CHILD BIRTH EDUCATION: LET’S PREPARE TO LEARN

I am the:    □ mom-to-be    □ her support person.

Have you had a baby before? □ Yes □ No

Have you been in the hospital before? □ Yes □ No

If yes, what was the situation? ____________________________________________

Tell us three things you are concerned about in relation to pregnancy, labor, birth, and the new baby?

1. __________________________________________
2. __________________________________________
3. __________________________________________

What are you hoping to learn more about during this class?

□ What will happen when we come to the hospital
□ What will happen during labor
□ What will happen during and after the baby’s birth
□ How to care for the new baby
□ Breastfeeding    □ Bottle feeding
□ Medications that may be used during labor and after giving birth
□ Other subjects: __________________________________________

Share three things that you think can make mom-to-be more comfortable during labor (massage, talking, music, etc.)

1. __________________________________________
2. __________________________________________
3. __________________________________________

What can the support person do that will help the most during labor and birth?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Please list any other questions you would like to have answered during this class:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
CHILD BIRTH EDUCATION

Instructors:
Dianna Porter RN
Christy Showalter RN
Susan Walsh RN

WEEK ONE
- Room Orientation
- Instructor and group introductions and stories
- Goals of the Course
- Course Outline and Questions
- Rights and Responsibilities of Expectant Parents
- Explanation of Common Pregnancy and Labor Terms
- 3 R’s video
- Role of Significant Other
- Suggestions for the class
- Setting Realistic Goals and Expectations Game
- Questions

WEEK TWO
- Stages of Labor (DVD)
- When to Go to the Hospital, What to Bring and Why
- Anatomy and Physiology of Pregnancy
• Indications of Labor, Timing Contractions, and Preterm Labor
• Variations of Stage One
  ▪ Induction and Augmentation
  ▪ Amniotomy
  ▪ Monitoring (Ultrasound, Doppler, Toco, and IUPC)
  ▪ Fetal Variations during Labor
  ▪ Back Labor
  ▪ Prodromal Labor
• Anesthesia versus Analgesia
• Introduction to breathing technique

**WEEK THREE**
• Relaxation and breathing techniques for Early and Active labor
• Role of significant other
• Relaxation Techniques – progressive, touch, selective and focal points
• Activity diet and physical and emotional changes in Active and Transitional labor
• Relaxation – visualization, music and Aromatherapy
• Peggy Simkins DVD
• Questions

**WEEK FOUR**
• Stage 2 – Delivery and Pushing Techniques
• Variations of Stage 2
  ▪ Forceps
  ▪ Vacuum
  ▪ Episiotomy
  ▪ Cesarean Birth – Indications, Procedures, Role of Significant Other

• Stage 3-Expulsion of Placenta
• Variations of Stage 3
  ▪ Retained Placenta
  ▪ Hemorrhage
  ▪ Immediate Postpartum

• Childbirth DVD
• Review progressive relaxation if time allows
• Birthing Center Tour

WEEK FIVE

• Feeding Your Newborn- Presentation and DVD
  ▪ Breast
  ▪ Bottle

Newborn Characteristics
Parenting skills Happiest Baby on the block “ DVD
Relaxation, breathing techniques review

WEEK SIX

• Early Reading
• Car Seat Safety
• Going Home
• Newborn Characteristics
• Community Resources
• Parenting Skills- “Happiest Baby on the Block” DVD
• Infant CPR
• Community Visitors
• Labor Rehearsal
Rights and Responsibilities of Expectant Parents

1. You have the **right** to a full explanation of any treatment, procedure, or test anyone may offer you or your child. You have the **responsibility** to ask questions if you do not understand, and to refuse to consent until you do understand and feel comfortable with your choice.

2. You have the **right** to refuse any treatment, procedure, or test anyone may offer you or your child. You must then take **responsibility** for the results of your choices.

3. You have the **right** to touch, hold, feed, kiss, nuzzle, and otherwise parent your newborn as soon as he/she is born, and to communicate the desire to do so to those attending your labor and birth (nurses, midwife, doctor, etc.). You have the **responsibility** to pay attention to what is happening immediately after birth, and to understand that if the nurses and/or doctors need to take your child to the warmer, it is for a medical reason.

