbirth education, clinical hypnosis, and lactation support.

Finding Your Way with Your Baby: The Emotional Life of Parents and Babies

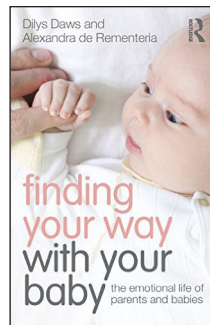
by Daws, D., and de Rementeria, A.

reviewed by Carol Clarke-Campbell, MSN RN

New York: Routledge, 2015, 262 pages,
\$34.95 paperback

This book explores the emotional experience between parents and infants during the first year of life. Authors Dilys Daws and Alexandra de Rementeria, both child psychotherapists, explore the psychological development of infants and provide an understanding of infant behavior through observations developed over decades of clinical experiences and many years of wisdom.

These authors address the emotional experiences frequently overlooked in parenting books and magazines. The book offers current, expert insight about pregnancy and childbirth that includes bonding issues and the ambivalence often experienced by mothers, fathers, and other significant adults. Based on many hours of listening to parents and observing babies, their wealth of experience is very evident. The book is very engaging and easy to read and encourages parents to explore for themselves. A refreshing contrast to other baby books which tend to offer rather prescriptive jargon and advice. The book is more like a wise older person, a supportive grandmother figure,



talking in a reassuring way. Included in the book is a great deal of descriptions by parents about their experiences with their babies. These reports are incredibly moving and open, and speak directly to the reader.

The authors include up-to-date knowledge about postpartum depression, and the emotional turmoil of being a new parent. Also provided is an

excellent chapter on why babies cry that is extremely helpful for new parents during the initial three months of life, when babies frequently cry a lot. The book offers simple, everyday interventions to comfort the fussy baby, and helps parents distinguish normal crying behavior. Other topics include bonding, feeding, weaning, and sleeping. Find-

ing Your Way with Your Baby is ultimately aimed at parenting but can serve as a useful resource for nurses, social workers, mental health professionals and others healthcare staff involved in infant services.

Carol teaches at Tennessee State University in the School of Nursing. She is currently working on a doctoral degree.

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