HEART AND HANDS POSTPARTUM DOULA TRAINING AND CERTIFICATION PROGRAM

April 1-4, 2024, Los Angeles, CA

(on Zoom)

Happy Mama Healthy Baby Alliance

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PERMISSIONS

Introduction

ABOUT THE ORGANIZATION

Happy Mama Healthy Baby Alliance is a community-based, non-profit training and **advocacy organization located in Los Angeles, California.** We are diverse perinatal and mental health professionals united in our mission to provide quality, wholistic maternity care for all childbearing families in Los Angeles County; engender birthing justice and improve birth outcomes for all mothers and infants.

WE ACHIEVE THIS THROUGH THE FOLLOWING ACTIVITIES:

Happy Mama Healthy Baby Community Doula Program – Volunteer Doulas provide Labor Doula Support, Postpartum Doula Care, Breastfeeding Counseling, prenatal and postnatal health education, and mental health screening and referral. Free for Medi-Cal. Sliding Scale.

Empowered Birth Choices Childbirth Education - A four-week childbirth education class for expectant parents. Promoting Informed Choices, Cultivating Trust in Birth. Free for Medi-Cal.

B.I.R.T.H. Mother-Mentor Program (Birth Information and Resources for Teen Health). A mentorship program for adolescent foster care-involved pregnant women; or pregnant and parenting refugees. We provide health education, parenting workshops, social support groups, and support and mentorship from experienced mothers. Free for Medi-Cal.

Professional Networking and Continuing Education - Conferences, Webinars, Plenaries, Film and Discussion Nights, Workshops, Interdisciplinary Peer Review, etc.

Birthing Justice Forum & Maternal-Child Health Champion Awards – Conference on Perinatal Human Rights, and awards ceremony recognizing exemplary perinatal professionals' service to the community.

International Birth Worker Exchange Program – A cross-cultural exchange program between African and American birth workers with learning opportunities and birth experience in a different culture.

Training and Certification Programs

- Perinatal Support Specialist Doula Training
- Heart and Hands Postpartum Doula Training
- Breastfeeding Peer Counselor Training
- Childbirth Educator Training & Internship Program

Introduction

ABOUT THIS COURSE

In this course, you will learn skills to support new mothers and care for newborns immediately following birth and the first months, More than a Baby Nurse, a Postpartum Doula provides emotional support, physical care and comfort to the new mother, provides instruction on self-care and baby care, and instills confidence in her clients for motherhood. Services also may include breastfeeding support, meal preparation, care of siblings, and linking families to supportive services in the community.

ABOUT THE CURRICULUM DEVELOPERS AND COURSE LEADERS

Geraldine Perry-Williams, RN, MSN, ASRN, PHN, LCCE, CLE – Curriculum Developer and Co-Course Leader (Emeritus)

This course was co-developed by the late Geraldine Perry-Williams, RN, ASRN, BSN, PHN, MSN, a public health nurse who worked as the Maternal, Child and Adolescent Health Director and Black Infant Health Program Coordinator for the City of Pasadena Public Health Department for 30 years. "Mama Gerri" passed away in June 2018, but she continues to inspire the course leaders. Geraldine received her Master's in Nursing in Nursing Education from The University of Phoenix. Geraldine worked in the field of maternal child health for over 30 years in various capacities working in the hospital postpartum unit, NICU and high risk and in public health for 25 years. Geraldine was active with CityMatCH, an organization of Maternal-Child Health Directors dedicated to improving maternal-child health in urban centers in the USA. Geraldine was a Birth Assistant/Doula, a La Leche League Trained Breastfeeding Counselor Trainer, a Lamaze Pregnancy and Childbirth Health Educator, State Certified Outreach Worker Trainer, S.I.D.S. Trainer and CPR Instructor and Black Infant Health Program Worker Trainings. She presented on numerous health topics and workshops throughout the community. Geraldine developed and implemented numerous programs for the community. She volunteered in a variety of activities to promote public health including Public Health Week, community health workshops, and facilitating workshops on Trauma Informed Care, Sudden Infant Death Syndrome (SIDS), Black women's health conferences, organizing health fairs and community baby showers in the community of Pasadena, Ca. She was married and active in church activities, and leaves behind four adult children and three grandchildren, all born healthy to healthy moms. Geraldine's joyous spirit and wisdom lives on through this course, which she had the pleasure to develop and instruct for over 10 years until her passing in 2018.

COURSE LEADERS

Cordelia Hanna, MPH, CHES, ICCE, CLE, CBA- Principal Course Leader (English Course), Curriculum Developer

Cordelia Hanna is a highly experienced professional in the field of maternity care, with over 34 years of expertise. She completed her Bachelor's degree in Theatre and Dance from Indiana University, Bloomington, in 1986, and later obtained her Master's degree in Public Health (MPH) in Health Education and Promotion/Maternal Child Health from Loma Linda University in Loma Linda, California, in 2008. Currently, she is pursuing her doctorate in Health Psychology at Walden University. Cordelia is a Certified Health Education Specialist (CHES), which is considered the gold standard for professional health educators accredited by the National Commission on Health Education Credentialing (NCHEC). Additionally, she is an ICEA-Certified Childbirth Educator, CAPPA-Certified Lactation Educator, and ALACE-Certified Birth Assistant. She has been teaching Childbirth Preparation Classes and Breastfeeding Education to hundreds of couples of all ethnic backgrounds and socioeconomic status since 1991 in various settings, including private practice, clinics, public health, hospitals, and communities.

Cordelia is a midwife who received training through apprenticeship. She has worked as an Assistant Midwife and Labor Companion/Monitrice in various settings, including homes, birth centers, and hospitals throughout Los Angeles County and Oregon since 1991. Cordelia is passionate about promoting grass-roots health promoters such as breastfeeding peer counselors, doulas, and community midwives to address ethnic health disparities occurring in their communities. These disparities include low rates of breastfeeding, high rates of prematurity cesarean section, and maternal and infant mortality that occur in communities of color. Cordelia has a global perspective on maternal-child health but focuses on taking local action.

Cordelia worked as a Perinatal Health Educator and Promoter for The Pasadena Public Health Department's Black Infant Health Program from 2002 to 2012. The program was funded by the California Department of Health to reduce African-American/Black perinatal health disparities. Here, she collaborated with her mentor the late Ms. Geraldine Perry-Williams, PHN, MSN, CD, CLE, LCCE, to launch and manage a Breastfeeding Peer Counselor Program. They also established the

first-ever Community-Based Doula Program for African-American/Black families in Los Angeles County. This program was successful in reducing the high rates of infant mortality and cesarean section among Pasadena's African-American population.

Between 2014 and 2019, Cordelia collaborated with Esperanza Community Housing Corporation's Promatora de Salud/Community Health Worker Program in South Los Angeles and the Harbor Corridor. Her role involved providing training on perinatal health and Doula support to Community Health Promoters/Promotores de Salud working in South Los Angeles. This region is known for having some of the highest rates of maternal and infant mortality, which can be attributed to negative social determinants of health.

Cordelia is a mother of two children who were born at home, breastfed, and slept in the family bed. They have now grown up to become bright and capable young adults. Cordelia is also a grandmother of two granddaughters and a grandson. Her life partner is from Ghana, West Africa, and together they enjoy an international lifestyle that spans two continents.

Carla Michael, MSW, CD, CPD, CLE, CPYT, CCE, Student Midwife – Co-Course Leader (English Course)

Carla Michael is an advocate for maternal and child health and a multifaceted professional with a deep-rooted commitment to addressing disparities in healthcare. With a Master of Social Work (MSW) degree from California State University, Los Angeles (CSULA), she brings a wealth of knowledge and experience to her work.

In addition to her MSW, Carla holds several certifications and qualifications that make her a well-rounded expert in her field. As a Full Circle Doula, she's passionate about providing holistic support to expectant mothers during pregnancy, labor, and postpartum. Her dedication to empowering women during this transformative journey is further exemplified by her certification as a certified lactation education specialist, ensuring that mothers receive the guidance and resources they need for successful breastfeeding.

A registered yoga teacher, Carla recognizes the importance of physical and mental well-being during pregnancy and beyond. Her yoga expertise allows her to offer valuable guidance on maintaining a healthy and balanced lifestyle, which is especially crucial for expectant mothers.

Carla's journey towards becoming a midwife reflects her unwavering commitment to addressing

healthcare disparities. With a keen focus on maternal and child health, she's working tirelessly to make childbirth a safer and more equitable experience, particularly for Black mothers and babies.

As a mother of three, Carla brings a personal perspective to her advocacy efforts. Her own experiences have fueled her dedication to creating a world where every Black family has access to the care and support, they deserve.

Her involvement with initiatives like AAIMM (African American Infant and Maternal Mortality) of Los Angeles County demonstrates her commitment to addressing racial disparities and promoting equitable healthcare. Through her work and passion, Carla is making a significant impact in the field of maternal and child health, ensuring that every mother and baby has the opportunity to thrive.

Carla is **Manager of our Community and Professional Education** and is **Program Director, *Generating African American Infant and Nurturers' Survival Initiative (GAAINS) Postpartum Doula Program.*** Carla co-teaches our professional trainings coordinates our scholarship and certification programs and community perinatal health education classes for expectant parents. She looks forward to sharing her wisdom and experience with you in this training.

Introduction

CORE COMPETENCIES FOR POSTPARTUM DOULAS

1. Describes the role of the Postpartum Doula as a member of the maternity care team and discusses ethical guidelines for Postpartum Doulas.
2. Describes social, political and personal reasons why women don't breastfeed.
3. Describes the benefits of breastfeeding to mothers, infants, fathers, grandmothers and society.
4. Demonstrates cultural awareness when working with mothers of diverse cultures.
5. Demonstrates communication skills to help address mothers concerns about breastfeeding, newborn care and postpartum.
6. Identifies and describes the anatomy of the lactating breast and the physiology of how the breasts make milk.
7. Describes the nutritional components of breastmilk and how they are uniquely suited to support the growth and development of human infants.
8. Demonstrates to support a breastfeeding mother and get the baby latched on.
9. Discusses how to manage breastfeeding so it works for the mother.
10. Discusses how to address common problems of breastfeeding and parenting the growing baby.
11. Describes an approach to childrearing which promotes strong family bonds and security in infants called Attachment Parenting.
12. Describes Kangaroo Mother Care—a method of caring for newborns which promotes physiological regulation of the newborn.
13. Discusses Sudden Infant Death Syndrome and two approaches to prevention.
14. Discusses the impact of birth interventions on breastfeeding.
15. Identifies normal and abnormal adjustments to motherhood in the postpartum woman.
16. Supports basic breastfeeding management.
17. Identifies and describes anatomy and physiology of lactation.
18. Provides care and assessment of full-term and premature newborns.
19. Provides physical care and emotional support for postpartum women.
20. Facilitates attachment and bonding of the mother-infant dyad.
21. Identifies and distinguishes between Baby Blues, Postpartum Depression and Postpartum Psychosis and describes appropriate resources for help.
22. Discusses holistic healing approaches for healing after childbirth and common issues of newborn infants.
23. Demonstrates communication and counseling skills for working with clients.
24. Serves as a resource person in the community, linking families to services.

25. Demonstrates care and soothing methods for babies.
26. Describes ways to involve father/partner in care of newborn and postpartum woman.
27. Describes ways to reduce parenting stress.
28. Identifies signs of child abuse and neglect and appropriate referral mechanisms.
29. Discusses impact of perinatal loss on families and demonstrates sensitivity when working with families after a loss
30. Demonstrates cultural competency when working with families of diverse backgrounds
31. Understands the impact of historical injustices, racism, micro-stressors and discrimination on maternal and infant health among women and infants of color and applies strategies to ameliorate stress related to these experiences for pregnant women and new mothers of color.

Introduction

CERTIFICATION REQUIREMENTS

Within ONE WEEK of end of course:

1. Complete certification exam given at last day of course with a score of 80% minimum. You may retake the exam once if your score is under 80%.

Within ONE YEAR of end of course:

2. Complete and Infant CPR course and submit proof of certification.
3. Compile a Community Resource List for Families.
4. Write a 2-page essay on the role of the postpartum doula in the care team, describing personal goals and mission in the profession.
5. Assist 3 families in the postpartum period and submit 3 parent evaluations and 3 self-reports. (Report Forms will be provided).

Recertification is bi- annual. $100 recertification fee plus proof of attendance at a continuing education course or a summary of a peer-reviewed journal article within the past three years must be submitted.

DAY ONE

1

Unit One: Professional Issues

In this unit, you will learn about the expectations and responsibilities of a Postpartum Doula and ways you can support the new family.

Unit One: Professional Issues

THE SCOPE OF WORK OF A POSTPARTUM DOULA & ETHICAL CONSIDERATIONS

The Postpartum Doula (PPD) is a member of the maternity care team that works with pregnant women and new mothers and their infants. More than a baby nurse, the Postpartum Doula provides in-home skilled, non-medical care and companionship for new mothers, cares for infants, and provides assistance to the family with household maintenance during the first days and weeks of the new baby's life. Her duties may include running errands such as grocery shopping, preparation of healthful meals and snacks for the mother and doing baby laundry.

As well, the Postpartum Doula provides emotional support to the new mother, helping her with her transition into her new role as mother by offering compassionate listening, in order to help her understand what occurred during the birth and help her articulate her feelings about it.

In addition, postpartum doulas may care for newborns by feeding, swaddling, bathing, etc. and may instruct the parents on newborn care, help set up a nursery, and connect families to community resources as needed.

Postpartum Doulas do not perform clinical skills such as weighing the newborn, taking temperatures, taking blood pressure, or other postpartum clinical skills of mothers and newborns, unless she has additional training such as midwife assisting, nursing assisting, lactation counseling, etc.

In addition, some Postpartum Doulas may provide complimentary services such as homeopathy, herbology, Ayurvedic medicine, infant and mother massage, if qualified and trained to do so.

The Postpartum Doula's role is not to usurp the role of the parents. It is an extra hand to fill a water glass, hand a weepy mother a tissue and give her hug, change baby diapers, prepare a bottle. The doula is not a baby-nurse or nanny, and she should not be expected to care for a baby all night long so parents can get 8 hours of sleep. The Postpartum Doula's role is short-term and very focused. The goal should be to educate and empower families and instill in them confidence to parent their baby and be self-reliant. We support the woman's adjustment to motherhood so she can be a fully capable mother.

Finally, while many of us enter this profession because we love babies and have a very strong feelings about how they should be cared for. We can make gentle suggestions and educate, based on the best scientific evidence, and then respect the parent's preferences. Ultimately they must parent their child in the way that works best for their lifestyle.

It goes without saying that we need to respect our clients' confidentiality and keep their names and details of their experience anonymous when sharing with peers in a learning situation.

Unit One: Professional Issues

TYPICAL SHIFTS WORKED AND LENGTH OF SERVICE OF A POSTPARTUM DOULA

SHIFTS WORKED

The types of shifts a Postpartum Doula works may vary depending upon the family's needs. Here are some possible shifts:

- Full Days - 9:00 am to 5:00 pm or until father gets home from work.
- Half Days – morning until lunch 7:00 am to 12:00 pm (4-6 hours) or afternoon or evening until bed (4-6 hours), for example, 5 pm to 9 pm.
- Overnights – from 9:00 pm or 10 pm until morning (between 6 am and 9 am).

FEES CHARGED

This will vary greatly. However, fees range from $25 per hour to $50 per hour. Postpartum Doulas may charge half day (4-6 hours) rate such as $100-200, or a full day (8 hours) rate such as $200-400. Overnight rates could range from $600-800 per night (16-24 hour shift). Weekly rates may range from $1000-1800. Fees will vary depending upon socioeconomic status of family served, commonly charged rates of peers, years of Postpartum Doulas experience and extra services offered (such as cooking, massage, herbology, being a Licensed Midwife or Registered Nurse, etc.).

LENGTH OF SERVICE

Things to consider when determining the length of service:

- Mother's experience with birth ○ Did she have a cesarean or a bad tear or episiotomy? If so she may be in pain and need a doula for longer.
- Multiples or Singleton Babies ○ A family with twins or multiples (especially if they have older children) are going to need more help.
- Temperament of the Newborn ○ A "high need" baby is going to require a lot of the new parents and they may need more reassurance or helping hands.

- Amount of Support the Family Has
    - Does she have a supportive network of family, friends, church, temple or synagogue members? What is her relationship like with her family? Do they stress her out or is she comforted by their presence?

- Mother or Baby Special Needs ○ If the baby is premature or has Jaundice, the mother has a lot of trouble breastfeeding, or some other issue, the family may need your help longer.
- Mother's Temperament
    - What is the mother like? Is she high strung and anxious or is she calm and relaxed? Is she over-functioning and unable to relax, ultra-perfectionistic or is she more laid back? Is she very insecure about her ability to parent? If so, she may need your encouragement and support longer.
- Father/Partner* Experience ○ How is dad/partner coping with everything? Many times, he feels at wits end, upset by his inability to make things better for the mother, s/he feels helpless, exhausted and overwhelmed as well. He/she may not have a clue on how to care for or bond with his/her baby. This is where the Postpartum Doula can make a real difference, teaching him/her what he can do to help his partner (bringing her water or a pillow when she nurses the baby), and teaching him/her how to bathe the baby or change a diaper. Dad/Partner may need additional support from other father/partners, and may also need your encouragement and guidance.[* the term father/partner is used, because the family may consist of two female partners]
- Couple's Relationship ○ Are they loving and supportive of each other or are they competitive, resentful of each other and taking out their frustrations on each other? If so, you may need to help them to learn to work together as a team, or refer them to a marriage/couples counselor. Part of the job of the Postpartum Doula is to listen to the parents and be empathetic and make suggestions if appropriate. However, unless you are trained to do so, don't be their marriage counselor. Refer to a professional counselor as needed.
- Older Siblings ○ If so, you may need to help with them as well, making them dinner, seeing that they are doing homework, showing them how to help with the baby.
- Financial Situation ○ This often will be the biggest factor on how long an assignment you will have with a family. Many times they are trying to figure out what they can afford. So, suggest that family or friends donate the postpartum doula care as a shower or new parent gift.
- Philosophy or Parenting Style ○ While the Postpartum Doula's role is to educate and promote evidence-based approaches to newborn care (i.e., breastfeeding, prevention of SIDS), you should always be sensitive and respectful to the parents' childrearing philosophy, or cultural traditions. Sometimes the simplest suggestion, such as changing baby diapers in the bed to minimize mother being on her feet too much, could be seen as "weird" by the mother. She may resist your suggestions. As a Postpartum Doula, you can ask that the mother try out what you recommend and see if it works for her. You need to be open to her adaptations as she is figuring out how best to parent her baby. Sometimes, it becomes a source of tension between the family and the Postpartum Doula if the family is not comfortable with your approach or the doula is not comfortable with the family's parenting style (such as crib sleeping or bottle-feeding). In which case, it may be appropriate to refer the family to a colleague who is a better fit with the family, or else you will need to work with their parenting style.

Unit One: Professional Issues

EXAMPLES OF TASKS WHICH MAY BE PERFORMED BY POSTPARTUM DOULAS

1. Lend a listening ear to an exhausted, overwhelmed new mother and father. Give hugs and reassurance and encouragement and acknowledgement.
2. Listen to the mother's story of her birth. Praise her, validate her feelings.
3. Give father handout on signs of postpartum depression and baby blues, and a referral to use if needed.
4. Tidy the kitchen, emptying the dishwasher, putting away dishes and taking out the trash.
5. Prepare healthy snacks for the mother such as vegetables, hummous and pita, cheese and crackers, hard-boiled eggs, etc.
6. Prepare lunch for mother, serve her in bed. Wash all dishes after she's done eating.
7. Prepare beverages and snacks and bring them to mother's bedside.
8. Set up mother with diapers, wipes, ointment, baby clothes and everything she needs (i.e., channel changer, cellphone, etc.) right near her bed to minimize walking.
9. Instruct mother on how to care for her perineum, cesarean incision, etc. Refer her to her caregiver as needed.
10. Help mother with bathing, showering, dressing, as needed.
11. Wash baby's clothing and fold it and put it away.
12. Play a game with the older child(ren) or engage them in doing laundry while mother sleeps.
13. Show father how to hold his baby skin-to-skin against his chest.
14. Discuss with mother the importance of Kangaroo Care and newborn physiological regulation, emphasizing the importance of the Maternal-Infant Dyad.
15. Show father how to clean his newborn daughter's genitals during a diaper change.
16. Show father and mother how to care for their newborn son's circumcision, or care for an uncircumcised penis.
17. Set up the newborn nursery per the mother's instructions.
18. Show parents how to swaddle the baby in a blanket and use a sling.
19. Show new parents how to soothe the baby using Harvey Karp's techniques.
20. Discuss the benefits of co-sleeping and describe guidelines for safe co-sleeping, or to crib-sleep safely.
21. Discuss the "Back to Sleep" approach to reduce SIDS with new parents.
22. Reassure Grandma that baby is getting enough milk through breastfeeding. Give her Le Leche League's information.
23. Educate new parents and grandmother on safe breastmilk handling and formula preparation guidelines.
24. Sterilize breastpump and bottles. Help new mother learn how to work her new electric pump.
25. Drive mother to the store to select a nursing bra.
26. Bring mother her vitamins or medications, as needed.