4. You have the **right** to determine what your baby eats—whether that is breast milk or formula. You have the **responsibility** to understand that a baby does not know 3am from 3pm, nor does he/she have any sympathy for exhausted parents. A hungry baby must eat, and so you must wake up and feed him/her—whether by nursing or with a bottle.

5. You have the **right** to seek the birthing experience you desire. You have the **responsibility** to be well educated regarding your choices and preferences, and to understand all of the possible repercussions.

6. You have the **right** to enjoy your birthing experience, wherever it takes you: cherish it, and take away memories that will last you forever. Please do not take this **responsibility** lightly.
QUESTIONS TO HELP MAKE INFORMED DECISIONS REGARDING SCREENING/DIAGNOSTIC TESTS

1. What is the purpose of the test?
2. Is it a screening test, or a diagnostic test?
3. How is the test done?
4. How reliable or accurate are the test results?
5. Are there risks or drawbacks for either the mother or the baby?
6. How will the information gained influence the management of my pregnancy?
7. What steps follow a negative or a positive result?
8. How much does the test cost? Is it covered by my insurance?
9. What are the consequences of not having the test done?
10. Are there other ways to get similar information?
# Common Pregnancy & Labor Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abruption</td>
<td>1. Partial or complete separation of the placenta from the wall of the uterus before the baby is born. It can cause the mother to hemorrhage and necessitates a Cesarean delivery.</td>
</tr>
<tr>
<td>Afterbirth</td>
<td>2. The placenta and membranes expelled from the uterus during the third stage of labor (after the baby is born).</td>
</tr>
<tr>
<td>Amniocentesis</td>
<td>3. Removal of a small amount of amniotic fluid from the amniotic sac in order to evaluate the baby's health.</td>
</tr>
<tr>
<td>Amniotic fluid</td>
<td>4. Fluid surrounding the baby in the womb to protect it from injury and temperature changes.</td>
</tr>
<tr>
<td>Analgesia</td>
<td>5. Relief of pain without loss of sensation or consciousness.</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>6. Loss of sensation. General anesthesia is loss of consciousness caused by anesthetics. Local anesthesia limits loss of sensation to one area of the body.</td>
</tr>
<tr>
<td>Apgar score</td>
<td>7. Numerical evaluation of a newborn at one and five minutes after birth. A score can range from one to ten; seven and up are normal scores.</td>
</tr>
<tr>
<td>Areola</td>
<td>8. Dark are of the breast surrounding the nipple.</td>
</tr>
<tr>
<td>Birth canal</td>
<td>9. The passageway from the uterus to the vagina through which the baby is born.</td>
</tr>
<tr>
<td>Braxton Hicks</td>
<td>10. Irregular contractions that may become somewhat uncomfortable near the end of pregnancy. They are often mistaken for true labor.</td>
</tr>
<tr>
<td>contractions</td>
<td></td>
</tr>
<tr>
<td>Breech birth</td>
<td>11. Delivery of the baby other than head first. Most breech deliveries are buttocks first.</td>
</tr>
<tr>
<td>Cervix</td>
<td>12. Narrow, lower portion, or neck, of the uterus.</td>
</tr>
<tr>
<td>Cesarean delivery</td>
<td>13. Delivery of the baby through an incision in the abdomen and uterus. The incision may be vertical or horizontal; horizontal is more common and does not dictate a c-</td>
</tr>
<tr>
<td>(&quot;c-section&quot;)</td>
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</tbody>
</table>
section in subsequent pregnancies. KGH does not schedule VBACs at this time, per policy. (See VBAC.)

<table>
<thead>
<tr>
<th>Term</th>
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<tbody>
<tr>
<td>Colostrum</td>
<td>The first fluid produced by the milk glands in the breast. It is high in protein and antibodies.</td>
</tr>
<tr>
<td>Contraction</td>
<td>Tightening of the uterus; usually occurs in a wavelike rhythm during labor.</td>
</tr>
<tr>
<td>Crowning</td>
<td>Moment during labor when the crown (top) of the baby’s head becomes visible at the opening of the vagina.</td>
</tr>
<tr>
<td>Dilation</td>
<td>Opening of the cervix during labor from zero to ten cm (full dilation), at which point a mother-to-be can begin to push her baby out.</td>
</tr>
<tr>
<td>Doula</td>
<td>A woman who cares for a woman during pregnancy, labor, and after giving birth (even cooking, light housekeeping, assisting with newborn care and more).</td>
</tr>
<tr>
<td>Electronic fetal monitoring (EFM)</td>
<td>Recording during labor of the baby’s heartbeat and of uterine contractions</td>
</tr>
<tr>
<td>Epidural anesthesia</td>
<td>Most common type of obstetrical anesthesia; injections of medication into the space surrounding the spinal cord to numb the body below the small of the back for as long as desired within safe reason.</td>
</tr>
<tr>
<td>Episiotomy</td>
<td>An incision into the perineum at the rear of the vagina to enlarge the vaginal opening.</td>
</tr>
<tr>
<td>Fetal distress/intolerance</td>
<td>Alteration in the well being of the fetus during labor, indicated by a change in the fetal heart rate or by meconium staining.</td>
</tr>
<tr>
<td>Fontanelle (soft spot)</td>
<td>Area of the baby’s skull not covered by bone at birth.</td>
</tr>
<tr>
<td>Fundus</td>
<td>Upper part of the uterus.</td>
</tr>
<tr>
<td>Hyperventilation</td>
<td>Dizziness caused by an imbalance of oxygen and carbon dioxide in the blood from breathing rapidly.</td>
</tr>
<tr>
<td>Induction</td>
<td>Artificially starting labor by giving Pitocin (synthetic oxytocin) or prostaglandin gel.</td>
</tr>
<tr>
<td>Involution</td>
<td>Return of the uterus to its non-pregnant size after birth.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>-----------------------------</td>
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</tr>
<tr>
<td>Kegels</td>
<td>28. Exercises to strengthen the pelvic floor (vaginal and rectal) muscles by contracting and releasing them.</td>
</tr>
<tr>
<td>Labor stages</td>
<td>29. First stage, complete dilation of the cervix; second stage, delivery of the baby; third stage, expulsion of the placenta.</td>
</tr>
<tr>
<td>Let-down reflex</td>
<td>30. Release of milk into the nipple area of the breast.</td>
</tr>
<tr>
<td>Linea nigra (black line)</td>
<td>31. Dark line that sometimes develops down the middle of the pregnant stomach.</td>
</tr>
<tr>
<td>Lochia</td>
<td>32. Bloodstained discharge from the vagina after delivery.</td>
</tr>
<tr>
<td>Meconium</td>
<td>33. Thick, greenish substance that is the baby’s first bowel movement(s).</td>
</tr>
<tr>
<td>Meconium staining</td>
<td>34. Presence of meconium in the amniotic fluid; can be an indication of fetal distress.</td>
</tr>
<tr>
<td>Midwife</td>
<td>35. “With a woman,” a health care professional who specializes in the holistic, care of women with uncomplicated, normal pregnancies and births; knowledgeable about the newborn; intervenes and/or refers to physician when necessary.</td>
</tr>
<tr>
<td>Non-stress test</td>
<td>36. Assessing fetal well being with External Fetal Monitoring by measuring the response of the baby’s heart beat to movement.</td>
</tr>
<tr>
<td>Obstetrician/gynecologist (OB/GYN)</td>
<td>37. A medical doctor who has been trained to focus on detection and treatment of obstetrical and gynecological problems; may view the process of pregnancy, labor, and postpartum as an event to be managed, thus administering interventions as deemed necessary.</td>
</tr>
<tr>
<td>Oxytocin</td>
<td>38. Hormone that causes the uterus to contract during labor and causes the milk ducts in the breast to release milk.</td>
</tr>
<tr>
<td>Perineum</td>
<td>40. Area between the vagina and the rectum.</td>
</tr>
<tr>
<td>Placenta</td>
<td>41. Organ that transfers nutrients and oxygen from mother to fetus and waste products from fetus to mother.</td>
</tr>
</tbody>
</table>
Post-dates 42. Pregnancy that exceeds 40 weeks.

Post-mature 43. Determined when a post-dates fetus has been tested for well-being, placenta function has been checked and the following characteristics are present: no lanugo, little vernix, long nails, loose, pale, dry, peeling or cracked skin, and unusual alertness; amniotic fluid may be low or stained with meconium. This condition is rare.