27. Discuss After-Pains and the appearance of lochia. Bring mother heating pad or hot water bottle as needed.
28. Give mother a massage, a homeopathic remedy or Bach Flower Essence if you are qualified and trained to do so.
29. Drive mother to pediatrician for baby check-up or to her midwife for a post-birth check-up.
30. Make a referral to a chiropractor, massage therapist, acupuncturist, placenta encapsulation specialist, or a more supportive pediatrician who supports breastfeeding.
31. Discuss care of the mother's perineum. Get mother ice pack to put on it if necessary.
32. Discuss basic management of breastmilk including how to deal with sore breasts and be sure the baby is getting enough milk.
33. Read a story to the big brother or sister, and tuck him or her into bed before leaving for the night.
34. Take the big brother to the park or for ice cream so mother can rest.
35. Stay overnight at family home and feed and change newborn at night.
36. Make menu plan based on what the family likes to eat, and grocery shop for ingredients to prepare meals for a week, put in freezer.
37. Explain to parents about normal newborn appearance: peeling skin, lanugo hair, vernix, Mongolian spots, cross-eyes, caput, "soft spot" on head, swollen genitals and breast tissue, discharge or blood in baby's vagina, etc.
38. Describe and demonstrate normal newborn reflexes: Babinski, Palmar, rooting, sucking, etc.

These are just typical examples and are by no means an exhaustive or exclusive list.

2

Communication Skills

In this unit, you will learn a communication technique for counseling and educating clients called
The Three Step Strategy.

Unit Two: Cultural Awareness and Communication Skills

COMMUNICATION SKILLS
ACTIVE LISTENING

ACTIVE LISTENING: WHAT IS IT?

As a Postpartum Doula, you'll use a counseling technique called "Active Listening." This is different from the "Social Listening" which we practice when we speak as friends.

The technique involves communicating concern and empathy without prying or invading the mother's privacy. Active listening helps us better understand and help mothers. When a mother knows you are really listening to her, she will feel cared for and important and comfortable sharing information with you, making it easier to help her effectively. Active listening will help you discover what each mother needs most from you; information, suggestions and ideas or reassurance and encouragement. Sometimes, all she will need is someone to tell her, "You're okay" or "That sounds normal." Active listening is a skill one needs to practice. With practice, Active Listening will become second nature to you. You will be able to use the technique without having to concentrate on doing it.

COMMUNICATE CONCERN/EMPATHY WITHOUT PRYING/INVADING MOTHER'S PRIVACY

The goal is to make her feel safe, cared for, and comfortable sharing information. Ask yourself what she needs: suggestions, reassurance, ideas, encouragement.

CONFIDENTIALITY

Any information a mother shares with you is confidential and not to be shared with others. If you need to consult with someone else regarding the mother's problem, do not use the mother's name. You are responsible for following HIPPA Guidelines.

KNOW YOUR LIMITATIONS

A Postpartum Doula is not a healthcare provider and does not give medical advice. A Postpartum Doula should always feel free to say, "I need to check on that. Let me call you back." (Then, if it's a medical issue, check with your program administrator, a nurse, a lactation consultant, a pediatrician, an obstetrician, or a midwife.)

Unit Two: Communication Skills
COMMUNICATION SKILLS
TIPS FOR POSTPARTUM DOULAS

COUNSELING GOALS

- To be a safe, nonjudgmental, informative, and helpful listener to whom mothers can talk about breastfeeding, their birth, infant care, relationship issues, or anything else.
- To help a mother clarify and understand her situation and to assist her to find her own solution to her situation.
- To offer information and assist the mother in discovering options which might be helpful in her situation
- To empower others and to show them the gift of themselves. To help them see themselves as capable people and boost their self-esteem.

COUNSELING DOES NOT MEAN GIVING ADVICE!

- What are the dangers of giving advice? Write your answer in the space below

COUNSELING SITUATIONS ENCOUNTERED

- Women are at different stages in their mothering careers
- What does giving practical help look like?

Unit Two: Communication Skills

COMMUNICATION SKILLS: TIPS FOR PHONE COUNSELING

REFLECTIVE LISTENING SKILLS

- Give in small pieces
- Get feedback: verbal or bodily response
- On phone check for voice tone and pauses
- Ask mother to restate information you gave her, as she understands it, for your clarification
- Write down, or have mother write down, or send lengthy information to her.
- Recommend a book, reprint or pamphlet.

CONCLUDING THE DISCUSSION

Ensure mother's self-esteem: uplift and praise her; leave the mother feeling good about herself as a mother. Any mother with a living child is doing something correctly. Look for things she is doing well. Be specific and genuine.

TELEPHONE ASSISTANCE

Goal in completing phone conversation is to build the mother's self-confidence and trust in her own mothering instincts. This helps create a strong bond between mother and baby, enabling the mother to solve many of her own problems simply by looking to her baby and responding to his needs.

The Postpartum Doula's physical environment; whether you are at home or in an office, you need to have some basic tools to be effective on the phone.

- The PPD's log is valuable for keeping accurate records.
- Pens, not pencils, allow you to keep permanent notes
- Telephones come in a variety of styles. Cordless models and headsets allow you to talk to mothers and still move around. Telephone assistance is different than giving assistance in person. The case manager cannot see the mother and baby. Much of the information gathered from observation is not available: mother and baby general health, activity level, interaction, positioning (if providing breastfeeding support). More questions need to be asked to get as many details as possible.
- If there is any doubt that the baby may not be thriving, the mother must be referred to someone who can observe the baby, her health care provider (HCP), a clinic visit, a lactation consultant.
- When the doula initiates the phone call, it is important to ask if this is a convenient time for the mother to talk on the phone.
- The doula must speak more slowly and clearly than in person.
- Handle crank calls by hanging up. Asking for the crank callers name will cause them to hang up.

Report repeated problems to the supervisor.

- When a mother decides to stop breastfeeding:
  ○ "I certainly wish your nursing experience had been more enjoyable." ○ "That must have been a difficult decision for you." ○ "You sound happier/relieved now that you have stopped." ○ "If I can be of further help, please call."

PRACTICING GOOD LISTENING SKILLS

- Be friendly, interested, supportive and accessible
- Use active listening
- Rephrase what the mother has said
- Identify the mother's feelings
- Let the mother set the pace
- Respond without judging
- Ask open-ended questions
- Sort out multiple concerns
- Share information rather than give advice
- Present information in a positive way
- Make suggestions
- Discuss options
- Share personal experiences cautiously
- Limit suggestions and new information to what is of immediate importance • When PPD's suggestions differ from the doctor's advice:
  ○ Say, "Many mothers have found..." ○ Encourage the mother to share her feelings, "Nursing is very important to me." ○ Encourage the mother to seek a second medical opinion. ○ Refer the mother to the lactation consultant or nutritionist or other health professional.

IF YOU DON'T KNOW THE ANSWER

- When you don't know the answer, it is a chance to learn. Tell the mother you will find out the answer and follow up with her.
  - When a mother asks for help beyond your expertise, refer her to the appropriate resource.
  - Recap the discussion.

DEVELOP A PLAN FOR FOLLOW-UP

- Mother to call back the PPD
- PPD to call the mother.
- Mother to come into the clinic.
- Mother to see her health care provider

Unit Two: Communication Skills

COMMUNICATION SKILLS

THE THREE STEP STRATEGY FOR COUNSELING

This is a counseling skill which is very valuable skill for the Postpartum Doula to have in her tool kit. It works well when time is short and quickly meets the client's needs.

1. **Ask Open Ended Questions** *(Gain understanding of her concerns by):*
    (a) Clarifying
    (b) Redirecting
    (c) Reflecting
    (d) Padding
2. **Affirm Feelings**
3. **Educate**

Question: "How are you feeling today?"

3

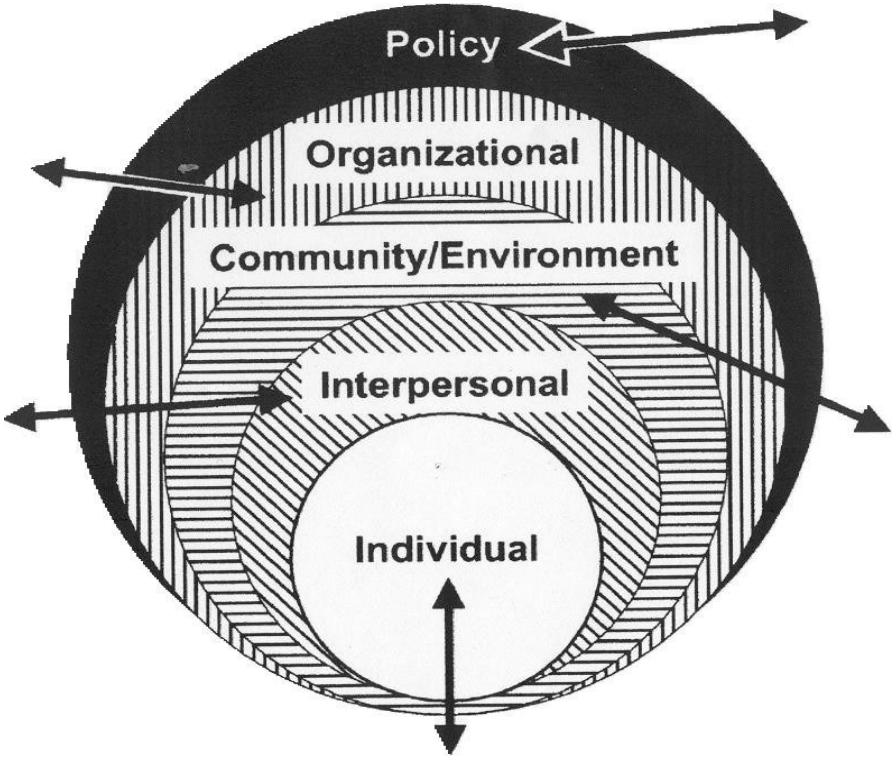
Unit Three: Supporting Breastfeeding

In this unit, you will learn why some women don't want to breastfeed, and how the social environment hinders or helps mothers breastfeed. You will also learn how to promote breastfeeding, and support breastfeeding mothers. You will learn about how the breasts make milk, the reason breast milk is the ideal food for growing babies, and how to help mothers get started and overcome common challenges of breastfeeding. You will also learn about breastfeeding in special situations and when to refer to a medical doctor or lactation consultant.

Unit Three: Supporting Breastfeeding

BARRIERS TO BREASTFEEDING SOCIOECOLOGICAL MODEL OF BREASTFEEDING

The reasons why women do not breastfeed are complex. There are various domains of influence over a woman's choice to breastfeed and to maintain breastfeeding. These include family, social circles, neighborhood, work environment, and public policy, etc. In the space below, write down the types of organizations, institutions, political factors and social conditions, environmental conditions, that might hinder breastfeeding.



Knowledge Beliefs Attitudes

Source: Bentley, E.B. et al, Amer. Soc. Nut. Sci (2003) Breastfeeding in Low Income African-American Women: Powers, Beliefs and Decision Making

Unit Three: Supporting Breastfeeding

BARRIERS TO BREASTFEEDING

SUMMARY: SOCIOECOLOGICAL MODEL OF BREASTFEEDING

WHY WOMEN DON'T BREASTFEED

- **Macro-Micro levels**

1. **Macro-Level influences**
    a. Mass media gives mixed messages
    b. Powerful and persuasive
    c. Affects social norms regarding breastfeeding
    d. Television commercials; billboards, magazines
    e. Marketing of "artificial baby milk" - Formula is the norm, breastfeeding is not
    f. Welfare reform – Women have to return to work or school early
    g. Hospital influences
    h. Give free formula upon discharge
    i. Introduction of formula bottles and pacifiers before they leave the hospital
    j. Separation of infants from mothers
2. **Micro-level influences**
    a. Lack of support from society
        i. Community members do not support breastfeeding
        ii. Lack of support from medical community, providers
        iii. Workplaces may not have facilities for pumping
        iv. High crime neighborhoods
        v. Need to use public transportation
    b. Social and personal networks
        i. Support or lack of support from social network – friends, Grandma, father of baby, care providers
    c. Cultural norms
        i. Support or lack of from American culture ii. Lack of role models — don't know anyone who breastfeeds

WHY WOMEN DON'T BREASTFEED

d. Individuals own knowledge and beliefs

i. Misconceptions

ii. wrong information

iii. Ethnicity

iv. Maternal age

v. Education level

vi. Employment

vii. Parity

viii. Mental status

ix. Fears

x. Pain

xi. Embarrassment of breastfeeding in public Lack of information about its benefits

> "Ultimately, breastfeeding is not a race issue, nor a women's issue. It is important for public health in general. Breastfeeding is always more successful if women have the support of partners and friends. In terms of public health and cost savings, everyone benefits from breastfeeding." Renata Forste, 2001.

HELPING WOMEN CHOOSE TO BREASTFEED

1. Complex set of reasons

a. Factors either reinforce or discourage a woman's decision to breastfeed.

b. The community and culture as a whole needs to change their view of breastfeeding and change messages about it. Increased outreach and education must be done.

c. Increased outreach and education

d. Reinforce and encourage their decision to breastfeed

e. Provide peer support and role models

Unit Three: Supporting Breastfeeding

MYTHS AND REALITIES OF BREASTFEEDING
BREASTFEEDING MYTHS
Falseheads that are commonly accepted as true

MYTH 1	Some formulas are better than breast milk because they have added vitamins.
MYTH 2	Breastfed babies should be fed on the same schedule as bottle-fed babies.
MYTH 3	Some mothers may not be able to produce enough milk for their babies.
MYTH 4	It is possible for a baby to be allergic to it's mother's milk.
MYTH 5	If a mother is sick with a cold or flu she should quit breastfeeding.
MYTH 6	It is not helpful for a baby to nurse before "the real milk" comes in.
MYTH 7	Breast milk looks just like formula.
MYTH 8	Breastfeeding ruins a woman's breasts.
MYTH 9	Nursing a baby during a menstrual period is unwise.
MYTH 10	Small-busted women cannot produce enough milk to feed a large baby.
MYTH 11	Babies should get used to the bottle as soon as possible.
MYTH 12	It is okay to use any kind of birth control pills while nursing.
MYTH 13	Mothers need to drink milk to make milk.
MYTH 14	Nursing mothers need to be on a special diet.
MYTH 15	Even breastfed babies need water in the early days when it's hot.
MYTH 16	A mother can never have too much milk.
MYTH 17	Nipples should be cleaned with soap and water before each feeding.
MYTH 18	All babies will wake up to nurse when hungry enough.
MYTH 19	A mother younger than 16 years old cannot nurse.
MYTH 20	If a mother quits nursing, then changes her mind, she cannot go back.
MYTH 21	A mother should never breastfeed for more than 5-10 minutes on each side at a feeding.
MYTH 22	Breastfed babies do not need to be burped.
MYTH 23	If a mother picks her baby up every time it cries, she will spoil the baby.
MYTH 24	If a mother gets sore nipples, she should not nurse as often.
MYTH 25	If a baby is gaining slowly, the mother probably does not have enough milk.
MYTH 26	Fat babies are healthier than thin ones.
MYTH 27	A breastfed baby's bowel movements look just like a bottle-fed baby's.
MYTH 28	A mother's social life is very limited if she breastfeeds her baby.
MYTH 29	Starting a baby on cereal is the best way to get him to sleep through the night.
MYTH 30	Adoptive mothers cannot breastfeed.
MYTH 31	If a mother needs to return to work, she will have to wean her baby.

Adapted from: La Leche League Breastfeeding Peer Counselor Training (1999)

ANSWERS TO MYTHS (All are False)

MYTH 1	Some formulas are better than breast milk because they have added vitamins. • *Breast milk cannot be duplicated.* • *Researchers are still making discoveries.* • *Some of the added vitamins and iron in formula may be harmful to baby* • *Milk is species-specific; whale for blubber and buoyancy, deer for running and survival, human milk for brain growth*
MYTH 2	Breastfed babies should be fed on the same schedule as bottle-fed babies. • *Breastmilk is readily digested* • *Breastfeeding meets babies' emotional needs as well as nutritional needs*
MYTH 3	Some mothers may not be able to produce enough milk for their babies. • *This is true although rare.* • *The key is frequent nursing.* • *Breastmilk is always available.*
MYTH 4	It is possible for a baby to be allergic to its mother's milk. • *It is usually something the mother ate.* • *It could be outside allergens*
MYTH 5	If a mother is sick with a cold or flu she should quit breastfeeding. Bottle fed babies have twice as many infections • *Baby is already exposed to germs* • *By the time the mother is sick, her body is making antibodies against the virus that goes through her milk.* • *Risk engorgement if stop breastfeeding*
MYTH 6	It is not helpful for a baby to nurse before "the real milk" comes in. • *Benefits of colostrum.* • *Nursing right way helps milk come in.* • *Nursing contracts uterus, lessens lochia.*
MYTH 7	Breast milk looks just like formula. • *Breastmilk will look different at different times (thin, bluish, thick, yellowish).*
MYTH 8	Breastfeeding ruins a woman's breasts. • *Changes occur in breasts due to pregnancy, get bigger, usually return to their normal size after nursing is over. Wearing a supportive bra is recommended.*
MYTH 9	Nursing a baby during a menstrual period is unwise. • *Hormones are natural.*
MYTH 10	Small-busted women cannot produce enough milk to feed a large baby. • *Breast size does not affect milk supply.*

MYTH 12	It's okay to use any kind of birth control pills when breastfeeding. • *No, progesterone only pills or shots should be used, not those with estrogen as this can reduce the milk supply.*
MYTH 13	Mothers need to drink milk to make milk. • *Cows don't drink milk.* • *Drink to thirst*
MYTH 14	Nursing mothers need to be on a special diet. • *Need more protein, extra calories* • *Aim for a balanced diet*
MYTH 15	Even breastfed babies need water in the early days when it's hot. • *No nutritional value for baby.* • *Could cause nipple confusion.* • *Breastmilk already contains water.*
MYTH 16	A mother can never have too much milk. • *Engorgement is common in early days.* • *Supply will eventually match demand*
MYTH 17	Nipples should be cleaned with soap and water before each feeding. • *Avoid soap.* • *Not necessary to cleanse the nipple area.*
MYTH 18	All babies will wake up to nurse when hungry enough. • *Wake baby every 3 hours in 1st week.* • *Nurse baby if breasts become too full.*
MYTH 19	A mother younger than 16 years old cannot nurse. • *Milk production is part of pregnancy.* • *If a girl is able to conceive and give birth, she can breastfeed.*
MYTH 20	If a mother quits nursing, then changes her mind, she cannot go back. • *Relactation is possible.* • *Milk remains in breasts for several months.*
MYTH 21	A mother should never breastfeed for more than 5-10 minutes on each side at a feeding. • *Fast vs. Slow eater (some babies are more efficient at emptying the breast).* • *Nutritional vs. emotional eating.* • *Sucking needs differ.* • *Baby may not be getting hind milk.*
MYTH 22	Breastfed babies do not need to be burped. • *Some do, some don't.* • *Gentle patting or rubbing is enough.*
MYTH 23	If a mother picks her baby up every time it cries, she will spoil the baby. • *Meet baby's needs – teaches baby to trust.* • *Compare with spoiled fruit.*
MYTH 24	If a mother gets sore nipples, she should not nurse as often. • *Important to nurse often.* • *Least sore side first.* • *Check latch on.*
MYTH 25	If a baby is gaining slowly, the mother probably does not have enough milk. • *Charts are often based on bottle fed babies* • *Does a chart have 6-8 wet diapers, 2-5 stools.* • *Is baby nursing on demand?* • *Is baby gaining 4-7 ounces per week?*

MYTH 26	Fat babies are healthier than thin ones. • B*abies can gain too much weight on formula or solid foods.* • *Healthy breastfed babies come in all sizes.*
MYTH 27	A breastfed baby's bowel movements look just like a bottle-fed baby's. • *Breastfed babies have very loose bowel movements.* • *Can range in color from green to yellowish.*
MYTH 28	A mother's social life is very limited if she breastfeeds her baby. • *Mother can take baby along.* • *Nurse before leaving.* • *Look at time in relationship to her whole life span.*
MYTH 29	Starting a baby on cereal is the best way to get him to sleep through the night. • *Normal for babies to sleep through the night—protective mechanism.* • *Allergy possibility.* • *Can nurse baby in bed to get to sleep.* • *Link to childhood and adult obesity- overfeeding.* • *Bowel obstruction.*
MYTH 30	Adoptive mothers cannot breastfeed. • *Even a woman who has never been pregnant can lactate with enough stimulation.* • *Even a mother who has not lactated for many years can relactate.*
MYTH 31	If a mother needs to return to work, she will have to wean her baby. • *She can express milk and store for her baby.* • *Breastfeeding helps with bonding when mothers and infants are separated.*

Adapted from: La Leche League Breastfeeding Peer Counselor Training (1999

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Unit 3: Supporting Breastfeeding

PRODUCTION OF BREASTMILK

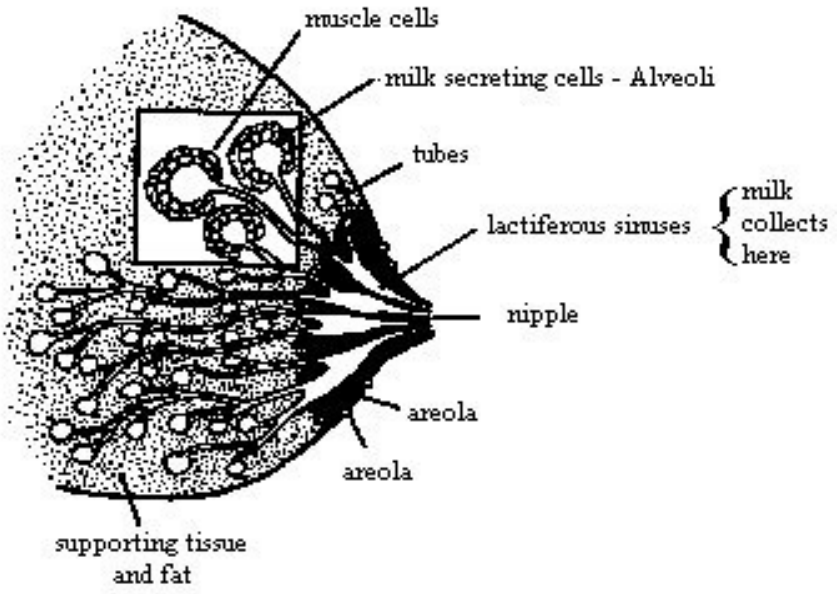


Fig. 3: Anatomy of the breast

HOW BREASTMILK IS PRODUCED

The female breast is the gland that produces milk. The female breast begins to prepare for lactation with the onset of puberty. As a woman matures there is a further mammary development giving a characteristic structure to the breast. During pregnancy, the glandular cells of the breast change into actual secreting cells. By the time the baby is born, the breast reaches a degree of development capable of producing milk.