Preeclampsia 44. A condition of late pregnancy in which the mother-to-be experiences swelling of her hands, face, and feet, high blood pressure, and protein in her urine.

Premature (preterm) labor 45. Labor before 38 weeks of pregnancy (counted from the first day of the last menstrual period).

Prolapsed cord 46. Umbilical cord that precedes the baby out of the uterus; may necessitate Cesarean delivery.

Puerperium (postpartum) 47. The six weeks after delivery.

Ripening 48. Softening of the cervix near term.

Stress test 49. External fetal monitoring test of the well-being of the fetus during contractions deliberately stimulated with oxytocin.

Toxemia 50. A severe form of preeclampsia.

Transition 51. End of the first stage of labor, from eight to ten centimeters dilation.

Umbilical cord 52. Thick, cable-like structure that connects the fetus and the placenta; contains two arteries and one vein.

VBAC 53. Acronym for vaginal birth after Cesarean.

Vernix 54. Greasy, whitish substance that covers the fetus in the uterus to protect its skin from exposure to the amniotic fluid.
PREGNANCY: WEIGHT GAIN AND NUTRITION

Pregnancy is NOT the time to start a diet. Your best choices, as far as foods go, will be to pick items that are as close to their original source as possible: choose a variety of whole grains, fresh fruits and vegetables, and unprocessed, unsweetened foods.

Your weight gain during pregnancy may look something like this:
- First Trimester: 3-5 pounds
- Second Trimester: 1-2 pounds per week
- Third Trimester: 1-2 pounds per week

The American College of Obstetricians and Gynecologists (as cited in American Pregnancy Association, 2007) makes the following weight gain recommendations:

<table>
<thead>
<tr>
<th>PRE-PREGNANCY WEIGHT</th>
<th>PREGNANCY WEIGHT GAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>(BASED ON BMI)</td>
<td></td>
</tr>
<tr>
<td>Underweight</td>
<td>28-40 pounds</td>
</tr>
<tr>
<td>Normal Weight</td>
<td>25-37 pounds</td>
</tr>
<tr>
<td>Overweight</td>
<td>15-25 pounds</td>
</tr>
<tr>
<td>Obese</td>
<td>Up to 15 pounds</td>
</tr>
</tbody>
</table>

Newer guidelines are suggesting less weight gain than the increments listed above; however, check with your health care provider to find out what is right for you. A healthful weight gain is important for your own body and for your baby.
• …that pregnancy requires, on average, only an additional 300 calories per day? This is more toward the middle and end of a pregnancy with one child (ask your health care provider about your caloric needs if you are carrying more than one baby). 300 calories could be three cups of non-fat milk, a bowl of soup, one extra serving of meat (three ounces) or a small banana accompanied by an English muffin with one tablespoon of peanut butter (IFICF & AAPA, 2007).

• …that your protein requirement increases by 10 grams over normal? That means you need about 60 grams of protein per day (IFICF & AAPA, 2007). Try a mixture of lean meats, poultry, fish, eggs, dried beans and peas, dairy products, peanut butter, or tofu. Keep in mind, most Americans eat more protein than the recommended amount. If you are a vegetarian, help meet your protein needs with egg and milk items. Vegans (people who eat only plant foods) should consult with their health care provider about making sure they meet their protein needs.

• …that you need 1,000 milligrams of calcium per day when you are pregnant (IFICF & AAPA, 2007)? The more you can get from a natural source (dairy products, dark green leafy vegetables, dried beans and peas, nuts, seeds and calcium-fortified foods like fortified orange juice), the better. If you take a supplement, choose calcium citrate for better utilization, and make sure that it includes magnesium. Your body needs 400mg of magnesium to each 1000 mg of calcium, along with Vitamin D for proper absorption and use of these minerals. Normally, your body makes Vitamin D from sunlight exposure on the skin (5-10 minutes on the arms or face can be enough for one day’s supply during the summer for a light-skinned person). In Alaska (Ketchikan in particular), it is important to supplement your diet with Vitamin D. Milk is often fortified with this important vitamin, as are some cereals. Oily fish, like salmon, are a source of Vitamin D as well. Remember, you are laying the foundation for strong bones and teeth in your baby; you need enough for your own body as well as your baby. Check with your provider about how much Vitamin D you should be
taking in with your diet and/or supplementing.

- …that iron carries oxygen in your blood? It helps in other vital functions as well, so make sure you are taking in **27 milligrams of iron** per day (IFIC & AAPA, 2007). Food sources of iron include red meats, fish, poultry, eggs, whole grain breads and cereals, beans, nuts, green leafy vegetables, and dried fruits. Iron is best absorbed by the body from meat sources; however, you can increase absorption from plants and eggs by also eating a food with a lot of Vitamin C (like red bell peppers or orange juice). Your health care provider might recommend routine iron supplements, and/or your prenatal vitamin might already contain iron (check the side panel of the bottle for the amount). Take the iron supplement between meals with water or juice. Milk, coffee, and tea can decrease iron absorption, so avoid these beverages around the time when you are taking an iron supplement.

- …it is important for a woman to take in at least **400 micrograms of folic acid or folate** per day during the month prior to conception, and daily throughout pregnancy thereafter? Also known as Vitamin B9, folate/folic acid decreases the chance of neural tube defects (spina bifida and other brain or spinal cord problems) from occurring in babies—especially during the first month of pregnancy when the brain and spinal cord are developing. You include folate in your diet when you eat fortified cereals, breads, pastas, leafy green vegetables, citrus fruits, and dried beans and peas. Prenatal vitamins all contain folic acid, and it is recommended that any woman of childbearing age who may become pregnant should make a habit of taking a supplement with folic acid on a daily basis (IFICF & AAPA, 2007).

- …that fatty acids contribute to the brain and eye development of your baby? DHA, or **omega-3 fatty acid**, can only be obtained by diet or supplement, as the body does not make its own essential fatty acids. Some experts recommend 200 milligrams of DHA per day for pregnant women (IFICF & AAPA, 2007). Oily fish, like salmon, are an excellent source; you can also ask your health care provider to recommend a supplement.

- …that **minerals and vitamins** are important in a healthful diet—pregnant or not pregnant? While your prenatal supplement can help to supply some vitamins and minerals, your best sources will always be in fresh fruits, fresh vegetables, and whole grains. Your body is able to process and better absorb nutrients from these sources.
• **sodium** (or salt) is important for maintaining water balance in the body? It is not necessary to cut salt out of your diet and you do not need to increase your intake either. Sodium requirements for women during pregnancy and breastfeeding do not differ from those of other women. The general recommendation for salt intake by the Institute of Medicine is 1500mg of salt (as cited in IFICF & AAPA, 2007). Most people, because of eating processed foods, eat twice the recommended amount. (One-half teaspoon of table salt is equivalent to 1200mg of sodium.)

• **fluids** are very important during pregnancy? Pregnant women should drink eight to 12 cups of non-caffeinated fluid per day (IFICF & AAPA, 2007), plus one extra cup of fluid for each hour of light activity. Water, juice, milk, soup, and other beverages (including coffee, tea, and soft drinks) all contribute to fluid intake. Water is always going to be your best choice. You are fully hydrated when your urine is very light yellow, almost clear.

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**CAUTIONS DURING PREGNANCY**

**Alcohol**

It is unknown as to what is a “safe” amount of alcohol during pregnancy. *No alcohol* during pregnancy is usually the general recommendation. Alcohol crosses the placenta, and can cause birth defects including mental retardation, behavioral, emotional, and learning problems, and actual physical defects (IFICF & AAPA, 2007).

**Drugs**

It is important to remember that most everything taken during pregnancy reaches the baby by crossing the placenta- whether over-the-counter, prescription, or illicit. Check with your provider about the medications/drugs that you use, or any over-the-counter medication you want to take; Tylenol is typically the pain reliever of choice during pregnancy. Illicit drugs can cause many problems for a growing baby. Here is an overview of possible problems caused by illicit drugs: poor growth in the womb, stroke, preterm birth or miscarriage, withdrawal after birth, behavioral and growth problems, and Sudden Infant Death Syndrome (SIDS) (ACOG, 2008).
CAFFEINE
Recent research shows that it is okay to consume moderate (200 to 300mg/day - which is two to three cups of coffee or six cups of tea, depending on the type and strength) amounts of caffeine while pregnant and breastfeeding (IFICF & AAPA, 2007). Keep in mind that caffeine increases the production of stress hormones in the body, and also serves to pull water out of your body (a diuretic). Check with your care provider about his/her recommendations for your specific situation.