Let's understand how milk is actually produced. The breast consists partly of gland tissues and partly of supporting tissues and fats (Fig. 3).The gland tissue (technically known as alveoli) are small sacs, made up of millions of milk secreting cells which goes along small tubes towards the nipple. Before they reach the nipple, the tubes become much wider, and form lactiferous sinuses in which milk collects. The nipple contains many sensory nerves so it is very sensitive. This is important for the responses which help milk to come. Around the nipple there is a circle of dark skin called areola. Beneath the areola are the lactiferous sinuses. Therefore, areola must go inside the baby's mouth in order to draw milk from sinuses.

HOW BREASTMILK FLOWS AND REACHES YOUR BABY

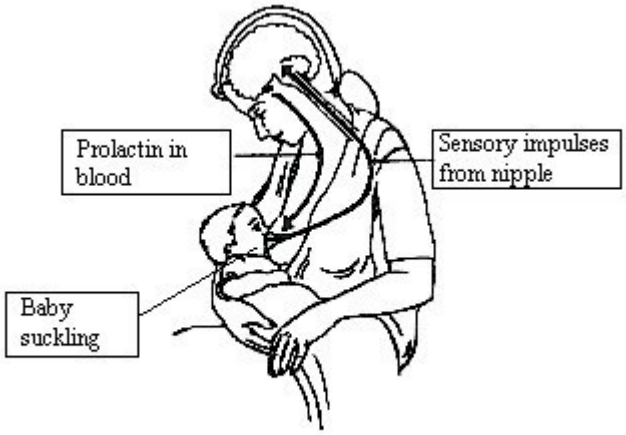


Fig. 4: The prolactin reflex or the milk secretion response

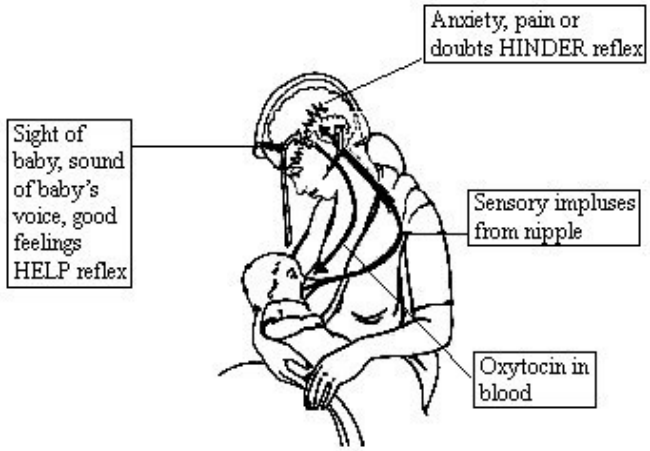


Fig. 6: The milk flow response

Every time your baby suckles at the breast, he stimulates the nerve ending in the nipple. These nerves carry message to the brain, which makes a hormone called prolactin. The prolactin goes in the blood to the breast and them secrete milk for this feed and the next feed. Prolactin works after the baby suckles and makes milk for the next feed. These events from the stimulation of the nipple to secretion of milk are called the milk secretion response, or prolactin reflex (Fig. 4). It is very important to understand the effect of suckling on milk production. If your baby suckles more, your breast will make more milk. If the baby stops suckling or if he never starts, the breast stops making milk. If you have twins and they both suckle, then your breasts will make extra milk for two babies. This is called the law of demand and supply. Feeding during night increases the supply of milk as more prolactin is secreted at night.

Ejection and flow of milk to your baby is due to production of another hormone called oxytocin. Stimulation of sensory nerves in the nipple by suckling also induces the production of 'oxytocin' (Fig. 5), which acts on the muscle cells around the alveoli causing the ejection and flow of breastmilk to your baby's mouth. These events are the milk flow response, or oxytocin reflex.

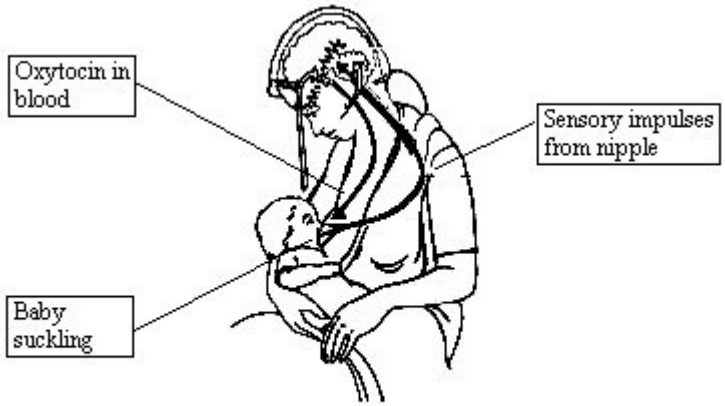


Fig. 5: The oxytocin reflex or the milk flow response

Oxytocin is produced quickly with the start of the suckling and is responsible for milk transfer from breast to the baby. If oxytocin is not produced adequately, the baby may have difficulty in getting the milk. It may seem that breast is not producing milk, but the fact is the milk is there but not flowing.

Oxytocin release is affected by your mental state. Good feelings, thinking lovingly of your baby, feeling confident that your milk is the best and enough for the baby will stimulate oxytocin reflex. The sight of your baby and the sounds made by the baby also help increase the oxytocin reflex.

If you lack confidence or doubt your ability to produce enough amount of milk for your baby it leads to decrease in oxytocin, and sets out a cycle of poor confidence, less secretion of oxytocin and you feel that the baby is not getting enough. Negative feelings like pain, worries, anxiety also inhibit the oxytocin reflex. (Fig. 6)

Unit Three

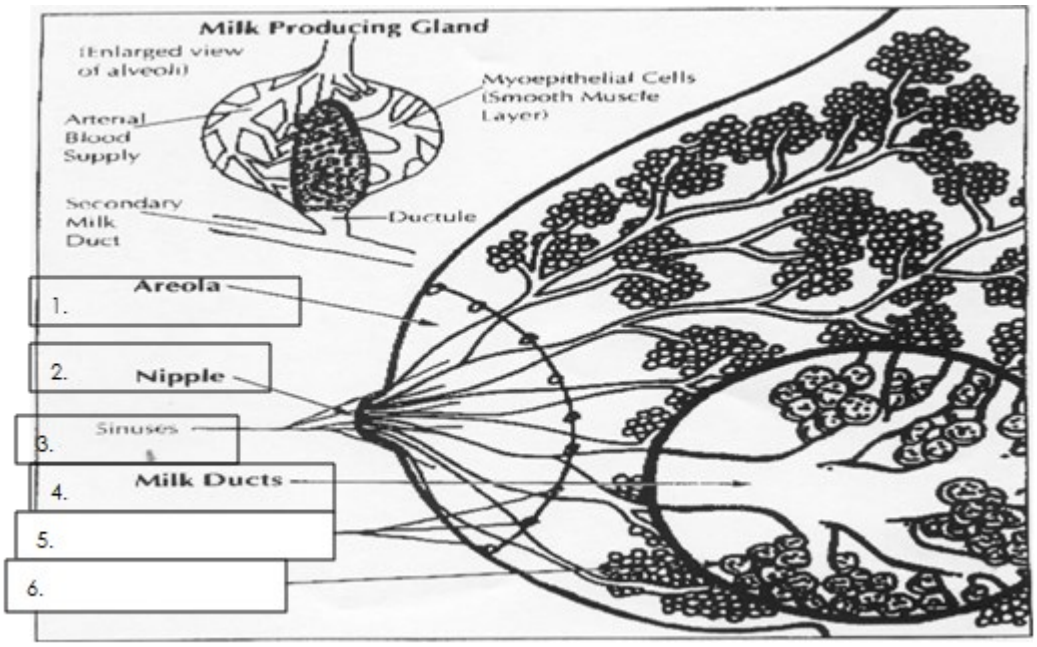
Supporting Breastfeeding: Anatomy and Physiology of Breastmilk

ANATOMY AND PHYSIOLOGY OF LACTATION PRACTICE TEST

Directions: Identify the parts of the breast anatomy.

Baby's suckling stimulates nerves in the nipple which, through the nervous system, sends the message to the pituitary glands in the mother's brain to secrete the hormones o_____and p_____ into the mother's bloodstream. The hormone p_____overrides o_____and causes the milk producing glands called a_____to activate and produce milk. The hormone o_____causes the smooth muscles (Myoepithelial Cells) surrounding the milk producing glands to contract, which ejects high-fat milk into and through the ducts to the s_____where the baby can "milk" it out. This is called the l_____ r_____.

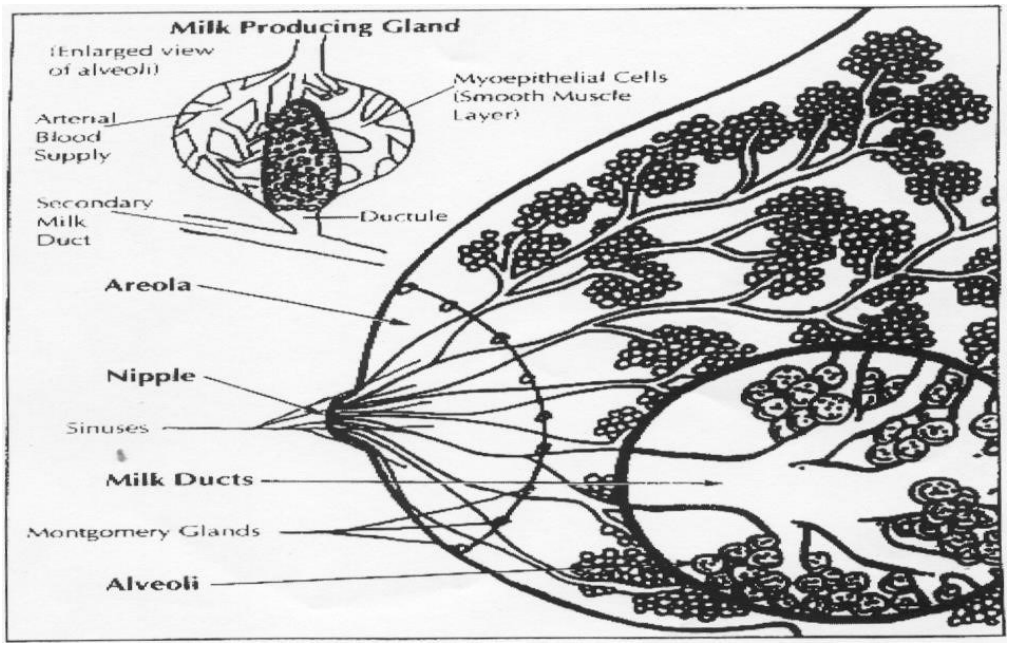
Directions: Identify the parts of the breast anatomy. Then, using the balloon and marker you were given, blow up the balloon. Then, draw the breast anatomy and label it.



Answers to breast anatomy are on next page.

Answers to The Nipple and Breast Anatomy:

1. **Areola** (the darker brown area of a woman's breast surrounding the nipple).
2. **Nipple** (holes in nipple where milk comes out).
3. **Sinuses** (where the milk pools – new research says they don't really exist).
4. **Milk Duct**s (branch like tubes extending from clusters of alveoli).
5. **Montgomery' Glands** (small, raised areas on the areola; lubricant for nipple; antibacterial).
6. **Alveoli** (grape like clusters that pool the milk).



What is the anatomical structure which scientists now tell us do not really exist?

Draw an X over the part new research shows does not exist

Unit 3: Promoting Breastfeeding

DEALING WITH INFANT/MOTHER SEPARATIONS

BREASTMILK PUMPING AND STORAGE GUIDELINES

- First, wash hands well.
- Wash breast pump equipment that contacts the breast, Milk, or collection containers in a dishwasher or by hand, in hot, soapy water. Rinse with cold water and air dry on a clean towel. Check with your hospital or doctor for any other instructions.
- When to pump depends on you and your baby's schedule. Your milk supply usually is most plentiful in the morning, so that is a good time. Try to pump midway between feedings. Be flexible. If your baby skips a feeding, nurses a shorter time than usual, or only nurses on one side, pump out the rest of the milk and save it. If you are planning to return to work and continue breastfeeding, begin pumping one to two weeks before you return. Try to simulate what your pumping schedule will be at work. Before pumping, get comfortably seated and relaxed. Pump your breasts.

Storage

There are several containers available for storing breastmilk. These include specially designed plastic bags, plastic bottles or glass containers. There are advantages to each.

1) If you are going to freeze your breastmilk, leave some space at the top of the container. Breastmilk, like most liquids, expands as it freezes.

2) When using plastic bags, use those designed for breastmilk collection. Before storing, fold the top several times and seal with freezer or masking tape.

   Place smaller bags in a larger bag to help protect against punctures. Medela's CSF bags come with twist ties for easy sealing and don't need to be double bagged.

3) Mark the date and amount on each container.

4) Freeze your milk in two ounce to four ounce portions. Smaller amounts thaw quicker, and you will waste less milk if your baby consumes less than you anticipated.

5) You may continue to add small amounts of cooled breastmilk to the same container throughout the day. Chill in the refrigerator until evening. Then, freeze in appropriate amounts.

6) You may also add to previously frozen milk. First refrigerate all freshly expressed milk until cold, and then add to the frozen milk. The newly added milk must be of a lesser amount than the previously frozen milk.[1]
7) If you carefully washed your hand before pumping or expressing, your breastmilk will be safe for a few hours at room temperature, 68'F. Immediate refrigeration, however, is recommended.[2]

8) Fresh milk may be stored in the refrigerator for up to 72 hours[3] at 39'F.

9) Frozen milk may be stored in the back of the freezer portion of a refrigerator-freezer for up to six months[4].

10) Frozen milk may be stored in a -20'C deep freezer for up to 12 months[5].

11) Defrosted milk may be kept for up to 24 hours in the refrigerator[6]. Breast Milk Storage Guidelines

	Room Temp.	Refrigerator	Home Freezer	-20'C Freezer
Freshly Expressed breastmilk	6-10 hrs[2]	5 days	6 months[4]	12 months[5]
Thawed breastmilk (Previously Frozen)	Do not store	24 hrs[6]	Never refreeze thawed milk	Never refreeze thawed milk

Defrosting

To defrost frozen milk:

- Place milk in refrigerator the night before you're going to use it. Refrigerator defrosting takes 12 hours.
- Place the frozen milk under warm running water or in a pan of warm water. Don't use hot water, as this can destroy some of the milk's immunological components.
- Fat in breastmilk will separate and rise to the top. By gently swirling the container, you can mix any fat that may have separated.
- Never refreeze thawed breastmilk.
- Remember, the color, consistency and odor of you breast milk may vary depending upon your diet.
- Discard any breastmilk you don't use during a feeding.

Caution: Never microwave breastmilk! Microwaving breastmilk can change the milk's composition destroying the valuable nutritional components.

Source: Medela

CITATIONS

[1]Lauwers J. Woesner C: Counseling the Nursing Mother, p. 436.
[2]Barger J and Bull P: A Comparison of the Bacterial Composition of breastmilk Stored At Room Temperature and Stored in the Refrigerator. Int J Childbirth Educ 2:29-30, 1987
[3]Instructions from Mothers' Milk Bank at Valley Medical Center, San Jose, CA, Maria Teresa Asquith, Ronald Cohen, MD.
[4]Ibid
[5]Ibid
[6]Lauwers J. and Woessner C: Counseling the Nursing Mother, second edition, P. 437, 1989
[7]Renfrew M, Fisher C, and Arm, S: Bestfeeding: Getting Breastfeeding Right for You, p. 5, 1990
[8]Scipien G, Barnard M. Chard M, Howe J, and1 Phillips P: Comprehensive Pediatric Nursing p. 218. 1975.

Credits Contributions

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Unit Three: Supporting Breastfeeding

MAKING BREASTFEEDING WORK:

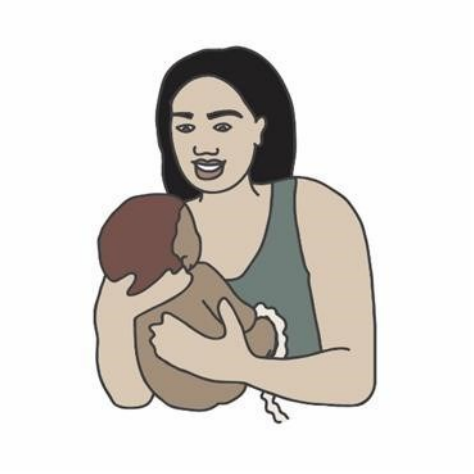
UNDERSTANDING BABY-TODDLER NEEDS

NURSE ON CUE INSTEAD OF SCHEDULE

- Watch the baby, not the clock.
- As baby goes through growth spurts he will nurse more.
- You cannot spoil a baby. Responding to baby's needs builds trust and security, and loving relationships. Help mothers realize their role is special and unique, instead of seeing the baby as demanding.

NIGHTTIME NURSING

- 25% of nutritional benefit comes from night feeding.
- Babies are not designed to sleep through the night.
- Babies gradually learn to fall asleep without parents. Responding to baby's nighttime needs does not cause them to be too dependent. In fact it fosters independence because of secure attachment.



PARENTING THE FUSSY BABY

- Could be because mother's milk supply is low. Work on increasing mom's supply.
- Babies have fussy periods as they grow.
- Use the 5 S's: Shushing, Swaying, Swaddling, Singing, etc. (See "Happiest Baby on the Block" by dr. Harvery Karp).
- Change of scenery can help: go for walk or car ride.
- May be result of mother's diet.
- Parents need to take god care of themselves. This is very stressful.

STARTING SOLIDS

- Babies need nothing but breastmilk for 6 months Signs of readiness: grabbing food off mother's plate.
- Introduce solids slowly. One food at a time. Cereal is usually first. Never in a bottle. Then fruit, vegetables and meat last. Follow pediatrician's advice.
- Weaning begins as soon as baby eats food. Wean gradually and with love.

TEETHING AND BITING

- Mothers often wean at sign of first tooth. But it's not necessary. Babies can be taught to nurse without biting.
- Have a toothbrush, wash cloth, teething ring available for baby to bite on.
- Reassure mom the baby is just finding out what happens when he uses his teeth. He is unaware biting hurts.
- Yelling, hitting, biting back is inappropriate, and should be discouraged.

NURSING STRIKES

- This is when a baby stops suddenly without any apparent reason. Baby is telling mom something is wrong—usually lasts 2-4 days.
- Mom can get baby back on breast with patience, persistence and perseverance.
- Common reasons are earache, mouth pain, stuffy nose, moving, traveling or other change in family life.
- Mother can feel rejected. Reassure her.
- Ideas to get baby back on: nurse while rocking, few distractions, skin-to-skin, etc.

SEPARATION ANXIETY

- Developmental milestone
- Responding to baby will not make him too dependent; he will learn the world is a safe place and his needs are met when mom returns.

SETTING LIMITS

- Boundaries ensure safety; allow child to do as she wants within safe limits.
- Young children need a lot of direction, redirection, distraction; parenting is not a spectator sport.

WEANING

- "Gradually and with love", this is Le Leche League's motto.
- Help toddler learn other ways of going to sleep, comforting, etc.
- Nursing is a relationship and ideally both parties should have a say when it should end.
- Some moms think weaning is all or nothing, but compromise can be reached. Ask mom to explore what level of nursing would be acceptable.
- Gradually reduce one feeding at a time.
- Toddlers can be taught "nursing etiquette" when it's okay to nurse and when it's not and what's okay to do and what's not (i.e., play with her other breast, lift her shirt in public, etc.).

Unit Three: Supporting Breastfeeding

BREASTFEEDING IN SPECIAL SITUATIONS

BABIES WITH METABOLIC DISORDERS

- Hypoglycemia

- This means low blood sugar
- Symptoms are baby is shaky, lethargic, limp, sweating, shivering, refuses to wake, breathing heavy, etc.

How it occurs:

- Delayed or inadequate feeding
- Glucose given to mom through IV
- Difficult labor and separation from mother being left to cry; stress depletes glucose
- Diabetic mom whose diabetes was not well-controlled in pregnancy.

What to do:

- Encourage mom to feed baby early and often
- If baby not allowed to breastfeed encourage mom to ask for cup, syringe or tube feeding

- Galactosemia or Phenylketonuria

- These are metabolic disorders which are genetic. Baby cannot process milk proteins and sugars.
- Baby can become mentally retarded if not put on low protein diet.
- Baby can breastfeed but must be under pediatrician supervision.

WHEN MOM IS HOSPITALIZED FOR ILLNESS

- If minor illness mom can continue to breastfeed. Breastfeeding is best in health or sickness.
- Many medications are compatible with breastfeeding, and there's almost always an alternate medication that she can use. Encourage her to ask her doctor for a medicine compatible with breastfeeding.
- Give mom support, encouragement and information but don't compete with doctor or nurse or give medical advice.