FOOD-BORNE ILLNESSES
Listeriosis is an illness caused by a bacteria that can be found in contaminated, processed meat products (hot dogs, lunch meats, etc.), any food made from unpasteurized milk (e.g. soft cheeses like feta, Brie, Camembert etc.), meat-based spreads (pâté), and uncooked, smoked seafood. Avoid unpasteurized products, and make sure any smoked foods or processed meats are heated until steaming before eating them. Avoid raw eggs (try a pasteurized product if your recipe has raw eggs in the finished product), and make sure your meats are thoroughly cooked to avoid salmonella or toxoplasmosis. Listeriosis and toxoplasmosis can cause severe problems for your baby (IFICF & AAPA, 2007). (Avoid changing your cat’s litter box or handling stray cats during pregnancy, as those are possible sources for toxoplasmosis.)

SEAFOOD
Make sure the seafood that you eat is low in mercury (check your list of recommended seafood from your care provider). Mercury is toxic to the human nervous system, especially a developing one like that in an unborn baby or small child. Seafood that is low in mercury includes, but is not necessarily limited to: shrimp, canned light tuna (one to two cans per week falls within recommended mercury limitations), catfish, pollock, and salmon. Fish that have a long lifespan and/or feed on other fish are likely to have higher levels of mercury in them. According to the Food and Drug Administration, Environmental Protection Agency, and US Department of Agriculture, pregnant women (and breastfeeding mothers) should especially avoid king mackerel, shark, swordfish, and tilefish (IFICF & AAPA, 2007). Keep in mind that albacore tuna is also extremely high in mercury. Here in Southeast Alaska, many enjoy the light flavor of halibut, which can grow to be very large and contain unsafe amounts of mercury. Smaller halibut (up to 40 pounds) are considered safe for a pregnant or breastfeeding mom to eat.
**Tobacco**

Smoking during pregnancy not only harms the mother’s body, but harms the body of the growing baby as well. Nicotine in cigarettes causes vasoconstriction (blood vessels become smaller), which decreases the amount of blood going to and from the baby. That in turn, decreases the amount of oxygen and nutrients going to the baby. Babies whose mothers smoke during pregnancy are at higher risk for: being a low birth-weight when born (less than 5 ½ pounds); having problems with their placenta; premature birth; being irritable from withdrawal after birth; and SIDS (ACOG, 2008). Babies and children who live in homes where people smoke are more at risk for developing asthma and other respiratory problems. While it is best to quit smoking before pregnancy, using pregnancy to cut down, or better yet-to quit completely, is the best thing a mom can do for herself and her baby. Please talk to your care provider if you smoke and want help quitting.

**Other Caution**

Avoid spending extended periods of time in a sauna or hot tub. Keep temperatures low; use 10 minutes as a guide but get out sooner if your body temperature rises one degree or more. Avoid prolonged exposure to electric blankets as well. Avoid exposure to radiation, or shield your torso well if exposure is unavoidable.

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**References:**


ONLINE RESOURCES

- ACOG patient education: Tobacco, alcohol, drugs, and pregnancy
  http://www.acog.org/publications/patient_education/bp170.cfm

  o About pregnancy and weight gain.
    http://www.americanpregnancy.org/pregnancyhealth/aboutpregweightgain.html
  o Exercise guidelines during pregnancy
    http://www.americanpregnancy.org/pregnancyhealth/exerciseguidelines.html

- International Food Information Council Foundation [IFICF] and American Academy of Physician Assistants: Healthy eating during pregnancy

- Mayo Clinic – Pregnancy nutrition
  o Pregnancy nutrition: Essential nutrients when you’re eating for two
    http://www.mayoclinic.com/health/pregnancy-nutrition/PR00110
  o Pregnancy nutrition: Foods to avoid
    http://www.mayoclinic.com/health/pregnancy-nutrition/PR00109
  o Pregnancy nutrition: Health eating for you and your baby
    http://www.mayoclinic.com/health/pregnancy-nutrition/PR00109

- MyPyramid for Pregnancy and Breastfeeding – Build a personalized menu plan
  to meet your nutritional needs during pregnancy, based on your height and weight, and due date.
  http://mypyramid.gov/mypyramidmoms/index.html

- United States Environmental Protection Agency – What you need to know about mercury in fish and shellfish
  http://www.epa.gov/waterscience/fish/advice/
WHEN TO COME TO THE HOSPITAL

Notify Your MD or OB Department for the Following Warning Signs:

- Severe persistent headache, dizziness, light-headedness or blurred vision, spots before your eyes.
- Sudden weight gain and swelling of face, hands, feet or ankles.
- Persistent nausea or vomiting.
- Marked decrease in amount of urine.
- Pain or burning when urinating.
- Vaginal bleeding.
- Gush or leak of water from vagina.
- Unusual vaginal discharge, sore or itching.
- Sharp on-going abdominal pain.
- Noticeable decreased fetal movement.
- Contractions, cramping before your 37th week of pregnancy (4 times or more in one hour).
- Backache.

Come to the Hospital for Labor:

- When your contractions are about 5 minutes apart and/or they are strong and rhythmic and require your total concentration. If you are unsure, call your physician or the OB unit. Discuss with your physician any special instructions.
- When your bag of water breaks.
- Vaginal bleeding greater than a bloody show.

What to Bring to the Hospital: (Avoid bringing valuables and large amounts of money to the hospital).

For Labor and Birth:

- Camera (batteries & film).
- Music (tapes or CDs).
- Hairbrush.
• Lip balm, toothbrush/toothpaste.
• Hard candy on a stick.
• Snack for coach.
• Phone numbers of people to call.
• Your baby book (so we can put footprints in).

For After Birth:

• Nursing bra (good support bra if bottle feeding).
• Comfortable going-home outfit for Mom.
• For baby:
  o One undershirt
  o Season infant outfit
  o Approved infant car seat
  o Hat and booties
  o Two seasonal blankets
Support Person’s Checklist of Comfort Measures for Labor (based on Simpkin)

Homework for support people: review this checklist to ensure you are familiar with each of these techniques. For each one: how is it done? At what point in labor is it helpful? Why is it helpful? Practice these with your partner in advance! Then pack this checklist in the bag you’re taking to the hospital so you can use it when you’re out of ideas for what to do next.

<table>
<thead>
<tr>
<th>Relaxation / Tension Release</th>
<th>Massage</th>
<th>Hot Packs / Cold Packs</th>
<th>Specific Backache Measures</th>
<th>Help from Birth Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Relaxation</td>
<td>□ Acupressure</td>
<td>□ On lower abdomen</td>
<td>□ Counterpressure</td>
<td>□ Suggestions / verbal reminders</td>
</tr>
<tr>
<td>□ Roving Body Check</td>
<td>□ Hand / Foot</td>
<td>□ On back</td>
<td>□ Double Hip Squeeze</td>
<td>□ Encouragement / Praise</td>
</tr>
<tr>
<td>□ Touch Relaxation</td>
<td>□ Effleurgre (Light stroking)</td>
<td>□ On perineum</td>
<td>□ Hands and Knees</td>
<td>□ Patience / Confidence</td>
</tr>
<tr>
<td>□ Distraction (movies, etc.)</td>
<td>□ Firm Pressure</td>
<td>□ Open Knee Chest</td>
<td>□ Walking</td>
<td>□ Immediate response to contractions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patterned Breathing</th>
<th>Attention-focusing / Mental activity</th>
<th>Body Positions / Movement</th>
<th>Hydrotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Greeting / Goodbye Breath</td>
<td>□ Visual focal point</td>
<td>□ Standing / Leaning</td>
<td>□ Bath / Whirlpool</td>
</tr>
<tr>
<td>□ Slow Deep Breathing</td>
<td>□ Music, voice, touch, smell</td>
<td>□ Walking</td>
<td>□ Shower</td>
</tr>
<tr>
<td>□ Hee Hee</td>
<td>□ Visualization</td>
<td>□ Lunge</td>
<td></td>
</tr>
<tr>
<td>□ Hee-hee-blow</td>
<td>□ Count off 15 second intervals</td>
<td>□ Hands and Knees</td>
<td></td>
</tr>
<tr>
<td>□ Slide Breathing</td>
<td>□ Chant, mantra, song, prayer</td>
<td>□ Sitting Up</td>
<td></td>
</tr>
<tr>
<td>□ Variable Hee-Blow</td>
<td></td>
<td>□ Sidelying</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bearing down</th>
<th>Hydrotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Avoiding Bearing Down</td>
<td>□ Bath / Whirlpool</td>
</tr>
<tr>
<td>□ Spontaneous</td>
<td>□ Shower</td>
</tr>
<tr>
<td>□ Directed</td>
<td></td>
</tr>
<tr>
<td>□ “Purple pushing”</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specific Backache Measures</th>
<th>Help from Birth Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Counterpressure</td>
<td>□ Suggestions / verbal reminders</td>
</tr>
<tr>
<td>□ Double Hip Squeeze</td>
<td>□ Encouragement / Praise</td>
</tr>
<tr>
<td>□ Hands and Knees</td>
<td>□ Patience / Confidence</td>
</tr>
<tr>
<td>□ Open Knee Chest</td>
<td>□ Immediate response to contractions</td>
</tr>
<tr>
<td>□ Pelvic Rocking</td>
<td>□ Undivided Attention</td>
</tr>
<tr>
<td>□ Walking</td>
<td>□ Eye Contact</td>
</tr>
<tr>
<td>□ Rolling Pressure</td>
<td>□ Take Charge Routine</td>
</tr>
<tr>
<td>□ Shower or Bath</td>
<td>□ Expressions of love</td>
</tr>
</tbody>
</table>