IF BABY IS HOSPITALIZED

- Encourage mom to be near and/or her baby and to pump milk or breastfeed her baby.
- Advocate for Kangaroo Care in NICU

JAUNDICE

- The baby's skin or whites of the eyes look yellow. Physiological Jaundice is the most common type and is normal. It occurs within a few hours or days after the birth from build-up of bilirubin in blood and tissues. It is released as red blood cells break down after birth. Baby's immature liver cannot handle the breakdown and an excess makes the skin yellow.
- It is more common that babies with Rh- mothers have jaundice.
- High levels potentially can cause brain damage in infant. This is called Kernicterus. This is a concern especially for premature infants.
- Many babies have normal jaundice which occurs about 3-4 days after birth.
- Late onset or "breastmilk jaundice" occurs about day 3-7 and can last 10 weeks or more. Will usually clear up on its own. Encourage mom to breastfeed often. Sometimes the baby will need to be hospitalized and receive phototherapy.

What to do:

- With Physiological Jaundice, advise mom to place baby naked in a sunny window for 20 minutes 2-3 times per day and breastfeed often.
- Usually doesn't require hospitalization.
- The mother should be encouraged to breastfeed often as that will increase bowel movements and move the bilirubin out through the baby's stools.
- Refer mother to a pediatrician.

BREASTFEEDING THE PREMATURE INFANT

- Breastfeeding or breastmilk is especially important if a baby is born too soon and too small. The milk is rich in fats essential for growth and protection of these fragile infants. While a peer counselor will not be working directly with premature infants, her role is to encourage mothers to breastfeed or pump colostrum and to give information on KMC and provide emotional support during this very stressful time. You will also need to be sure the mother has the support of an IBCLC.

BREASTFEEDING MULTIPLES

- African-American moms have the highest rate of multiples in the USA unassisted by reproductive technology. In Africa twinning occurs more frequently than the rest of the world. Twins and multiples are more likely to be born premature. Therefore they have an immature suck and may need to be tube or syringe fed. Many moms will fed one baby at a time, and may not exclusively breastfeed. There are several positions for breastfeeding two babies at once; double football, V-hold, parallel. Multiple Moms need a lot of help and encouragement.

WHEN A MOTHER HAS HIV OR AIDS

- The HIV virus has been found in bodily fluids, including blood, semen and breastmilk in small amounts. For this reason the American Academy of Pediatrics guidelines discourage mothers with HIV or AIDS to breastfeed their infants. However, international and US guidelines differ. In the US the American Academy of Pediatrics

does not recommend breastfeeding when a mom has HIV or AIDS. WHO/UNICEF have a different recommendation. Moms with HIV and AIDS are encouraged to breastfeed. They state that exclusive breastfeeding has many benefits for babies born in HIV endemic areas. However, as a peer counselor working in America, you cannot recommend breastfeeding when a mom has HIV or AIDS.

RELACTATION

- This is when a mother who has stopped nursing temporarily wishes to resume nursing her baby. A mother who has stopped nursing for a while can relactate if she stimulates her breasts often and regularly. She will need a breastpump, the baby to nurse often and for longer sessions and perhaps a galactogouge tea. Refer mother to a IBCLC.

INDUCED LACTATION (ADOPTIVE MOTHERS BREASTFEEDING)

- Adoptive mothers may be able to breastfeed their adopted baby. It may require a lot of pumping and baby suckling and use of some galactogouge medicine or tea. Many adoptive moms do not fully breastfeed, but they can use a supplemental nursing system and the baby still gets all the emotional benefits of skin-to-skin contact. Refer the mother to an IBCLC.

WET OR SHARED NURSING

- This is when a pair of mothers share nursing of each other's babies and their own. It is considered strange or even inappropriate in our country, though it is not uncommon in other cultures and may be practiced by immigrant women, or among sisters or close friends. Most agencies that the peer counselor will be working for will not officially endorse this practice. However if mothers choose share nursing, the message counselors should make is that some communicable diseases may transfer through breastmilk and the mothers should be tested for these and know each other's lifestyle before beginning a shared nursing relationship.

Unit Three: Supporting Breastfeeding

SITUATIONS TO REFER TO AN IBCLC OR PHYSICIAN

As a Postpartum Doula, your scope of lactation support is to work with normal challenges of breastfeeding such as low milk supply, sore nipples, etc. However, you must be able to recognize abnormal lactation issues in newborn or mother. In these cases, the Postpartum Doula should refer the mother and/or baby to a Pediatric Medical Doctor or an International Board-Certified Lactation Consultant (IBCLC.

HERE ARE SOME GUIDELINES:

REFER TO IBCLC

- When there is a need for breastfeeding equipment like supplemental nursing systems (SNS), shells, shields or other aids.
- Unresolved latching problems.
- Severe engorgement
- Nipple abnormalities
- Premature Infant
- Twins or Multiples
- Relactation or Induced Lactation(Adoptive Nursing)
- Poor sucking
- Mothers with breast implants or reduction surgery

REFER TO A MEDICAL DOCTOR

- Signs of thrush or mastitis
- Infant with slow weight gain
- Special needs infant such as one with a cleft palate, Down 's syndrome, PKU, Galactosemia, Hypoglycemia, etc.
- Dehydration, tremors or lethargy in infant
- Jaundice
- Illness in baby or mother
- Tongue Tie
- Inadequate wetting or stooling

Unit Three: Supporting Breastfeeding

TIPS FOR HELPING MOTHERS BREASTFEED AFTER A CESAREAN

One in three women give birth by cesarean in the U.S. today so this is a situation you will encounter often. The woman needs to know that she can still breastfeed after a cesarean section. However, she may face unique challenges. So, she will need extra help and encouragement from the Postpartum Doula and her family members.

ADVANTAGES OF BREASTFEEDING AFTER A CESAREAN

- Oxytocin produced during lactation makes the woman's uterus contract and lessens her postpartum bleeding (lochia).
- The emotional closeness of breastfeeding can help baby and mom bond after a separation which often occurs after cesareans.
- Breastfeeding can for some women heal her disappointment about not giving birth vaginally.

CIRCUMSTANCES THAT MAY AFFECT BREASTFEEDING

- General anesthesia is rare, but she will be unconscious and groggy after the birth, so breastfeeding will be delayed.
- If baby is doing well, help mother to breastfeed on the delivery table. Ask the doctor if her hands can be free to hold baby and mask removes so she can speak to her baby.
- If mother cannot breastfeed on table, encourage the mother to request her baby be brought to her in recovery so she can start breastfeeding within the first hour. If the baby is healthy, he may only need to be in the nursery briefly. Work to get baby and mother back together as soon as possible.
- Encourage rooming in with her baby, and remind her to say "no bottles, no pacifiers." If hospital policies make it difficult to have rooming in, reassure her that breastfeeding can still work. She needs to ask for her baby to nurse every couple hours.
- If mothers or babies have problems postpartum, nursing may be delayed. If mother is fine but baby is unable to nurse, mother can pump her milk and save it for her baby. Pumping will help her milk come in more quickly.

POSITIONING THE BABY

- Help her with picking up baby, positioning at breast, switching sides. Football hold works best.

- Mother will be hooked up to an IV, so help her maneuver around the IV tubes, open her gown, etc.

- Use many pillows or rolled towels. Place a pillow over her belly to protect her incision. Place pillows under her knees, behind her back, or wherever she needs to be most comfortable.

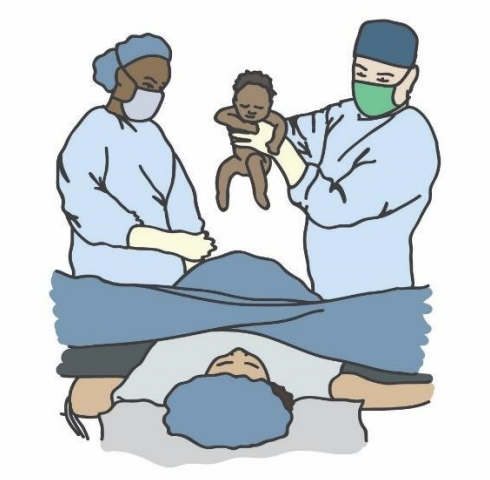
- Encourage her to use the minimum amount of pain medication because it can cause drowsiness in her baby.

- Make sure she has enough support at home with household chores and other children. She will need help for several weeks with getting in and out of bed, walking, toileting, etc.

- Make sure she has everything she needs besides her: diapers, wipes, baby clothes, snacks and beverages, phone, TV channel changer, books, address book, etc., to minimize walking.

- Make sure she has plenty of healthy snacks on hand, such as carrots, fruit, sliced cheese, etc., and healthy beverages such as herbal tea, juice, and water. She should also take her prenatal vitamins.

- Give her extra emotional support – she will be in pain and that may make her exceptionally tearful. She may also feel disappointed about the birth. Let her know she is not a failure as a woman and she is a good mother. Help her focus on her beautiful bab(ies) and help her to bond with the baby (keep baby close by her side, breastfeed on demand, etc.).



Heart and Hands Postpartum Doula Training

Unit Three: Supporting Breastfeeding

BIRTH INTERVENTIONS AND BREASTFEEDING

While most of us do not make the connection between birth interventions and breastfeeding problems, what occurs during birth has a profound effect on the newborn's ability to breastfeed. Many key hormonal responses in the newborn occur due to the baby moving through the birth canal.

HORMONES DURING NORMAL SPONTANEOUS VAGINAL DELIVERY

The following describes what occurs during a normal, spontaneous vaginal birth:

- Catecholamine and stress hormones build up in baby's system and help him stay awake after birth for breastfeeding. This state is called the "quiet alert state" and is the opportune time to initiate breastfeeding within the first 10-20 minutes after birth.

- Oxytocin stimulates the vagus nerve in the baby's brain and increases gastrointestinal juices and tells the baby to get hungry.

- Passage through the birth canal squeezes the fluid out of the baby's lungs so that he can breathe at birth and suck at the breast.

- Coming out of the vagina and coming in contact with the mother's perineum colonizes the baby with bifidobacteria that help prepare the baby's digestive tract and protect the baby from respiratory illness and allergies.

HOW OBSTETRIC INTERVENTIONS IMPACT BREASTFEEDING

Obstetrical Interventions and medications impact breastfeeding in various ways:

- Medications in epidurals may make the areola lax and may not evert (stick out) very well. Research shows babies latch better with natural birth. Narcotic medications can affect babies ability to root, crawl and suck decreasing ability to self-attach.

- Traumatic delivery and c-section decrease skin-to-skin time and babies who are separated even briefly may show decrease in crawl to breast neurological patterning; appear to be disorientated or despondent at the breast and unable to self-attach.

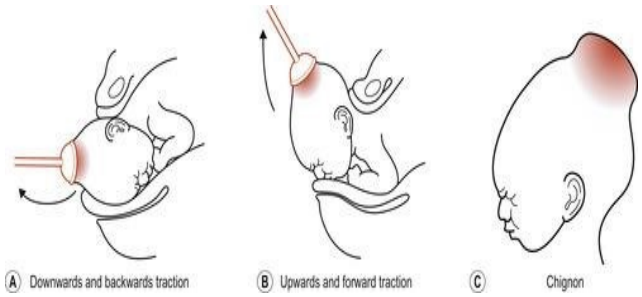
- Traumatic birth impacts glucose stabilization which increases risk baby will be given a bottle leading to nipple confusion making breastfeeding more difficult.

- Moms with a traumatic or unexpected cesarean may be depressed and not feel like nursing their babies.

- Moms who had an episiotomy may be in pain and not feel like nursing right away.

- Babies who received deep suctioning for meconium or intubation may exhibit “oral aversion” and not want to feed at breast as they are traumatized. Cup or tube feeding may be necessary.

- Vacuum extraction births create torsioning and twisting of baby’s neck and the cranial nerves involved in chewing and sucking. The baby who fusses at the breast or refuses to suck on one side may be in a “whiplash” type of pain and not want to breastfeed. Cranial sacral therapy by a cranial sacral therapist is recommended.



Vacuum Extraction Delivery / Hematoma of Infant Head

4

UNIT FOUR:

Supporting Bonding and Attachment

In this unit, you will learn about lowering the risk for Sudden Infant Death Syndrome and the lifelong importance of mother and infant attachment for normal human development. You will also learn about ways to facilitate bonding between the newborn baby and her parents.

Unit Four: Supporting Bonding and Attachment

SUDDEN INFANT DEATH SYNDROME

SUDDEN INFANT DEATH SYNDROME-SUDDEN UNEXPLAINED INFANT DEATH

Definition of SIDS-SUIDS is when a baby dies from and unexplained cause. This means after an autopsy and an investigation of the site where the baby died, biological causes or circumstances in the environment are not found to be the cause of death.

WHO IS AT RISK

African American babies are at highest risk of SIDS. This is probably related to the fact that more African American babies are born premature, a risk factor for death within the first year of life. Male babies are more at risk from SIDS as well.

HOW CAN RISK BE REDUCED?

Two Approaches to SIDS Prevention:

- Back to Sleep Campaign (American Academy of Pediatrics)
- Co-Sleeping (Dr. William Sears, MD and McKenna and McDade)

FACTORS KNOWN TO INCREASE SIDS RISK

- African American race
- Bottlefeeding
- Smoking
- Infants placed on tummy
- Alcohol or drug use (dad or mom)
- Leaving infant unattended
- Mother sleeping w/ baby on couch, waterbed

Unit Four: Supporting Bonding and Attachment

THE PROTECTIVE EFFECTS OF SHARING SLEEP WITH INFANTS

CO SLEEPING AND SIDS REDUCTION

Here in the U.S., Co Sleeping is a growing trend among families. But parents are afraid to admit it publicly for fear of being criticized by medical providers and their family. However, more parents are choosing to share a bed with their infants. Since 1993, the practice in the U.S. has grown from about 6 percent of parents to 24 percent in 2015.

But the practice goes against medical advice in the U.S. The American Academy of Pediatrics is opposed to bed-sharing: It "should be avoided at all times" with a "[full-]term normal-weight infant younger than 4 months," the AAP writes in its 2016 recommendations for pediatricians. AAP cites seven studies to support its recommendation against bed-sharing.

But a close look at these studies — and an independent analysis from statisticians — reveals a different picture. And some researchers say it might be time for the U.S. to reassess its recommendation and its strategy to stop SIDS. There is no question that many moms have an instinct to sleep with their babies. And many babies have strong opinions about wanting to sleep with their moms. Demanding to be held is a newborn's forte.

There is good reason for this mutual pull toward each other, says Drs. McKenna and McDade, anthropologists at the University of Notre Dame who has been studying infant sleep for 40 years.

"Human babies are contact seekers. What they need the most is their mother's and father's bodies," McKenna says. "This is what's good for their physiology. This is what their survival depends on.'

What's more, the practice of bed-sharing is as old as our species itself. *Homo sapien* moms and their newborns have been sleeping together for more than 200,000 years, says anthropologist Mel Konner at Emory University.

Modern hunter-gatherer cultures provide our best insight into the behaviors of our early ancestors, and bed-sharing is universal across these groups, he says.

The practice continues to be widespread around the world. Bed-sharing is a tradition in at least 40 percent of all documented cultures, Konner says, citing evidence from Yale University's Human Relations Area Files. Some cultures even think it's cruel to separate a mom and baby at night. In one study, Mayan moms in Guatemala responded with shock — and pity — when they heard that some American babies sleep away from their moms. McKenna and his colleagues transformed his laboratory into an apartment, recruited dozens of moms and babies, and analyzed their bodies while they slept. "We measured heart rate, breathing patterns, chest movement, body temperatures, brain waves — even the carbon dioxide levels between the moms' and babies' faces." They even had infrared cameras to watch how the babies moved around at night.

What McKenna and McDade found was remarkable. When the mom is breastfeeding, she essentially creates a little shell around the baby. This helps moms regulate the babies physiology in various ways that may be protective. In

fact, McKenna and McDade found that when mother-infant pairs who are considered high risk for SIDS, i.e., urban African American mothers and infants slept together and breastfed, their risk was lower than it was for their counterparts who did not breastfeed and slept apart.

As a Postpartum Doula, your job is to educate parents on how to co sleep safely, rather than telling them not to do it at all. Many mothers are relieved to know it is alright to keep baby nearby at night, and they find they sleep better when they do. In fact, mother and baby sleep cycles synchronize, making mother more aware, not less aware of her baby.

SUMMARY OF BENEFITS OF CO SLEEPING

- **Immunological Protection** – babies who sleep near mom get more breastfeeding and breastmilk boosts babys immune system
- **Breathing Harmony** –mom is respiratory pacemaker, reminding the baby to breathe.
- **Mutual Awareness** – mom and baby go through same sleep cycles, therefore, mom is more aware of her baby at night, not less aware, so rolling on baby is unlikely.
- **Thermal Regulation** –mother keeps baby warm; cooling suppresses breathing in the infant
- **Enhanced Development**-baby gets more touching and this increases development
- **Sucking at Night** – Improves oxygen level in preemies
- **Touching**- respiratory stimulant**,** when mom touches her baby it reminds him to breathe**.**
- **Hormones increased** – increased maternal awareness of her infant

SAFETY GUIDELINES FOR CO-SLEEPING WITH INFANTS

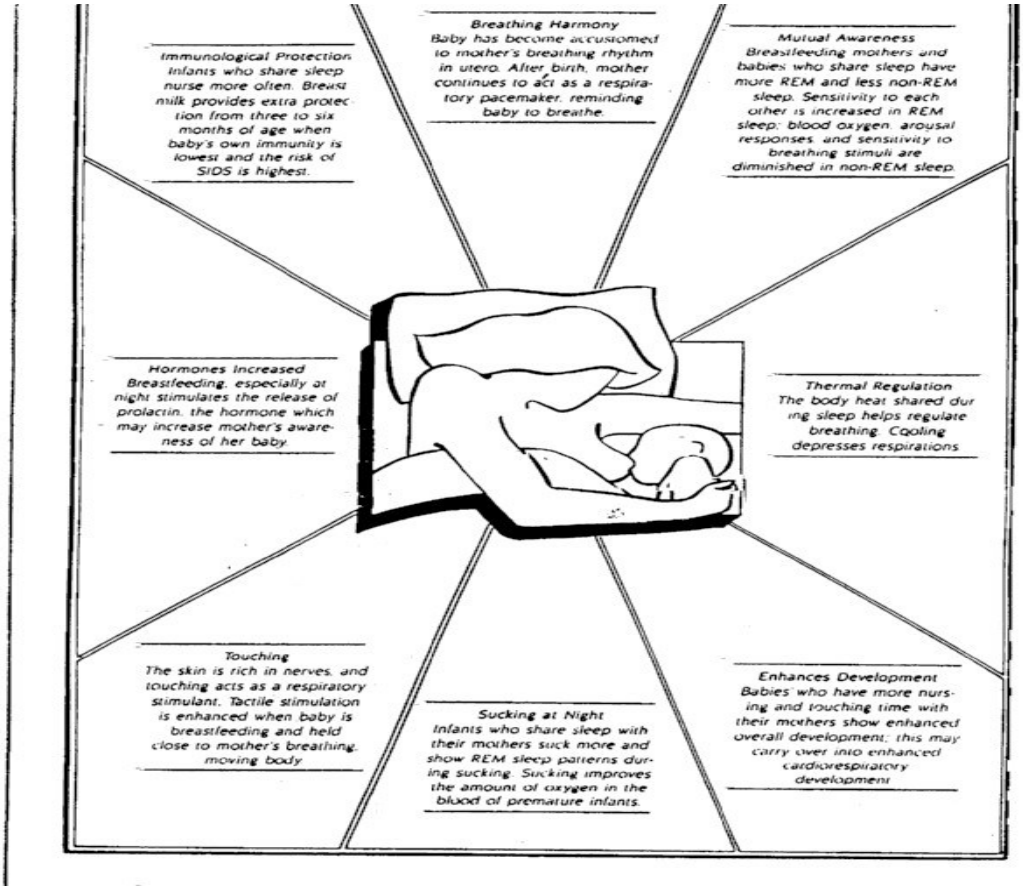
McKenna says we should never recommend Bed Sharing. However, when a family chooses to cosleeping, we should explain the safety recommendations for safe cosleeping**.**

- Place baby beside mother, not in between father-partner and mother.
- Prevent baby rolling out of bed
- Ensure there are no slats in the bed where baby can get stuck
- Secure pillows so they do not fall over baby's face.
- Do not let anyone sleep with baby who has smoked or is under influence of drugs or alcohol
- Only a responsible aware person sleeps with baby; preferably mother.
- Don't place baby on waterbed, bean bag, couch, leave unattended in adult bed
- Don't let siblings or animals sleep with baby, they could roll on top of baby causing smothering. This is why father-partners should not sleep next to baby.

Source

Douceleff, M. Is Sleeping With Your Baby As Dangerous As Doctors Say? May 21, 2018

PHYSIOLOGICAL BENEFITS OF COSLEEPING BY DR. WILLIAM SEARS



Source

Nighttime Parenting by Dr. William Sears, MD

Unit Four: Supporting Bonding and Attachment

ATTACHMENT PARENTING PHILOSOPHY AN APPROACH TO CHILDREARING

WHAT IS ATTACHMENT PARENTING?

Attachment Parenting are practices which create strong emotional bonds. Encourages strong parental responsiveness. The child learns his needs will be met and therefore is a secure human being. This flies against what we have been taught in American culture that babies will be spoiled if we attend to them when they cry. Actually, when a parent is aware, available and consistently responsive, it teaches the infant that their needs will be met and the world is a safe place. They will become secure human beings able to form secure attachments with others as an adult. Insecure attachment during infancy and early childhood can lead to problems in adulthood such as addiction and inability to form healthy relationships.

THE EIGHT IDEALS

1) Prepare for Childbirth take a childbirth preparation class, learn ways to cope with labor without pain medication and minimal medical interventions which can cause trauma for mother and baby.

2) Be Emotionally Responsive children need at least one aware, emotionally responsive and consistently available parent. In our modern society, parents are increasingly stressed and emotionally unavailable. Parents should be encouraged to learn stress relieving measures so they can be emotionally and physically present for their infants and young children.

3) Breastfeed breastfeeding is good for baby immunity, but it also provides a close bond between mother and child and helps create secure attachment which has a lifelong impact.

4) Wear the baby (Slings) human babies need to be held almost all the time by their mothers where they have access to the breast whenever they want it.

5) Parent at Night – Co-sleeping helps the mother to easily and quickly respond to baby needs at night.

6) Avoid frequent and prolonged separations from baby in our modern society where both parents must work, parents must leave their babies early on and are away from them for long periods of time. Working parents should be encouraged to prioritize their time with children when not working.

7) Use positive, age appropriate discipline teaching parents about child development and non violent ways of parenting can help reduce trauma in young children.

8) Maintain balance in family life it is very easy for parents to get overwhelmed with too many outside responsibilities with work, so parents should be encouraged to prioritize their activities so that family time is protected. For more information, go to http://www.attachmentparenting.org.

Adapted from Attachment Parenting International

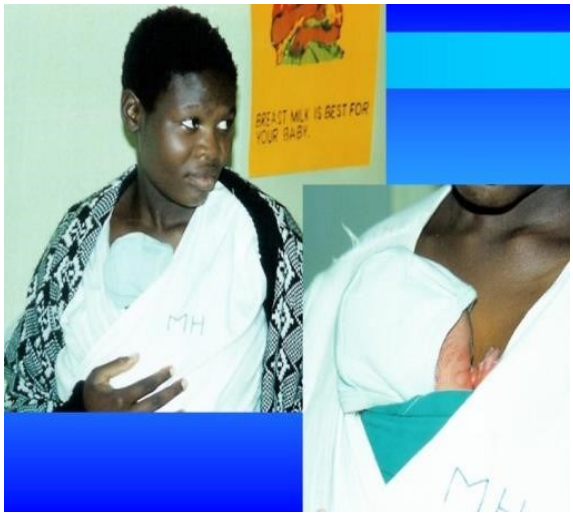
Unit Four: Supporting Bonding and Attachment

KANGAROO MOTHER CARE
THE "NATURAL HABITAT" FOR NEWBORNS

"For species such as primates, the mother is the environment."
--Dr. James McKenna, PhD

WHAT IS KMC?

KMC stands for Kangaroo Mother Care. The idea is that like Kangaroos, human infants need continuous contact with their mothers for normal brain and emotional development and growth. The practice has also been called Marsupial Mothering. Dr. Nils Bergman, MD, a neonatologist in South Africa developed it as a way to care for premature infants. He described the mother's chest as a "natural habitat" for newborn infants. It has significantly improved survival rates for premature infants. It can be used for term newborns as well.



THE NICHE CONCEPT

Dr. Nils Bergman says that when any animal (including babies) are in their normal habitat they will behave normally. Babies who are separated from their mothers display "protest despair" behavior: crying intensely and then in despair and exhaustion, fall asleep. This protest despair behavior is very stressful for babies and raises their heartbeat and respiratory rate due to stress hormones. Dr. Bergman says the "Natural Habitat" for newborns is the mother's chest.

THE COMPONENTS OF KMC

- Skin to Skin
- Exclusive Breastfeeding

WHY IS IT IMPORTANT?

- Mother's body keeps baby warm and regulates breathing better than an incubator.
- Dr. Bergman says human babies should be cared for by "carry care" method. This means almost continuous carrying, co-sleeping, immediate responsiveness of mother, frequent or continuous feeding, and temperature regulation by mother. All this promotes bonding.

HOW IS IT DONE

Baby is placed only wearing a diaper chest to chest on mother between her breasts with a sling or binder. The strip of cloth holds baby close, sometimes called Kangashirt

SKIN TO SKIN CONTACT

Early, continuous, and prolonged skin-to-skin contact, between mother's breasts. The mother to keep baby close, warm and calm wears a special wrap shirt. When baby is against his mother, his heart rate is normalized, his body temperature is regulated, his oxygen uptake is better, and his breathing rate is steadier. As baby's temperature decreases, mother's body temperature rises and baby's rises, keeping baby's temperature even more stable than an incubator does. Breathing, heart rate, and temperature stabilization are essential for premature babies as their systems are underdeveloped, and this makes them more unstable than term babies.

EXCLUSIVE BREASTFEEDING

Skin-to-skin contact promotes breast milk production.

DAY THREE

5

Unit Five: Physical Care of Postpartum Mothers

In this unit, you will learn how to provide physical care for the postpartum woman and to recognize abnormal situations which require medical intervention.

Unit Five: Physical Care of Postpartum Mothers

CARING FOR MOTHERS AFTER BIRTH

HOW THE POSTPARTUM DOULA CAN PROVIDE SUPPORT

As a Postpartum Doula, your role is as a non-medical provider member of the maternity care team. You will provide Informational Support, Emotional Support, and Referrals. You are expected to know the normal physical adjustments in a woman's body following childbirth, to recognize abnormal signs and refer the woman to a medical provider for treatment. In this capacity, you have a vital role, as you may be able to alert the family to seek medical care promptly. However, unless you are a nurse, midwife, or other certified or licensed practitioner, you cannot diagnose or prescribe a particular problem or remedy. You can, however serve as a resource person and provide educational materials and information and link parents to qualified practitioners. Hence, knowing normal physical adjustments and a general awareness of various healing modalities can be very helpful. This is why you need to be sure you have resources at your disposal to link parents to needed services. Here are some of the normal manifestations of postpartum.

AFTER PAINS

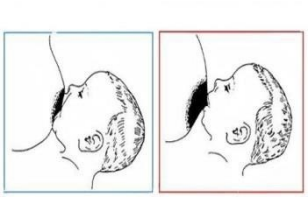
What it is: After childbirth, some women experience pain as the extended uterus contracts back to its normal size. This is a process called "involution," and the post-childbirth uterus can take 6-8 weeks to return to normal size. Women may experience cramping after birth, sometime when they are nursing and for other women, it will occur without nursing. Women who have had more than one baby (multiparous women) will usually have more painful contractions than those who are having their first baby (primagravidas).

What to Do: Assure her that this is a normal process and her uterus is cramping because it is working to return to normal size and lessen the amount of postpartum bleeding (lochia). You can assist her by placing a hot water bottle or heating pad on her abdomen (wrap in a towel to avoid burning her skin). She can ask her doctor or midwife if she can take Motrin or Tylenol. Do not suggest Aspirin as it can make her bleed too much. Acupuncture, Oriental herbs and moxibustion ("mother roasting") , and encapsulated placenta capsules may be helpful. This may make her less willing to nurse her baby. Try to encourage her to breastfeed and make her comfortable. Keep siblings from bouncing on the mother's bed, and keep visitors to a minimum until she feels better.

When to Refer: If Tylenol or Motrin and hot packs are not lessening her pain, then have her call her care provider. She may need a stronger medication such as an analgesic.

BREAST OR NIPPLE PAIN

What is it? Pain in the breasts or nipples during or after breastfeeding. This can happen when the milk comes in which is usually around Day 3. Her breasts can feel very full – like boulders on her chest and the veins in the breasts are very visible and prominent. It can also occur from extra fluids given in labor. Nipple pain is usually present in the first couple days of breastfeeding. It is more often in light skinned mothers, especially red-heads.

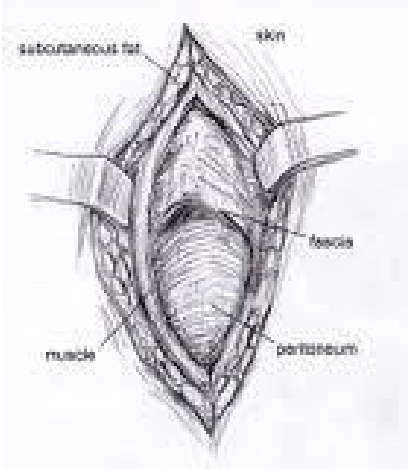


What to Do: Assure her that it will get better in a few days. Encourage her to continue to nurse to relieve the pressure in her breasts from milk build up. Discuss the importance of the baby getting Colostrum. Discuss breastfeeding management, with appropriate number of feedings, alternating sides, and length of time at breast to ensure proper weight gain of baby. Suggest a breastpump if she's really in a lot of discomfort. Check the positioning of the baby, ensure that the baby's mouth is open wide when she is put on the breast and she is taking most of her mother's areola into her mouth, not sucking on the tip of the nipple. Check that mother breaks suction by inserting a finger into the side of baby's mouth and pulls baby off of the breast, not pulling her nipple out of baby's mouth. Also ensure that baby is close enough to mother's breast, not laying on her back and pulling or dragging on mother's nipple.

When to Refer: If her breasts are hot to touch, have red streaks or patches, and/or she has a fever and chills, call the doctor or midwife. Have her wash her nipples with a clean cloth or gauze pad in sterilized water (hot water boiled for 20 minutes), express a bit of milk in a sterile medicine container, and take to the doctor for testing. She may need an antibiotic. She should be encouraged to continue to breastfeed her baby while she's recovering. You or she can gently stroke the red lumps in a downward motion while the baby nurses.

CESAREAN BIRTH RECOVERY

What is it? Delivery of baby was via abdominal surgical incision instead of the vagina. In a cesarean, seven layers are cut through to remove the baby. These include:



1. Skin
2. Fatty layer
3. Fascia (thickness covering the muscles)
4. Muscle separation (often using retractors)
5. Smooth surface (peritoneum) lining the inside of the abdomen
6. Bladder flap (smooth surface overlying uterus that is separated to make incision in the lower uterine segment)
7. Uterus (in most cases, this is a horizontal incision above the pubic bone)

Once inside the uterus, the surgeon makes an incision in the amniotic sac to remove the baby. S/he then closes three layers (skin, fascia, and uterus) at a minimum, using sutures. The skin layer may be stapled or sutured. Therefore, there may be a considerable amount of post-operative pain and scar tissue.

What to Do: Women need help to get in and out of bed, and to nurse the baby. Pillows on the abdomen and/or "football" clutch hold may be less painful than having the baby lie on her belly. She will need to remain in bed longer and will need to have some pain medication. Her doctor may prescribe Vicodin after surgery while she is in the hospital. By the time she goes home, which is usually 3-4 days post-operation, she will likely only be taking an iboprophen. She may be bleeding vaginally as well.

Emotionally, she may be alright with having had a cesarean, if she feels it was "necessary". For other women, feelings of disappointment, regret, shame, and inadequacy may be present. Whatever she is feeling, your role is to validate her feelings and be respectful of the choices she made in labor, even if you feel they led her to have a

cesarean section. Don't say things like "at least you have a healthy baby", or "your cesarean wasn't needed". Don't try to make her feelings go away. On the other hand, even if you suspect that the cesarean may have been "unnecessary", now is not the time to discuss that. Stay connected with her and when and if she feels ready to discuss what happened, you can be there for her. Give her information on Vaginal Birth After Cesarean (VBAC) and referrals to cesarean support groups such as International Cesarean Awareness Network (ICAN).

When to Refer: If she has a lot of pain or bleeding, her discharge has a foul odor, or there is an oozing bleeding or bad smell coming from her incision, or if it appears to be red and swollen, have her call her doctor. Many women will need 8 weeks to feel they are fully recovered. If she has had a previous cesarean section she may have pain for longer period of time. If her pain persists beyond 2 months postpartum, and she feels the need to continue with pain medication, have her consult her doctor.

DIAPHORESIS

What is it? Profuse Sweating. This is a way that her body is trying to eliminate all the extra fluids from pregnancy and/or IV fluids.

What to do? Help her to stay cool. Open a window, give her a cool washcloth, spray her with cool water, change her nightgown, or fan her. Bring her water and cool herbal tea, encourage her to drink.

DIURESIS

What is it? Frequent Urination. This is the body's way of eliminating extra fluids. During pregnancy, there was an increase in fluid volume. In addition, if she had an IV in labor she may have a lot of fluids to discard.

What to Do: Encourage her to empty her bladder often (a full bladder can also impede involution of the uterus, and increase cramping and lochia). Encourage her to drink water and herbal tea, to help eliminate fluids.

When to Refer: If she is very bothered by it, or experiences any burning when she urinates or feels an ongoing urgency with inability to pass urine, she may be getting a bladder infection. Have her call her doctor or midwife. If she has a fever, you need to report it to her care-provider.

PERINEAL PAIN

Female Perineum

The perineum is the area between a woman's anus and vaginal opening. The post-delivery pain in the perineum can come from a vaginal tear or an episiotomy.

What is it? Episiotomy is an incision made by the doctor or midwife at the moment of birth to enlarge the vaginal opening. Some women also experience. lacerations (tears) during childbirth. There are several degrees (extensiveness) of laceration and episiotomy: 1st degree, 2nd degree, 3rd degree and 4th degree. The types of lacerations/episiotomies are:

First degree: Vaginal mucosa (just the inside of the vagina, sometimes called "Skid Marks" by midwives)
Second degree: Vaginal fascia and perineum (extends into the external perineum—the area between the vaginal opening and anus)
Third degree: External Anal Sphincter (partial or complete – extends into the anus)
Fourth degree: External Anal Sphincter (EAS), Internal Anal Sphincter (IAS), and rectal mucosa. (extends into the top layer of the anus or the deeper layer of the rectum).

Women with 2nd-4th degree tears and/or episiotomies may be in a great deal of pain and this can impact her emotionally and make her unwilling to nurse her baby. Some short-term complications may include:

- Bleeding
- Infection
- Bruising
- Swelling
- Difficulty controlling bowels

What to Do: Keep ice pack on her perineum for the first 24 hours. Heat packs thereafter (hot water bottle or warm wash cloth).

You can make an herbal perineal pack. Make a tea with herbs Comfrey, and Goldenseal. Boil hot water and pour 8 ounces of hot water into a casserole pan, and put 2 tablespoons of the bulk herb into the water, and mix together. Using sterile rubber gloves take several large size sanitary pads and soak them in the herbal mixture. Allow them to soak up the water. Put each pad in a plastic sandwich bag and place in the freezer. Once they are frozen, you can put the pack against her perineum; hold it against the skin with a mesh panty that she received at the hospital or plan cotton underwear. Change it when it is no longer frozen. The herbs are antimicrobial and also comforting to traumatized tissues.

You can suggest homeopathic remedies. You can also suggest she take Arnica Montana, a homeopathic remedy for bruising and muscle soreness which is taken orally.

You can suggest a stool softener. The woman's caregiver may also suggest that she take a stool softener. A stool softener is a medicine that helps to soften her bowel movements. Stool softeners may help to decrease pain caused by straining during a bowel movement. Bowel movements tend to slow after birth, so it is best to give her something to help her go such as prunes, coffee, etc.

Care of the Perineum

Prepare a peri-bottle (hand-held squirt bottle) for the woman with Betadyne Anesthetic wash (1/3) and water solution (3/4), which she should have received from the hospital. Show her how to use a peri-bottle to rinse her perineum. Have the woman rinse her perineum with water while sitting on the toilet and before you help her put on a new peri-pad. She can squirting warm tap water (or cool water if she has urethral tears) on her perineum will soothe it and keep it clean and may provide comfort for pain. Instruct the woman to wash her hands, wash your hands, and put on gloves before doing perineal care. Remove the soiled peri-pad starting at the front (vaginal area) to the back (anus). While she's sitting on the toilet, have her rinse her perineum, aiming the bottle opening at her perineum and spray so the water moves from front to back. Pat the area dry with toilet paper or cotton wipes starting at the front and moving to the back. Put on a fresh peri-pad (sanitary pad). Apply the peri-pad from front to back by placing the front part of the peri-pad against the perineum first. Do not touch the inner surface of the peri-pad. You can use the net panties from the hospital to keep it in place or put on some loose cotton panties. Wash your hands and have her wash hers too after doing perineal care. If she has a lot of perineal pain, the following are some things that you can do for her to decrease pain in her perineum. If she is in a lot of pain, have her call her careprovider.

Prepare a Sitz bath. This may provide comfort, decrease pain, and help to heal the perineal area. To take a sitz bath, fill the bathtub with about four to six inches of warm water (too much water can get inside of her

open cervix into the womb and cause an infection, so she should shower to bathe until the lochia stops). There are herbal sitz bath packets that are available, which contain healing herbs. You may also use a portable sitz bath instead of drawing water in the bath. Have her sit for 20 minutes two to three times a day. Put on a fresh peri-pad after the bath.

Prepare an ice pack. Fill a plastic bag or plastic glove with crushed ice. Wrap the ice pack in a wash cloth. Gently place the ice bag between the woman's legs against her perineum for 15 to 20 minutes. Remove the ice pack for at least 10 minutes before placing it between her legs again. Also use the frozen peri-pads which have been saturated in comfrey herb as described above.

Apply an Antiseptic Spray. Her caregiver may have given her a antiseptic medicine spray or wipes soaked with numbing medicine to decrease the pain. Use medicine sprays after perineal care or a sitz bath. Compresses or pads that contain an herb called Witch Hazel may also help to reduce pain.

Instruct her to tighten her buttocks. To reduce pain while sitting, instruct her to tighten the muscles of her buttocks before sitting down. Sitting on a Donut shaped pillow may be comforting. Best of all, she should be in her bed, with her panties off to allow for a lot of air to circulate (yeast grows in warm, dark, damp places like the perineum especially saturated with blood). Put a towel or a "chux pad" (plastic backed cotton sheet found at drugstore ie, Depends Adult Underpads) underneath her, and change it often.

LOCHIA

What is it? After birth bleeding from the vagina. It is caused from the separation of the placenta from the wall of the uterus. She has a wound inside her body the size of a dinner plate and it is forming a scab and healing. blood loss occurring within the first 24-hour period after childbirth is termed as Early postpartum hemorrhage. And the same type of blood loss after the 24 hour time frame is called late postpartum hemorrhage. Late postpartum hemorrhage can happen after days or weeks after childbirth. During the birthing process, it is most common for women to lose a little blood immediately after the placenta gets separated from the uterus. The pregnant body is well equipped to handle the situation since the body gets an almost 50% increase on blood level during pregnancy, unless severe blood loss occurs, which is called postpartum hemorrhage. She should have less and less bleeding each day if all is normal and the color of the blood will change color. It progresses through three stages:

Lochia Rubra (or Cruenta) is the first discharge, red in color because of the large amount of blood it contains. It typically lasts no longer than 3 to 5 days after birth. It is sterile.

Lochia Serosa is the term for lochia that has thinned and turned brownish or pink in color. It contains white blood cells (leukocytes). This stage continues until around the tenth day after delivery. Lochia serosa which persists to some weeks after birth can indicate late postpartum hemorrhaging, and should be reported to a physician or midwife.

Lochia Alba (or purulenta) is the name for lochia once it has turned whitish or yellowish-white. It typically lasts from the second through the third to sixth weeks after delivery. It contains fewer red blood cells and is mainly made up of leukocytes, and other substances. Continuation beyond a few weeks can indicate a genital lesion, which should be reported to a physician or midwife.

WHEN TO CALL 9-1-1:

- She's bleeding heavily
- She looks pale, white
- She has a fever and/or chills
- She's sweating heavily and feels "hot flashes"
- She seems confused or disoriented or "out of it"
- She's unconscious or fainted briefly

Write the family's address and phone near the phone, that way you can read it to the 9-1-1 operator.

What to do: Bright red spotting reappearing after lochia has already lightened may just be a sign that she needs to slow down, get her off her feet, preferably laying down. If she continues to spot after taking it easy for a few days, have her check in with her midwife or doctor. Passing a blood clot is normal and not a cause for concern. Sometimes after the clot passes, her bleeding will lessen.

When to Refer:

If she's soaking more than two hospital size pads in an hour. Don't wait to call if her bleeding is getting progressively heavier, or if it just keeps dripping, and not stopping.
Her lochia is still bright red four days after baby's birth. Her
lochia has a foul odor and she has a fever or chills.

She has abnormally heavy bleeding (saturating two or more sanitary pads in an hour or having blood clots bigger than a golf ball). This is a sign of a late postpartum hemorrhage and requires immediate attention. The leading cause of maternal death (from a pregnancy-related cause) is from postpartum hemorrhage. This is especially a concern if she has a lot of young children and is trying to care for them after having just had a baby. You must help her to understand the seriousness of her situation and get her to get help and get off her feet.

If she's bleeding profusely, or it seems that there is a slow trickle of blood that won't stop and goes on and on for hours or days or weeks, or she's feeling hot flashes or feeling faint, call 911.

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Unit Six: Physical Care of Newborns

In this unit, you will learn how to provide physical care for the newborn baby and to recognize abnormal situations which require medical intervention.

Unit Six: Physical Care of Newborns
CARE OF THE NEWBORN BABY

NEWBORN APPEARANCE

SKIN
Peeling - The baby may have peeling skin, this is due to the nine months in the womb. There is no need to peel it or apply lotion or oil. It will fall off on its own in a few weeks.

Lanugo Hair – Some babies have soft downy hair on their upper shoulders, back and face. In premature babies, there may be more hair. It will disappear in a few weeks.

Mongolian Spots – These are dark pigments which appear on the buttocks of newborns. They are more pronounced in babies of Native American, Asian, Hispanic or African descent. They may look like bruises.

Vernix – This is a white cream-cheese-like substance that covers the skin of the newborn and protected him during his nine months in water. It's more common in premature babies, but may be found in the creases of thighs and underarms of newborns. Some parents prefer the baby not be bathed. The vernix can be massaged into the skin, it's like "nature's cold cream".

Stork Bites – These are small red spots or patches found on the neck, face. They are caused by tiny superficial blood vessels. They are more visible in fair-skinned babies. They are not caused by injury. They will fade within a few months, or may be permanent.

Milia – These are tiny pores on the baby's face that look like whitehead pimples. They should not be squeezed or poked to pop them, as this could cause an infection.

HAIR
Some babies are born with a full head hair (usually dark-haired babies of African, Hispanic or Asian, or Southern European descent), others are born bald (usually those of Northern European descent). The hair may have blood or meconium or vernix in it immediately after the birth. The head can be washed if the parents like.

SUCKING BLISTER ON LIP
Some babies form a blister on the upper lip when sucking. It needs no treatment and will disappear on its own. The skin on the lip may shed, do not peel it.

EYES
Newborn babies can see 7-18" in front of them from birth on, so it is important to have close contact with mother or father right after birth. The color of the eyes may be black or brown if the baby is of African, Asian or

Hispanic descent. Caucasian babies often have grey-blue eyes, and the color will may change over a period of months. Newborns do not produce tears until they are about a month old. Some babies have a crossed-eyed appearance. This is because the muscles of the eyes are not strong yet. They should correct themselves in a few weeks

EARS

Fetuses hear very early in their development in utero. The newborn can even respond to familiar voices and will turn his head towards the father or a sibling. They calm and soothe with high voices as well as shushing sounds. Testing of newborn's hearing is now becoming a standard during well-baby check-ups. This is so that there is early detection and intervention of hearing problems, as this can have an impact on language acquisition and reading and speaking.

HEAD

Newborn heads are much larger than their bodies. The head is often molded (shaped) by coming through the vaginal canal. The plates of the head are apart until the baby is almost a year old, but will slowly close over time. You can feel the sutures of the baby's head by running the fingers along the ridges. There will be a diamond shape on top of her head and a triangle in the back The plates of the head overlap during pushing. In addition, there may be a swollen area called Caput, which crosses the suture lines (the intersection of the plates of the head). There may also be a Hematoma – which is an injury the baby endured during birth, where swelling and bruising is on either side of the suture lines and does not cross them. There may also be a vacuum extractor bruise or a red swollen spot where the internal scalp electrode was placed during birth. You can put homeopathic Arnica cream on the baby's head, such as Traumeel. The baby may also develop "cradle cap" as she gets older. This should not be scraped off. You can put Cradle Cap cream on it and rub it in.

BREASTS, GENITALS

Newborn infants may have swollen breast tissues, and the labia or scrotum may be red and swollen as well. This is from the mother's hormones and is natural and normal. Female babies may have a drop of mucousy-discharge or blood in their vagina. This is also perfectly normal. The condition usually disappears within a few weeks and is no cause for concern.

Unit Six: Physical Care of the Newborn

CARE OF THE NEWBORN BABY

REFLEXES AND SENSES

Postpartum Doulas are not nurses or midwives and therefore will not be assessing the newborn for its reflexes. However, it is important to understand the normal responses to be able to explain them to parents. Newborns that are full term and have no neurological problems will have the following reflexes; there are a few reflexes that likely assisted in the survival of babies during human evolutionary past (i.e. the Moro reflex). Other reflexes such as sucking the startle response and grabbing, help establish gratifying interaction between parents and infants.

MORO OR STARTLE REFLEX

It is more commonly known as the Moro response. The Moro reflex is present at birth, peaks in the first month of life, and begins to disappear around 2 months of age. It is likely to occur if the infant's startled by a sudden noise. The legs and head extend while the arms jerk up and out with the palms up and thumbs flexed.

WALKING/STEPPING REFLEX

The walking or stepping reflex is present at birth; though infants this young cannot support their own weight. When the soles of their feet touch a flat surface they will attempt to "walk" by placing one foot in front of the other. This reflex disappears at six weeks and occurs again in early toddlerhood.

ROOTING REFLEX

This is a bobbing of the head with the mouth open and is one of the hunger cues. The babies also roll on fat checks to move their heads into position to nurse. They also bring the closed fist to the mouth and roll their head side to side when hungry.

SUCKING REFLEX

In full-term babies, this is present from birth. It is one of the last reflexes to develop in utero so premature babies may have less ability to suck than a term baby from birth.

TONIC NECK REFLEX

When the baby head is turned to the side, the arm on that side will straighten and the opposite arm will bend (sometimes the motion will be very subtle or slight). If the infant cannot move out of this position or the reflex continues to be triggered past six months of age, the child may have a disorder of the upper motor neurons. According to researchers, the tonic neck reflex is a precursor to the hand/eye coordination of the infant. It also prepares the infant for voluntary reaching.

PALMAR GRASP REFLEX

This appears at birth until five or six months of age. The baby will grasp a finger or anything put in his hand immediately upon birth. The opening of the hand can be triggered by stroking the back or side of the hand.

PLANTAR REFLEX

This a normal reflex that involves plantar flexion of the foot, which moves toes away from the shin and curls them down. An abnormal plantar reflex (aka Babinski Sign) results in a dorsiflexion of the foot (foot angles towards the shin, big toe curls up). This also occurs in babies under one year of age due to immature development of neurology; in time, the normal plantar reflex develops.

SWIMMING REFLEX

The swimming reflex involves placing an infant face down in a pool of water (which is very dangerous and should not be done!). The infant will begin to paddle and kick in a swimming motion. The reflex disappears between 4–6 months. Babies should not be put in swimming pool until at least 3 months of age.

MAMMALIAN DIVE REFLEX

Newborn mammals, especially water mammals, are born with the ability to hold their breath under water. This is called "Mammalian Dive Reflex", and some practitioners of water birth explain therefore they allow the newborn to emerge from the mother's birth canal into the water, and swim to the surface on their own. Though he is getting oxygen from the umbilical cord, when the cold air hits the face, the newborn takes his first breath.

NEWBORN SENSES

Smell – newborns can smell within the first week and he can smell his mother's milk and distinguish it from another mother's milk.

Taste – newborns prefer sweet over sour or bitter substances.

Touch – the baby responds to being stoked, massaged, bounced, and swayed; this can calm him when fussy. The idea is to create a womb-like environment for him, with swaddling him tightly to mimic the uterus, keeping lights low, held close to father or mother's chest so he can hear the heartbeat, and skin-to-skin where he is kept warm. Mother (or father) regulates baby's breathing and heartrate and temperature by keeping him closeby. This is especially important for premature babies who have less developed physiological self-regulation. He also needs not to be too cold or hot (don't over dress him, though he loses heat through the head and feet so keep hat and socks on him). The rule is to keep him dressed in the same amount of clothing as the mother. If it is a 90-degree day and she is wearing shorts and a T-shirt, the baby only needs a diaper and T-shirt, socks and hat, and perhaps a light receiving blanket.

Hearing – fetuses develop ears and hearing very early in their in-utero development and newborns respond to higher pitched voices. Some parents play music to their baby in-utero. This music can soothe him once he's born. Vision – He can see 7-18" from birth and is quiet and alert when not stressed. Babies from birth can imitate their mothers such as opening the mouth, in response to her doing so. Researchers think this has something to do with language acquisition.

Unit Six: Physical Care of Newborns

THE AMAZING NEWBORN

Newborn Behavior States

QUIET ALERT

In this stage, his eyes are wide open, bright and aware, and the infant is focusing his attention on any stimuli. As an infant grows, he typically spends more and more time in this quiet-alert stage. This is the stage when he will be most responsive to feeding or one-on-one time with a parent or caregiver.

ACTIVE ALERT

An infant in the active-alert state has her eyes open, though they're not as bright and attentive as in the quiet- alert state. She may become more active and can eventually progress to a fussy or crying state with too much disturbing stimuli. In the active-alert state, an infant typically has a slightly delayed reaction to stimuli like hunger or handling. The infant can transition to the quiet-alert state with gentle handling or meeting of needs like hunger.

CRYING

When a newborn is crying, he is communicating that he either needs something or that his limits have been reached. A crying newborn can be responding to internal stimuli like hunger, fatigue or discomfort, or he can be responding to external stimuli like a loud noise or an uncomfortable temperature. A crying infant, particularly a newborn, generally needs adult help to return to a more settled state, since he will be very responsive to any unpleasant stimuli. Swaddling, rocking or alleviating hunger or other discomfort can help a crying baby return to a more settled state.

DROWSY

In the drowsy state, an infant will typically either become more awake or fall asleep, depending on the type of stimulation she receives. The infant's eyes may open and close slowly or be partially closed, as though she is falling asleep. She may have a delayed reaction to sensory stimulation but can sometimes be roused to a more alert state with noise or touch. An infant in the drowsy state who is not stimulated may eventually fall asleep on her own.

DEEP AND ACTIVE SLEEP

The two sleep states of a newborn are "quiet sleep" and "active sleep." Quiet sleep is also known as "deep sleep." When your infant is sleeping deeply, his breathing will be deep and regular, and he will show very few eye or facial movements. An infant in deep sleep is very difficult to wake. Active sleep is also called REM (rapid eye movement) sleep. During active sleep, you may see more eye and facial movement and hear more irregular breathing. Infants in this state of sleep sometimes make brief fussy or crying sounds, even though they are not fully awake.

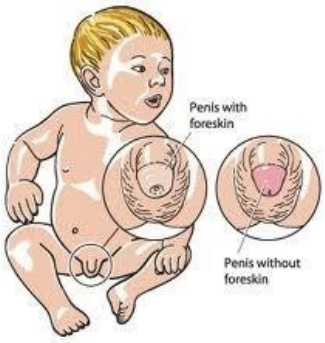
Unit Six: Physical Care of the Newborn
CARING FOR THE NEWBORN BABY
Medical Procedures

The Postpartum Doulas role is not to perform the newborn medical procedures, but rather it is to educate parents about the procedures and to answer any questions they may have. Also, the PPD should know how to care for newborns with certain conditions or who have received certain procedures. The following summarizes the common medical procedures done to healthy, normal full-term newborns. Premature babies will have far more procedures and it will take a PPD with specialized skills in caring for preterm babies to work with these infants. Former NICU nurses will make excellent PPDs for families with preterm infants.

CIRCUMCISION

Circumcision is the removal of the foreskin of a baby boy's penis. It is controversial subject among parents and professionals. Many people have very strong feelings about it. For many Jewish or Islamic families, it is a religious requirement. The procedure is called Brit Milah in the Jewish tradition, and is performed at eight days of age by a Moel (Rabbi/Doctor) in a special ceremony. Khitān (Arabic: ختان) or Khatna (Arabic: ختنة) is the term for male circumcision carried out as an Islamic rite. As in Judaism, circumcision in the Islamic religion is considered by some as a sign of belonging or introduction to the wider religious community. For Jews it is represents a covenant with God. For non-religious parents, they may have it done before they leave the hospital or at the pediatrician's office within a few days after the birth.

A few things to educate parents about:



- Vitamin K - Parents who choose to circumcise should have the baby receive a shot of Vitamin K to prevent bleeding, as the newborn cannot clot his blood until around 8 days of age, this can prevent Hemmorhagic Disease of the Newborn.
- The baby will feel pain from the procedure. How much pain is point of much debate. Opponents of circumcision often stress that the newborn feels pain more acutely than an adult, when measuring their physiological response. The opposition also argue that there may be profound psychological trauma as a result with far-reaching effects. The traumatic impact of surgery on children is well-established. As for long-term psychological effects, without published studies, current knowledge of men's feelings about their circumcision is generally based on reports from self-selected men who have contacted the Circumcision Resource Center (CRC) and other circumcision information organizations. The feelings reported generally include anger, sense of loss, shame, sense of having been victimized and violated, fear, distrust, grief, and jealousy of intact men. The overwhelming majority of these men were circumcised as newborn infants. The memory of this event is not in their conscious awareness. Consequently, the connection between present feelings and circumcision may not be clear. Proponents of the procedure argue that the baby can be

given pain reliever prior to and after the procedure. Opponents counter that this is insufficient pain relief.

- Complications - can occur including bleeding, infection and scarring.

- Research on Cancer, STDs and UTIs - Some studies indicated that there was a slight increase in cancer of the foreskin in uncircumcised elderly males though this seemed to be related to a lack of hygiene over a lifetime. The incidence of penile cancer in elderly males is less than 1%. There is no evidence to show that circumcision lowers risk of prostate gland cancer nor does it prevent sexually transmitted infections. Some studies showed an increase in UTIs in the first year of life among uncircumcised babies. However, the incidence of UTIs is 1% and breastfed babies have a far lower risk.

- Effect on Adult Sexual Performance - The evidence on whether lack of circumcision or circumcision enhances sexual performance is conflicting and inconclusive.

- HIV and AIDS - The World Health Organization in 2007 endorsed male circumcision as "an important intervention to reduce the risk of heterosexually acquired H.I.V." The American Academy of Pediatrics adopted a more encouraging stance than its previous neutral position due to new evidence regarding H.I.V. prevention.

Despite a worldwide campaign for circumcision to slow the spread of AIDS, the rate of circumcision among American baby boys appears to be declining; non-circumcision has been the norm in the Western Region of the U.S. for more than a decade, according to the National Center for Health Statistics. The nationwide circumcision rate had been fluctuating in the low 60 percent range for some years, but a decline in the percentage of boys circumcised started in 2002 and continued into 2003. From 2002 to 2003 declines occurred in all four census regions. After a comprehensive review of the scientific evidence, the American Academy of Pediatrics found the health benefits of newborn male circumcision outweigh the risks, but the benefits are not great enough to recommend universal newborn circumcision. The AAP policy statement published Monday, August 27, 2012 says the final decision should still be left to parents to make in the context of their religious, ethical and cultural beliefs.

If the family chooses to circumcise, the Postpartum Doula's role is to educate parents on the AAP's position. Also, since it is considered elective surgery, the PPD should inform the parents that insurance may not pay for it. The PPD should support parents informed decision, while informing the parents that there are some risks to the procedure (infection, pain, bad surgical results) and teach parents how to care for the circumcised penis. If parents choose not to circumcise, the PPD should teach parents how to care for an a baby with an intact foreskin.

Care of the Circumcised Penis

The circumcision gauze will need to be removed and replaced. Put a fresh gauze pad--dabbed with petroleum jelly or other ointment--on the penis with each diaper change. This will help you avoid getting the penis wet. It will also prevent any undue friction which will surely cause discomfort. Consider using double diapers for the first day of the circumcision to help cushion the penis and keep the baby's thighs from pressing against it. This

isn't usually necessary, but it's worth considering if your baby seems to be suffering. Avoid getting the penis wet. Bathe without submerging the baby in water. Some pediatricians will say that a little bit of warm water is alright if necessary. Keeping the penis dry will help it heal faster so that's an important thing to consider. Administer some pain reliever (liquid infant Tylenol) if your baby seems really uncomfortable. Talk the pediatrician about what he recommends using and what dosage is appropriate for baby. If there is any swelling, pus, or the baby seems inconsolable, instruct the parents to contact their pediatrician.

Care of the Uncircumcised Penis

If parents choose not to circumcise, the foreskin should never be retracted. Clean the foreskin of the penis, but do not pull it back. This can damage the boy. The child can be taught to care for himself as he gets older.

Unit Six: Physical Care of the Newborn

CARE OF THE NEWBORN BABY

Newborn Medical Procedures At-A-Glance

The following are common medical tests and procedures that will be done to baby before he leaves the hospital.

Procedure:	Vitamin K
What it is:	An injection given to baby after birth.
Why it is Done:	• Helps baby's blood clot • Newborns bodies cannot manufacture Vitamin K, a blood-clotting factor, until they are approximately 7 days old. This injection is given as a protection against a rare but serious condition called Hemorrhagic Disease of the Newborn, a condition where baby is bleeding internally; can be fatal.
Effects:	• Injection may be painful for baby. • Helps baby's blood clot.
Alternatives:	• Breastfeeding immediately prepares the baby's intestine to create Vitamin K. • Some parents who are breastfeeding exclusively may chose not to do it. • Recommended for parents who are planning to circumcise.
Procedure:	Newborn Screening Tests
What it is:	A blood sample taken from baby's heel, the sample is sent to state lab for analysis.
Why it is done:	Screens for metabolic disorders such as PKU, Sickle Cell, Galactosemia, Cystic Fibrosis, Hypothyroidism, etc. Many of these disorders can cause mental retardation.
Effects:	• Causes baby some pain as heel is lanced and blood is taken. • If baby has any of these disorders, baby will need special care to help him develop normally.
Alternatives:	• State law requires it to be done to all newborns, but the law allows for philosophical or religious exemptions. You can sign waiver at hospital if you choose not to do it. • Since many tests are not accurate until baby has fed; baby can be nursed or bottlefed before tests are done.
Procedure:	Hepatitis B Immunization
What it is:	An immunization given at birth.
Why it is done:	To prevent baby from getting Hepatitis; a liver infection passed from mother who has the infection.
Effects:	Babies who are infected can become jaundiced (yellow) at about 3-4 mos.
Alternatives:	• Some parents may choose to delay this immunization until baby's first pediatric visit. • If baby has been vaccinated and mother has Hepatitis B, breastfeeding is safe and will help baby's immune system.
Procedure:	Antibiotic Eye Ointment
What it is:	Ointment that is put in baby's eyes after the birth
Why it is done:	• To prevent the spread of Chlamydia or Gonorrhea infection from mother to baby. • If mother passes infection to baby, may cause eye, nose and throat, ear, rectal, intestinal, vulvae infection and blindness if untreated.
Effects:	• Ointment can cause the baby some blurred vision. Does not hurt the baby's eyes.

Alternatives:	California state law requires it to be done (although you can decline if you sign an informed/consent and release of liability.)
Procedure:	Circumcision
What it is:	Surgical removal of the foreskin of the penis of the male baby.
Why it is done:	• Some parents believe it will be easier to keep the boy clean and reduce chance of infection and cancer during adulthood. Some parents circumcise for religious reasons. (Jews and Muslims, and some Christians). Other parents circumcise for social or personal reasons. • Parents may feel family pressure to do the procedure. Parents who choose not to may experience stress as they go against family expectations.
Effects:	• Some parents are concerned it may be extremely painful, stressful and traumatizing or cause shock for baby. • May reduce penile cancer, a rare condition. • According to 2007 W.H.O. reports, studies have been shown to reduce HIV transmission in Africa. • Although baby is given two local injections prior to surgery, some parents are concerned these can be painful. Some parents worry that pain may not be completely reduced during and after the surgery; but giving more anesthetic has undesirable side effects for newborns.
Alternatives:	• Some parents whose religious tradition includes circumcision but who have aversion to circumcision have a naming ceremony instead of a circumcision religious ritual. • Some non-Jews who want to circumcise have found a "Moyel" (Rabbi/Doctor) to perform a home circumcision without the religious ceremony. • The baby's pediatrician can perform the surgery in the doctor's office. • Circumcision can be delayed for 8 days to allow the baby to manufacture clotting factors. Vitamin K at birth is recommended at birth for parents who plan to circumcise. • Mothers can be encouraged to breastfeed after the procedure to soothe and comfort baby. • The American Pediatric Association, after conducting several studies and reviewing the findings, stated that it is an unnecessary procedure for most male children. Therefore it is considered elective surgery and most insurance will not pay for the procedure. AAP recommends that parents make an informed decision based on their cultural, religious and ethics.
Procedure:	Suctioning
What it is:	A thin plastic tube that is inserted into baby's trachea (airway) to clear the airways of meconium (baby's stool) or amniotic fluid.
Why it is done:	If baby inhales thick meconium (baby's stool) it can stick like glue to the lungs causing lung infection and breathing problems.
Effects:	• Baby's breathing may be too fast. • Baby's heartbeat may be too fast. • Baby may have to go to NICU, which will delay breastfeeding and bonding. • Baby may need to stay in hospital for several days
Alternative:	None. If baby inhales thick meconium into her lungs can make the baby very sick or can be fatal.
Procedure:	Positive Pressure Ventilation (PPV) / Ressuscitation
What is it:	A mask is put over baby's mouth and nose and is oxygen is forced into the lungs.

Why it is done:	• Within a minute after birth, if the baby's heartbeat is too low, or he is not breathing, or if his color is white, grey or blue or he is limp, it can get baby's heart beating normally and help him breathe. • Greater chance it will be needed for babies whose mothers have used recreational drugs during pregnancy or pain-relieving drugs in labor.
Effects:	• Helps baby's heart to beat and helps baby to breathe. • Can cause a pneumothorax (hole in baby's lungs) requiring surgical repair, if done for an extended period of time.

Unit Six: Physical Care of the Newborn

CARE OF THE NEWBORN BABY

CARE OF FEMALE BABY'S GENITALS

Always wipe baby girl's front to back to keep feces out of her urinary tract. You may need to open up her labia and clean her inside gently.

BATHING THE BABY

Babies often will prefer being immersed in water instead of sponge bathing. They do not need to be bathed often, once a week is sufficient.

Sponge Bathing

Place baby on a firm surface, with a folded towel underneath. Fill the sink or baby tub with warm water. Start by washing baby's eyes and face gently with wash cloth, then put a small amount of baby shampoo in her hair making sure not to get water in her eyes. Place a hat on her head afterwards. In fact take care to make sure there are no drafts in the room, as baby's get chilled easily. Then wash her upper body and her bottom and genital area. Wrap her quickly in a warmed towel.

Tub Bathing

Fill the baby tub with warm water, halfway full. Make sure it is not too cool or too hot. While holding her head in your arm and holding onto her arm, lower her into the bath. Her body should be covered with water, head above water. Wash her eyes and face as described in sponge bathing, and her hair. Wrap her in a warm towel and dry her thoroughly before dressing. Some parents will enjoy having a bath with the baby. Once mom (or dad) is in the bath, someone can hand him/her the baby. Mothers and babies alike enjoy being immersed in warm water and nursing. This is a stress-buster for mother and soothes the baby as well, as she "unfolds" in the familiarity of warm water which is akin to the uterine environment. You should help mother when getting out of the bath, so she should hand you the baby before stepping out, to avoid falling with the baby.

BOTTLE FEEDING BASICS

While Postpartum Doulas promote and support breastfeeding, when a mother chooses to quit, or not breastfeed at all, we still need to support her and teach her safe feeding practices.

- Follow the directions on the formula can when making bottles. Do not over dilute to save money as this could result in baby not getting the necessary nutrients needed for growth.
- Most babies will prefer the milk warmed. Be sure it is not too hot. Test it on your inner wrist before feeding the baby. Never warm a bottle in a microwave. As microwaves do not heat evenly, there may be hot pockets in the milk and this can scald a baby.
- Do not reheat or reuse formula. When baby is done, discard any unused formula.
- Wash and sterilize all bottles and nipples before each feeding.
- Allow the milk to fill the nipple before feeding to avoid having the baby swallow air.

- Keep baby's head a bit upright when feeding. Like breastfeeding, you should switch sides at each feeding. Switching sides has something to do with exercising facial muscles and also brain development which has to do with language acquisition.
- The baby's head should not be sideways when drinking as this makes swallowing harder.
- Be sure the flow of the milk is not too fast or slow; check the holes of the nipple.
- Babies do not need to finish the bottle. Follow baby's cues and stop when she seems done. Overfeeding is one of the reasons that bottle-fed children have more tendency to be overweight than breastfed children.
- Hold the baby skin-to-skin against the chest, as baby will benefit from this close contact.
- Do not prop a bottle or put baby to bed with a bottle. This can lead to serious problems such as ear infections, cavities, and over feeding. Feed baby and then put her to bed, or lay near baby and feed her until she seems satiated.
- Dentists recommend that all infants—including breastfed ones—have their gums and teeth washed with a wash cloth after feeding to lower tooth decay.

HELPING WITH TWINS AND MULTIPLES

- Help the family set up their routines to make life easier. Such as prepping bottles ahead of time. Having changing stations throughout the household.
- Help with siblings, if needed. Assist with the nigh time routine, take them for walks to the park, play games, read stories, engage the sibling in helping with the laundry or diaper changes of the baby, etc.
- Help with changing and swaddling and holding and feeding to allow parents to get naps or sleep longer at night.
- Prepare extra meals for the family to make their life less hectic.
- Encourage breastfeeding and pumping. Bring her the baby or babies to nurse. Not all twins nurse at the same time.
- Show the parents how to use a sling.
- Don't dress everyone alike – encourage individuality. If identical twins, you may suggest the parents pain one toe of the baby with nail polish to tell them apart.
- Twins and multiples are often premature, so they may be developmentally delayed, and more fragile. They may be on a breathing apnea monitor, have more trouble feeding, so may be syringe-fed or by a Supplemental Nursing System. Mom may need more assistance at feedings. Also, you will want to promote Kangaroo Mothercare.
- Mothers of multiples may have delivered by cesarean, so she will need more assistance than a mom who delivered vaginally.
- Have a referral list for parents of multiples.

Positions for nursing two babies at once

Unit Six Physical Care of the Newborn

CARE OF THE NEWBORN BABY

When Baby is Ill: What to Do

WHEN BABY IS SICK

If baby is ill and less than 3 months old, here's what to do.

Call the health care provider right away if baby:

- Has temperature 100.4 degrees Fahrenheit by rectal thermometer
- Skips more than 2 feedings, or refuses to eat.
- Has projectile vomiting, or doing more than spitting up after feeding.
- Has stools that are not normal, have a very bad odor, have blood in them, or mucous.
- Has blood or mucous in the urine
- Does not have 4-6 wet diapers in a 24 hour period after day 3
- Cries more than normal and is inconsolable
- Has a very high pitched cry, or wheezing sound when crying, or does not cry as loudly as usual
- Is sleeping more than usual or does not seem as alert as she was
- Seems weak or floppy
- Has eyes or skin that look yellow
- Has unexplained bruises on body (that are not Mongolian spots)
- Refuses to feed on one side
- Has a purple rash that does not lighten when you press it

CALL 9-1-1:

- Baby has trouble getting air in or out or is grunting, laboring to breathe
- Baby's skin is turning blue
- Baby is choking

Write the family's address and phone near the phone, that way you can read it to the 91-1 operator.

DAY FOUR

7

Unit Seven: Emotional Support of Postpartum Mothers

In this unit, you will learn how to provide emotional support to new parents in the postpartum period. You will be able to distinguish between normal and abnormal emotional adjustments to new parenthood and learn what you can do to help.

Unit Seven: Emotional Support of Postpartum Mothers
HELPING MOTHERS PROCESS THEIR BIRTHS

There are few experiences that can match the profundity of childbirth. For many women it is less than satisfying, for some it is disheartening or worse, traumatic. For a few, it is an ecstatic experience which leaves a woman profoundly changed forever and empowered in all areas of her life. Women go through many emotional changes during the birth process, including exhaustion, fear, pain, and exhilaration. For most women, it demands everything they have to give birth. Women usually have a need to make sense of what happened. She may feel joyful, triumphant, powerful and deeply satisfied and full of pride in herself. On the other hand, she may feel confused, angry, and these feelings tend to fester and grow until she can find someone to talk to, to help her make sense of what happened and sort out how she feels about it. If she is angry and depressed or angry about what happened, she needs to process it somewhere. She may have post-traumatic stress disorder or postpartum depression and may be disappointed in herself or angry at her partner, or her care-providers (including her doula who many times becomes the safest person to direct her anger towards). If she is angry towards people who were at her birth, or about the things that occurred at the birth, she needs to have a listener who can offer her empathy, non-judgmental listening, and validate her feelings. This person or a trained therapist may be able to help her reframe her experience to a more positive perspective.

GOALS OF REVIEWING THE EXPERIENCE WITH CLIENT

- For the mother to feel heard, understood, respected and nurtured.
- To clarify or to correct any misunderstandings or misperceptions the mother may have about the birth.
- For the doula to understand what the woman's experience was like from her perspective, even if she was at the birth.
- For the doula to get feedback from the mother to help her grow and improve her services.
- To help the mother process guilt, anger, disappointment about her birth (sometimes the doula will be the target of these emotions).
- To understand how to integrate her new role as a mother.
- To bring closure to the client/doula relationship.

SOME QUESTIONS TO DISCUSS WITH CLIENTS

Set aside some uninterrupted, private time for you to talk for an hour or more. Ask open-ended questions. Here are some suggestions:

- What do you remember about the birth? What stands out for you most?
- Tell me the story of your birth from beginning to end.
- In what ways do you wish it could have been different?
- When you think about the birth, what makes you feel happy about it? What makes you feel disappointed about it?
- Is there anything that you need or want from me or anyone else?

Unit Seven: Emotional Support of Postpartum Mothers

RISK FACTORS FOR POSTPARTUM DEPRESSION

The Postpartum Doula is not a mental health practitioner or professional counselor. However, her role is to provide emotional support to women after birth. She should also be knowledgeable about the normal psychological adjustments and abnormal adjustments to postpartum and be able to refer women to appropriate mental health providers.

RISK FACTORS FOR POSTPARTUM DEPRESSION

- Relationship issues with baby's father or partner
- Relationship issues with mother
- Issues with differences in baby-mother temperament, a high need, colicky baby, developmental delays, disrupted attachment issues (due to separation due to complications or illness)
- Traumatic or disappointing birth experience
- Twins or Multiples
- History of Sexual Abuse or Assault
- Perfectionistic personality; very rigid, inflexible, task-oriented, very schedule-oriented
- History of PMS
- History of Depression in self or family
- History of Bipolar Disorder or other mental health issue in self or family
- History of Anxiety Disorder, Panic disorder
- History of Eating Disorders
- Unresolved issues around perinatal loss, abortion, miscarriage, infertility
- A lot of stress: marital issues, illness in family, death of someone close to her, change in financial situation, recent move
- Inability to sleep at least 2 hours in the postpartum period

- From DONA International

Unit Seven: Providing Emotional Support to Postpartum Women

UNDERSTANDING THE DIFFERENCE BETWEEN "BABY BLUES," POSTPARTUM DEPRESSION, AND POSTPARTUM PSYCHOSIS

Many women have the baby blues in the days after childbirth. This is normal. Reassure your client that many women have felt the way she does, including you (if you did). However, you need to be on the lookout for more serious problems such as postpartum Depression and Postpartum Psychosis. Postpartum psychosis is rare. It occurs in about 1 to 4 out of every 1,000 births. It can be exacerbated by pre-existing mental health issues, closely spaced births, and other factors. Women who have bipolar disorder or another mental health problem called schizoaffective disorder have a higher risk for postpartum psychosis. (Adapted from Postpartum Adjustment Society).

Baby Blues	Postpartum Depression	Postpartum Psychosis
Signs: • Have mood swings • Feel sad, anxious, or overwhelmed • Have crying spells • Loss of appetite	Signs: • The symptoms of postpartum depression are like Baby Blues, but last longer than that of Baby Blues, and are more severe.	Signs: • Thoughts of hurting the baby Thoughts of hurting herself Not having any interest in the baby • Seeing things that aren't there • Hearing voices telling her to do things or that she's an unfit mother • Feeling confused and disoriented • Having rapid mood swings • Attempts at or thinking about hurting herself or the baby.
Length of Duration: • The baby blues most often go away within a few days or a week. The symptoms are not severe and do not need treatment. She may have a good day followed by a bad day.	Length of Duration: • Postpartum depression can begin anytime within the first year after childbirth. If she has postpartum depression, she also may have any of the symptoms of depression. She may feel depressed for days on end.	Length of Duration: • It usually begins in the first 2 weeks after childbirth.
What to Do: • Take a walk, get some sleep, take a shower or bath, get help with the children and house, eat some high carb food, call a friend, cry, get a hug, watch a funny movie	What to do: • Refer her to a mental health professional for assessment. Talk to her partner about your concerns and see if he can help to get her help. Continue to check in with her more often and help as much as you can. But leave the psychotherapy to a professional.	What to do: • Postpartum depression needs to be treated by a psychiatrist specializing in the condition. Be sure you have a referral handy. You will need to be supportive of the partner during this difficult time. She may need to be hospitalized. PPD may be hired to help with the newborn care or children or household.

Unit Seven: Emotional Support of Postpartum Mothers

PARENTING STRESS

Parenting is one the hardest jobs there is. All parents experience stress from time-to-time. Many feel overwhelmed and frustrated at times when dealing with their children. However, in modern North American society, parents are increasingly stressed due to economic pressures. Parents must spend 9 to 10 hours per day away from their children at work each day. When parents come home exhausted, frustrated and overwhelmed, it is hard to be present emotionally and responsive instead of reactive to children. This leads to power struggles between parents and children who are acting out because they want their parent's attention, even if it is negative. Absent minded parenting can be experienced by young children as neglect, which is traumatizing since children usually blame themselves for their parent's mood, and results in loss of closeness with their primary source of love and attachment, something that human beings are hardwired to need for their survival. This is caused Attachment Trauma and it has a profound effect on the child's development. According to Gabor Mate, MD, it can result in short term coping mechanisms such as tuning out to survive the trauma, which becomes a malfunctional pattern in adulthood. Dr. Mate asserts that the increase in the prevalence of Autism and ADHD in North America is a result of this intrauterine and early exposure to maternal-parental stress, which triggers an epigenetic effect the turning on of genes predisposed towards these disorders.

The Postpartum Doula can help the new mother prepare for the demands of caring for a newborn 24 hours a day. Especially if she has older children, and she works outside the home or her partner is gone away at work for long periods of time, her stress may be even greater. Sometimes parents under a great deal of stress can take it out on their children. If you suspect a child has been harmed or is in danger, you must report it to Child Protective Services. However, every culture has its own ways of parenting, so you must be respectful and conscious of these differences. What may be considered positive parenting in one culture is looked down on in another. Discipline practices also vary from culture to culture. One culture may rarely discipline unless real danger exists, others approval of physical punishment, others use indirect methods such as shame. However, newborns should be treated with care, and not spanked, shaken, or left alone to cry it out for long periods of time. Some examples of what to look for are listed below. You may want to keep a watchful eye if mother has:

- History of neglect or abuse as a child
- Very controlling, perfectionistic personality
- History of spousal abuse
- Lacks social support, and is isolated from friends and family
- Severe financial concerns
- History of substance abuse or her partner has
- Mental illness
- Had a cesarean or a very difficult birth
- A child with problems such as birth defects
- A premature baby
- Twins, multiples
- Children spaced closely together
- Says the kids are driving her crazy
- Says she can't take it anymore
- Says she's losing control

- Says the baby is "bad" or she can't handle the baby
- You see her shaking baby, hitting or threatening her other children
- Yells or swears at the children
- Lets the baby cry it out for long periods of time without comforting him (though this could be cultural practice)
- Ignoring a preschooler's need for help or attention

SIGNS OF DEPRESSION IN NEW MOTHER

- Feelings of discouragement over a long period of time
- Loss of interest in activities that used to interest her
- Crying for no apparent reason
- Difficulty doing usual tasks like caring for family or self
- Being highly anxious – sweating, irritation, rapid heartbeat, shaking, upset stomach obsessing over small details or imagined disasters, etc.
- Feeling hopeless and helpless, unable to cope and have hope that things will be better in the future
- Lack of energy, difficulty concentrating
- Agitation and restlessness, cannot sleep
- Headaches, unable to sit still
- Loss of appetite
- Sleeping all day long
- Difficulty concentrating on small things or conversations – seems detached or preoccupied
- Feeling guilty, worthless
- Having delusions, hearing voices, disturbing dreams or thoughts
- Thinking about hurting herself or someone else

As a Postpartum Doula, you are not a mental health provider, but if you see signs that are of concern you should make a referral to a mental health specialist for treatment.

WHAT TO DO IF PARENTS SEEM STRESSED

- Let parents know what to expect in first weeks and months – give them guidelines such as "sleep when the baby sleeps", "get help with the housework and older kids, not the baby", that this period in the baby's first days and weeks is a "honeymoon phase—keep visitors and stress to a minimum, stay in bed for 2 weeks, etc."
- Let them know what many parents experience: baby waking every 2 hours to feed, that newborns don't sleep through the night, etc.
- Give suggestions: "you may want to try"… "some parents find___helpful."
- Build her up. Example: "it is clear you love your baby"…."I can see you want to be a good mother."
- Focus on joys as well as challenges: "being a mom is a tough job. What do you like about it? Are there times it seems worth all the effort?" Or, "at first the baby gives little back in return, but in time, she will reward you with smiles and kisses."
- Praise her. "you really did a great job organizing the nursery". "It's so nice to see a parent who…" "I like the way you…" "you are really good at…." Or "you did the right thing…your instincts are good."

- Help the mother say positive things about her child. "what a curious child. She really wants to find out about the world. Let's see if we can get her to explore something other than the TV." Or, "let's see if we can figure out a better way." Or "would you like help in finding a way that works?"
- Give non-threatening supportive advice. Instead of using words like "you shouldn't have", instead, say "have you considered?" or "you may feel better, or get better results if you…"
- Emphasize the need for social support. The isolated mother can feel very overwhelmed. Discuss her social support system and encourage her to reach out to friends, church or family members, or a support group.
- Give resources for outside assistance. Give a phone number of a parent stress hotline, support groups for new moms, etc.
- Emphasize self- care. Insist that she get rest, eat well, and get a little bit of time to herself. Even if is just having dad hold baby when she takes a shower, or walks around the block.
- Elicit Dads help. Get father, grandmother or friends to help mom by prepare food for her, do the baby care, like changing diapers and bathing, etc. so that mom can just focus on resting and nursing baby. Give father/partner encouragement too. The father/partner may feel overwhelmed and at wits end and not know how to help. So give suggestions on how to soothe baby, show him the Harvey Karp "Happiest Baby on the Block" methods, for example.

CHILD ABUSE AND NEGLECT

According to California state law, the PPD is NOT required to report actual or suspected abuse or neglect to the authorities. However, if you are working for an agency providing postpartum support, you may be required to report. You do not need to know who did it. The authorities will investigate. Types of abuse are listed below:

Physical Abuse – non-accidental physical injury, usually result of corporal punishment. In infants, it may be shaking the baby, which could cause brain damage or death. Burning, biting, cutting, poking, kicking, slapping, pinching, twisting limbs, are examples.

Physical Neglect – endangering child by not providing adequate food, clothing, shelter medical care, or supervision, or by having child exposed to drugs and excessive alcohol use by parents.

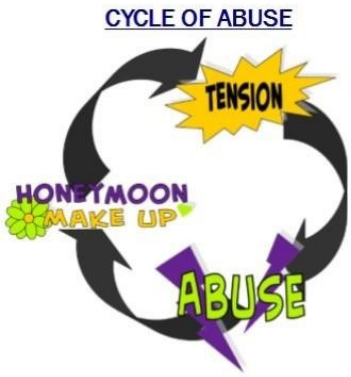
Sexual Abuse – rape, incest, sodomy, molestation and other acts, sexual exploitation (exposure to or participation in pornography trafficking, prostitution) or exposure to sexual acts or images, etc.

Emotional Abuse – verbal abuse and emotional deprivation, though such cases are very difficult to prove and only cases of "willful cruelty or unjustifiable mental suffering" must be reported.

SUGGESTIONS

- A Postpartum Doula working freelance is not a mandated reporter a person who is required by law to report abuse. However, ethically, you may need to make a report. Alternately if you are working as a Postpartum Doula at a social service agency, you may have to report abuse to a licensed clinician such as a RN or LCSW at your workplace who are mandated reporters. At the first visit with the parents, you may want to inform the family you're a "mandated reporter" and are required legally or ethically to make a report if any abuse or neglect is suspected or witnessed. Assure parents all other conversations will be confidential except in these cases.
- If you must make a phone call to report abuse or neglect you may want to have the parents present.

- When you make the report, you must give your name (which is confidential unless court ordered disclosure). You are not liable as a health care professional unless you made a report you knew was false.
- If you feel the baby or children are in serious danger, report at once. Look in the phone book or internet under County Social Services for Child Protective Services or Department of Child and Family Services.
- Hopefully you can continue to support the family after the report was made. Do not take it personally if they choose to terminate your contract. You did the right thing, as required by law.
- Refer family for help. Parenting classes, family, couple or individual therapy, preschools, public health nursing "warm-lines" for parenting, 12 step meetings for spouse of addict/alcoholic and/or addict/alcoholic.
- Likewise, if you suspect partner abuse of woman, you should report. If she has injuries or reports emotional or economic abuse, help her to get support. Learn about the cycle of abuse and also resources for help. Have a domestic violence shelter on your resource list. You also must submit a Suspected Violent Injury Report and send it to authorities within 2 days of abuse, or report to law enforcement agency. Inform the client of your duty to report the abuse. Help her to create a safety plan. Children who grow up in an abusive household suffer physically and emotionally, even if children do not witness the battering, they are negatively affected by being cared for by a depressed or anxious mother. If the mother is aware of the impact on her children she may be more willing to seek help.



- Take a training on Domestic Violence or read up on the issue so you can know what to do to help your client

Unit Seven: Emotional Support of Postpartum Mothers
COPING WITH PERINATAL LOSS

There are many types of perineal losses. A Postpartum Doula is not a mental health specialist, yet, during your career, you will likely encounter a situation in which a mother has a loss. Therefore, the Postpartum Doula needs to know how to be supportive and when refer clients to a mental health professional.

TYPES OF PERINATAL LOSS

The following are some types of losses experienced by pregnant women.

ADOPTION

Even when a mother chooses to give her baby up, she will experience some grief afterwards and possibly will reexperience grief in subsequent pregnanc(ies). As a Postpartum Doula, this is the least likely type of situation you will be involved in, but she may have given up a baby previously. She may not want other family members to know of her relinquished child, and she may be grieving about not having enjoyed her time with the child she gave up, as she holds her new baby in her arms. Your role will be to be supportive and help her to connect with her new baby. If she prefers the family not know about the child she gave up, this will be your duty to keep the information confidential.

FETAL DEATH OR NEONATAL DEATH

A fetal death, sometimes called a stillbirth, is sometimes anticipated (as in case of known fetal anomaly) or it may be unexpected. Neonatal death is the death of the baby from 28 days gestation to 28 days after birth. It is very important for the healing process that she have the chance to hold and name her baby. The PPD can help by preparing a photo album, including things of significance to the mother and father/partner. This could be a lock of baby's hair, the hospital bracelet, her pregnancy test results, the footprints of the baby, or any other memorabilia. The PPD can also arrange for her church, temple, synagogue or family members to bring food to the house or take care of older children to give the family time to grieve. One doula organized a candlelight healing ceremony with the mother and her friends a few days after the loss of her baby, and organized a Blessingway Ceremony with the couple's friends when she was expecting her next child. If you are involved in the woman's next pregnancy, she may have a lot of fears and anxieties and such a ceremony can be healing for her. [Watch Video: "Blessing the Way" by Sage Mountain Films, http://sagemtnfilms.com]. She may be very eager to get pregnant again right away, but recommendations are that she wait 12-18 months before her next pregnancy.

MISCARRIAGE (SPONTANEOUS ABORTION)

Miscarriage is the loss of an embryo or fetus under 20 weeks gestation. It is estimated that 1 in 5 pregnancies result in a miscarriage. Care providers may refer to it as a spontaneous abortion—the use of the term may be offensive to some women. Women's response to miscarriage varies. Some will feel it was "God's will" or state that the baby had a problem and it was "just as well." Others will refer to the loss as a "loss of a baby" which indicates how bonded she was with the fetus, or the depth of significance having a baby has for her. If she's been infertile or trying to conceive for a long time – or at the end of her reproductive years and this baby was long

awaited or an unexpected last chance to be a mother, the loss may be profound for her. All of these factors impact the grief response. Try not to interject your own explanation or spiritual interpretation into it. Saying, "the fetus probably had a birth defect incompatible with life" may not be appropriate. Nor would saying, "your baby is in heaven now, and you can have other children in the future" be appropriate. Let her talk about it in the way she needs to in order to make sense of it, and use your reflective listening skills. Also, know that not all grief responses look the same. Some women may be sad and cry, others may not. Fathers and partners will too go through emotions. He/she may deal with it more privately, but he/she needs support too. ELECTIVE OR THERAPEUTIC ABORTION (CHOOSING TO TERMINATE THE PREGNANCY)

In some situations, a therapeutic abortion may be needed, due to a maternal health issue or if the baby has an anomaly, the parents may elect (choose) to terminate the pregnancy. The woman may feel okay about the decision, as it was likely made after much soul searching. You may be the one to help her understand her options. You can educate her on the option of raising a child with this problem or help her explore how she would feel about terminating the pregnancy. The PPD's role is to help her to open up about her feelings about it when she is ready and help the parents clarify their values and ethics. Women may feel some guilt over their choice as well. Reassure her it is not her fault if the fetus had a problem.

Also, you may work with women who have had several elective abortions and/or miscarriages prior to the current pregnancy. Women may have residual emotions about this, ranging from guilt to grief or she may be self-reproachful. She may also have anger towards the biological father, perhaps because he didn't want to father a child, or because of the loss of the relationship. If the pregnancy was a result of rape or incest she may need professional psychological help. Help her to feel comfortable with you so she can open up about this, and you can help her grieve, forgive, and heal.

TRAUMATIC BIRTH OR LESS THAN IDEAL BIRTH

Many women have "pictures" of how they want their birth to be. If the birth was less than perfect, if she felt she was pressured to make certain decisions, or she felt she was not treated with respect, she may have feelings of disappointment, anger or blame. She may have wanted a vaginal birth and ended up with a cesarean, or she planned to give birth naturally and ended up with an induction and an epidural. She may have expected her partner to be more involved or to support her better. She may direct this disappointment and anger towards her doula, her partner, or towards the doctors or nurses. Often it is directed at the doula. She cannot afford to "rock the boat" in her relationship with her partner even though s/he may have not met her expectations. If you were her doula, try not to personalize her backlash. Listen and reflect back her feelings. Don't defend what you did or didn't do. This will go a long way towards helping her heal. Maybe in time, she will be able to reframe what happened. If she's angry with her doctor you can suggest she write a letter (sending it or not is her choice), or speak with the hospital when she's ready, and make a complaint. She can also seek counseling with a mental health professional. Some women will have a post-traumatic stress response. If this is the case, encourage her to seek professional support. Listen to her story, and allow her to grieve and don't try to help her reframe the experience until she's ready for that. The gift of your compassionate listening cannot be underestimated.

A CHILD WITH A PROBLEM OR THE WRONG GENDER

If the baby was born with a problem, this may be a sudden, unexpected situation. If they knew ahead of time and chose to continue the pregnancy, it may be easier. Hopefully parents will come to love their baby unconditionally. However, they may be grieving the loss of the ideal for some time and also be overwhelmed with caring for a

baby with a problem. Connect them to community resources and support services and social support groups. Some parents will have long-term grief as they deal with a child with permanent health anomalies.

In some cultures, there is a preference for male children. Some families may be disappointed if the child is a female. While you may not share their preference for male children, or find it hard to comprehend they are disappointed it is a girl, you must put aside your opinion and use your reflective listening skills. You can also try to facilitate the parents' attachment to the baby by pointing out her beautiful qualities, try placing her in the parents' arms. If the mother and to a lesser degree the father/partner seems unusually disinterested in the baby after a few days, you may want to be on the watch for signs of neglect and abuse.

LOSS OF PREGNANT STATE/PRE-PREGNANT LIFE

Some women love being pregnant and can feel disappointed when it is over. Also, scientific research has shown that women experience an emotional "valley" after the placenta is expelled due to the drop in hormones. This may be part of the reason she is feeling sad.

Also, there is a major change in lifestyle once the baby arrives. This may especially impact young mothers who had an unplanned pregnancy, as her friends are still living the lifestyle she used to lead and she feels they've forgotten her or that she's not having any fun and can resent the baby. Also, an older woman who was totally focused on her career prior to having a baby may feel she is worthless or unproductive. Caring for a baby is a different type of work and she may have trouble adjusting.

Relationships change after a woman becomes a mother. Friends without children may no longer call or come around. The mother may need to form new friendships with other mothers, help her to find support groups and play groups. Relationships with in-laws and parents and partner may change as well. Allow her to discuss her feelings with you. Offer encouragement and support. Use reflective listening. Connect her with resources, or a mental health professional for some individual counseling. If you are a parent, you can share that you too felt the same way and share what you did to get support, and how you adjusted to parenthood.

Unit Seven: Emotional Support of Postpartum Mothers
THE DOULA'S ROLE IN HELPING CLIENTS BECOME A FAMILY

When there's a new baby in the family, all the relationships in the family dynamic change. This is a big adjustment to everyone's identity and roles within the family. The Postpartum Doula can help the family adjust to the changes in the household and relationships.

Couples often find that their relationship changes drastically, as the demands of running a household and 24hour a day parenting can be daunting. Finding time to be together and a lot of new financial pressures can be a strain on a relationship, and the new parents now find themselves focusing on the new baby instead of each other. Sometimes, the stay at home parent (usually the mother in the first weeks at least) feels she is doing the majority of the work and she feels lonely and on her own, and may feel that the partner does not have the loss of freedom and workload that she has caring for a baby and taking care of the household. The father/partner working outside the home has a lot of extra responsibility and the burden of being a provider is an immense responsibility, for which he/she may feel underappreciated.

Older siblings may feel the baby gets all the attention and they may act out or revert to earlier behavior (like wetting the bed, wanting to nurse, talking in a baby voice, etc.).

Grandparents may become more involved and this can be either a support to the family or cause more stress as old unresolved parent-child relationship issues surface or the over-functioning grandmother tries to give unsolicited or conflicting advice to the new mother.

Friendships may change. Those with children of their own may be supportive and helpful. Those without children may drift away and this can be particularly troubling to an already isolated new mother.

WHAT THE DOULA CAN DO

The PPD doula should ask questions of the family and help them to define how the new responsibilities will be divided and offer a caring stance and compassionate listening and make suggestions. Here are some examples:

- What chores should be done and by whom? Stress to parents to focus more on the baby than having a clean house, at least for a while. Or hire someone to help.
- Who should care for the baby at what time of day or night?
- Who should care for the older siblings and what time of day or night?
- What activities would the mother like to do for herself and at what time?
- What activities would the father/partner like to do for him/herself and at what time?

- When will the parents have time alone as a couple and who will care for the baby then?
- Where can the parents find new friendships with other parents?

- Where can the older siblings find new playmates and activities?
- How should the finances be arranged? How long will the mother stay at home and not bring in income?
- When does the couple want to have another child and what are their plans for travel, work, school, etc.
  and how do having more there is an emotional "valley" children fit into that plan?
- What form of family planning will the couple use until they are ready to have another child?

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Unit Eight: Cultural Awareness

In this unit, you will learn about the aspects of culture and how to work with people who are culturally different from you. You will examine your own implicit biases and increase your awareness of yourself and others.

Many cultural differences exist among people related to diet, health practices, health beliefs, health decision-making, and communication styles. As a Postpartum Doula, you may experience challenges working with clients from different cultures.

However, learning about other people's attitudes, beliefs, feelings and reasons for their behavior can help you work effectively with many types of families from different cultures. You will also learn about the highlights of historical traumas that have occurred in reproductive health for women of color, primarily African American, Native-American, and Latin-American. You will discuss the impact of these injustices on birth outcomes and maternal and infant physical and mental health.

Unit Eight: Cultural Awareness
WORKING WITH THE CULTURALLY DIFFERENT
Role Play Exercise

INSTRUCTIONS

1) Pair up with someone you do not know well
2) Identify who will be #1 Pink; who will be #2 Blue
3) Read instructions on your sheet but DO NOT show your partner what your paper says
4) Your topic is *"Have you thought about how you'd like to feed your baby?"*

Unit Eight: Cultural Awareness
EXPLORING CULTURAL STEREOTYPES

INSTRUCTIONS

Using the space below, write down the stereotypes of that ethnic group. Discuss the food they eat, music they listen to, where they live, job they have, level of education, family size, foods they eat, religion, language, clothes they wear, physical features. Remember these are stereotypes so don't edit yourself. Write down the first thing that comes to mind about this group.

1) AFRICAN-AMERICAN/BLACK:

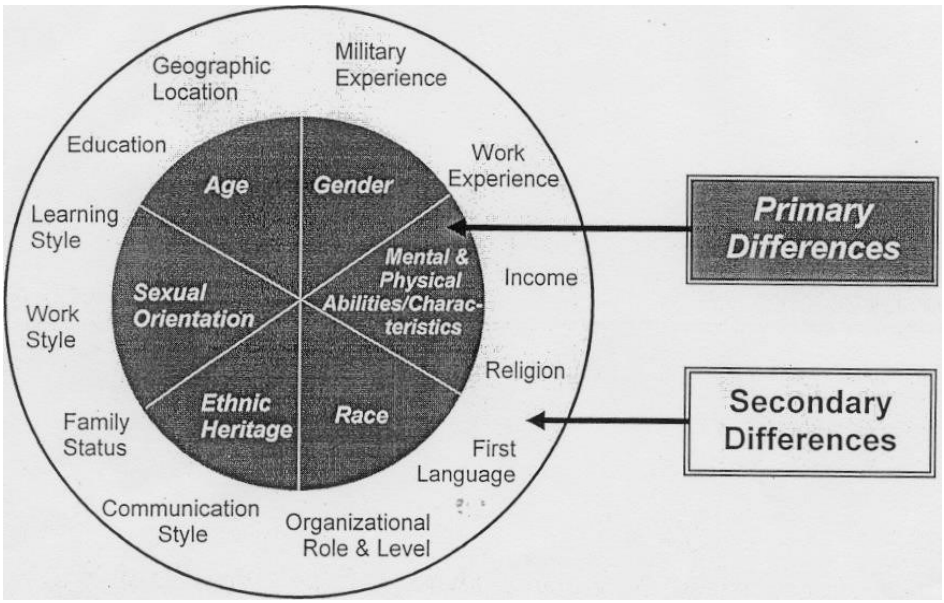
2) HISPANIC/LATINO:

3) CAUCASIAN/WHITE/EUROPEAN-AMERICAN:

4) ASIAN/ASIAN-PACIFIC ISLANDER:

5) AMERICAN INDIAN/NATIVE AMERICAN:

Unit Eight: Cultural Awareness
THE DEMENSIONS OF HUMAN DIFFERENCE



Primary Differences

These are those we are born with and over which we have little or no control. Most (but not all) primary differences are immediately obvious—people can see them just by looking.

Secondary Differences

These are those over which we do have control, and some of them can be changed. Most secondary differences are not immediately obvious.

From: The Inclusive Workplace, City of Pasadena Human Resources Department
Organization Development and Training Division (9/2/04)

Unit Eight: Cultural Awareness
FIVE AREAS OF HUMAN DIFFERENCE

APPROACHES TO COMPLETING TASKS

There are different ideas about how relationship-building and task-oriented work should go together. Such as does a meeting involve socializing before getting down to the work at hand, or is socializing considered frivolous and inappropriate in business dealings

ATTITUDES TOWARDS CONFLICT

Some cultural norms allow for addressing conflict head on or aggressively and directly. In other cultures it is believed that it should be avoided.

DECISION-MAKING STYLES

- Varies widely from culture-to-culture
- Group dynamics in decision-making differs
- Individual's expectations about their own roles in shaping decision-making may be influenced by their cultural frame of reference.

ATTITUDES TOWARDS DISCLOSURE

- Some cultures it is appropriate to be frank about emotions, reasons behind conflict, misunderstandings and personal information. Keep this in mind when in dialogue.
- When in conflict, be mindful of that people differ in what they are comfortable revealing.
- Variations in attitudes among cultures about disclosure must be considered before you make a conclusion you have an accurate understanding. Assertiveness or lack thereof in communication can lead to an opportunity for misunderstanding. EPISTEMOLOGIES WAYS OF KNOWING Examples of ways of knowing:

- Europeans: Cognitive (Thinking) ○ Counting measuring; considered more valid than other ways of knowing in Western cultures
- Africans/Hispanics: Affective (feeling/visceral) ○ Symbolic imagery ○ Rhythm
- Asians: Spiritual ○ Knowledge gained through striving for transcendence

  - Recently, our society is paying more attention to previously overlooked ways of knowing.
  - Knowing how different cultures have approached knowing could affect analysis of and resolution of community problem.
  - Note that not everyone believes that illness is caused by microorganisms

(Western/European/American view), some cultures (i.e., indigenous) believe it is caused by supernatural forces or disharmony with nature.

COMMUNICATION STYLE DIFFERENCES – OVERT ACTIVITY DIMENSION
NON-VERBAL/VERBAL

American Indians	Asian Americans/Hispanics	Whites	Blacks
Speak softly/slower	Speak softly	Speak loud/fast to control listener	Speak with affect (emotion)
Indirect gaze when listening or speaking	Avoidance of eye contact when listening or speaking to high-status persons	Greater eye contact when listening	Direct eye contact (prolonged) when speaking but less when listening
Interject less/seldom offer encouraging communication	Similar rules	Head nods, nonverbal markers	Interrupt (turn taking) when can
Delayed auditory(silences)	Mild delay	Quick responding	Quicker responding
Manner of expression low keyed, indirect	Low-keyed, indirect	Objective, taskoriented	Affective, emotional, interpersonal

Source: Counseling the Culturally Different, p. 67, by Derald Wing Sue and David Sue, 2nd Ed. (1990: New York: Wiley and Sons)

Unit Eight: Cultural Awareness
FREQUENT BIASES
Examining our attitudes towards others

IMPLICIT BIAS

Also known as implicit social cognition, implicit bias refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner.

ETHNOCENTRISM

The common feeling or belief that one's own culture or ethnic group (including its beliefs, values, modes of living and patterns of adaptation) is superior to other groups. It is typically coupled with a generalized contempt for members of the other groups.

PREJUDICE

- A pre-conceived judgment or opinion; usually based on stereotype or negative past experiences.
- An adverse opinion or leaning formed without just grounds or sufficient knowledge.
- An irrational attitude of hospitality and/or contempt directed against an individual, a group, a race, or their supposed characteristics.

BIGOTRY

Having very strong opinions and beliefs, especially on matters of politics, religion or ethnicity, and refusing to accept different views. Also, typically coupled with an attitude of hostility and/or contempt towards those who have different views, opinions and beliefs.

CHAUVINISM

A belief in the superiority of one's own gender, group or kind.

RACISM

The belief that people's qualities are influenced by their race and that the members of other races are not as good as the members of your own, or the resulting unfair treatment of members of other races.

Unit Eight: Cultural Awareness

STRATEGIES FOR CROSS-CULTURAL COMMUNICATION

General knowledge of others' cultures helps solve communication problems. A person needs to feel comfortable with her own culture before she can understand and be comfortable with others (like falling in love).

1) Mirror, not mimic the behavior of others.
2) Verbalize your discomfort – it's OK to let people know you're uncomfortable.
3) Acknowledge you don't know everything about other cultures; be willing to learn from then (generate more data).
4) Know your own cultural script.
5) Develop sensitivity – be aware that not all cultural scripts are the same (don't judge based on your scripts).
6) Don't pre-judge.
7) Be patient.
8) Listen more and talk less.
9) Maximize situational control – don't try to control the situation yourself.
10) Have a sense of humor!
11) Express a caring attitude.
12) Try not to take defensive postures.
13) Be aware of language differences.
14) Refuse to get offended – don't take it personally.
15) Acknowledge your own cultural biases – deal with them and try and overcome them.
16) Educate yourself on the cultures of others – we're all learners.
17) Acknowledge differences but also the commonalities.
18) Establish rapport using the commonalities.
19) Recognize you have limitations.
20) Disclose information about yourself.
21) Understand there is no right or wrong cultural script – just difference.

Note: Be aware of "The Halo Effect": Those people who are attractive to us are better; i.e., good-looking people are good people.

Unit Eight: Cultural Awareness
QUICK GUIDE TO CROSS-CULTURAL COMMUNICATION

PREPARING FOR COUNSELING

- Understand your own cultural values and implicit biases.
- Acquire basic knowledge of cultural values, health beliefs, and nutritional practices for client groups you routinely serve.
- Be respectful of interested in and understanding of other cultures without being judgmental.

ENHANCING COMMUNICATION

- Determine the level of fluency in English and arrange for an interpreter, if needed.
- Ask how the client prefers to be addressed.
- Allow the client to choose seating for comfortable personal space and eye contact.
- Avoid body language that may be offensive or misunderstood.
- Speak directly to the client to choose seating for comfortable personal space and eye contact.
- Speak directly to the client whether through an interpreter is present or not.
- Choose a speech rate and style that promotes understands and respect for the client.
- Avoid slang, technical jargon and complex sentences.
- Use open-ended questions or questions phrased in several ways to obtain information.
- Determine the client's reading ability before using written materials in the process.

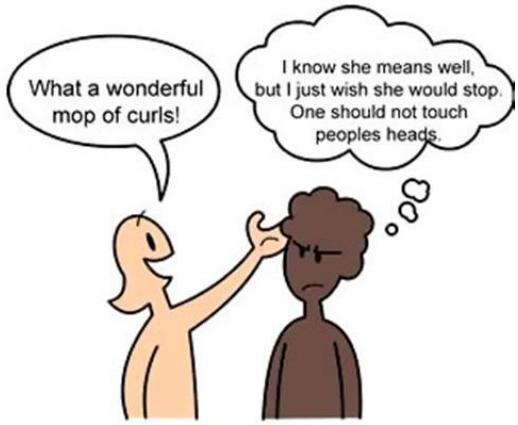


Illustration depicts misunderstanding between health care workers. It highlights cultural differences in both non-verbal communication and the social codes of conduct.

WHEN CROSS CULTURAL CONFLICT ARISES

- Both parties should be willing to accept that they have implicit biases which caused the conflict.
- Assume no deliberate harm was intended by the other party instead of assuming it was intentional injury.
- Rise above the right/wrong and us/them mentality.
- Identify the misunderstanding. Learn to see from the other persons eyes. Stand in their shoes. Understand how the incident occurred from their point of view. Don't judge them. Just consider how it occurred for them. There is no right or wrong perspective.
- Try to understand the possible reasons/causes of the challenging situation by consultation with the person/s themselves, relatives, co-workers, supervisor, doctor and/or looking at resources for information and possible explanations.

- Develop and implement strategies to try to improve the situation.
- Observe and describe the outcome of your strategies—i.e., the success or failure of the strategies Share your expertise with your colleagues to prevent the same problem from happening again (inform your supervisor, other colleagues).

PROMOTING POSITIVE CHANGE

- Build on cultural practices, reinforcing those which are positive, and promoting change only in those which are harmful.

- Check for client understanding and acceptance of recommendation.

- Remember that not all seeds of knowledge fall into fertile environment to produce change. Of those that do, some will take years to germinate. Be patient and provide counseling in a culturally appropriate environment to promote positive health behavior.

Unit Eight: Cultural Awareness

GUIDELINES FOR WORKING WITH OR AS AN INTERPRETER

WHAT YOU CAN DO

1) Speak directly to the client. For example, do not say, "ask her how she is feeling" to the interpreter. Do say, "how are you feeling?" directly to the client.
2) Look client while talking, not at the interpreter.
3) Ask the interpreter to speak in the first person if they are not already doing so. For example, s/he should say, "I am feeling well" not "she is feeling well".
4) Refrain from asking questions of the interpreter. The interpreter is only there to facilitate communication, not to participate, give opinions or advice.
5) Provide examples in your conversation there are a lot of differences between languages, such as:
    - Ok: "Do you have any allergies to medicine?"
    - Better: "When you take pills from the doctor, have itchy areas appeared on your skin?"
    - OK: "What symptoms are you having?"
    - Better: "are your eyes itchy, is your nose runny, do your breasts feel hot?"
    - 6) Speak at your normal rate unless you are asked to slow down.
    - 7) Thank her at end of appointment.

THE INTERPRETER IS SUPPOSED TO

1) Interpret everything that each person says.
2) Use language/mode of communication preferred by client.
3) Let the speaker know if they need to speak more slowly.
4) Take responsibility for correcting an interpreting error.
5) Adhere to the Interpreter Code of Ethics.

THE INTERPRETER IS NOT SUPPOSED TO

1) Talk aside with either party during the communication.
2) Discuss the interpreting session with anyone. The rights and privacy of the client must be protected. The information imparted in the session is confidential.
3) Participate in the conversation by giving own opinion or advice.

COMMUNICATION HINTS

1) Speak more slowly rather than louder.
1) Remember there are three people involved: The interpreter, the client and the interpreter. Don't forget to address client with your body language.
2) Speak in first person directly to the client. Do not reduce the client to a non-entity who is being talked about rather than talked with.

3) Give interpreter time to restructure the communication in his or her mind and present it in a culturally and linguistically appropriate manner.
4) Have patience. Do not expect a word-for-word translation; sometimes, a long interpretation in another language communicates a seemingly simple point in your language.
5) Understand that working with an interpreter may feel uncomfortable and out of control. Just think how uncomfortable the client must feel. Relax!
6) Plan for extra time when working with a client who does not speak your language.