HISTORICAL BACKGROUND OF CHILDBIRTH EDUCATION

DR. GRANTLY DICK-READ (1890-1959)
1. English physician that published “Natural Childbirth” (1933) and “Childbirth Without Fear” (1944).
2. First to introduce natural childbirth and childbirth education.
3. Believed that childbirth is a natural process not meant to be painful.
4. Introduced the concept of the fear-tension-pain cycle. Believed the fundamental cause of pain was fear. Fear causes tension which produces pain, causing still more tension and pain.
5. Relaxation is the key to comfort measures.

DR. FERNAND LAMAZE (1891-1957)
1. Introduced the psycho-prophylaxis method (PPM) based on the stimulus-response theory (1952).
2. Believed pain is a conditioned response and that women can be conditioned not to experience pain in labor.
3. Controlled muscular relaxation with a focal point.
4. Structured breathing patterns.

DR. ROBERT BRADLEY (1917-1998)
1. Denver obstetrician that published “Husband-Coached Childbirth” (AAHCC).
2. Strong emphasis on education for the husband and the wife. Responsible for bringing the father in the delivery room.
4. Discourages the use of analgesics or anesthetics.
5. Encourages relaxation with slow, deep breathing.

SHEILA KITZINGER (1929-PRESENT)
1. English anthropologist, author of numerous books and mother of five children.
2. Developed the psychosexual approach (1960’s). Birth is a personal, sexual event with many parallels to sexual experiences as labor progresses to the climax of birth.
3. Believes the woman should respond to her own body.
4. Breathing is a tool in achieving total relaxation.
5. Encourages touch relaxation.

INA MAY GASKIN (Started “The Farm” with Husband in 1971, practicing midwife)
1. Sphincter Theory
# LABOR SUMMARY

## STAGE ONE – LABOR

### PROGRESS:
- **EARLY PHASE**
  - Cervical Effacement – 0% to 100%
  - Cervical Dilation – 0 to 3 cm

- **ACTIVE PHASE**
  - Cervical Dilatation – 4 to 7 cm
  - Baby moves further down into the pelvis (station increases)

- **TRANSITION**
  - Cervical Dilatation – 8 to 10 cm (complete)

### CONTRACTIONS:
- **EARLY PHASE**
  - Intensity – Mild
  - Length – 30 to 60 seconds
  - Intervals – 20 to 5 minutes apart

- **ACTIVE PHASE**
  - Intensity – Increasingly stronger
  - Length – 45 to 60 seconds
  - Intervals – 5 to 3 minutes apart

- **TRANSITION**
  - Intensity – Strong, may peak rapidly and repeatedly, erratic
  - Length – 60 to 90 seconds
  - Intervals – 2 to 1-1/2 minutes apart

### DURATION:
- **EARLY PHASE**
  - First labor – 6 to 8 hours
  - Subsequent labors – 2 to 5 hours

- **ACTIVE PHASE**
  - First labor – 3 to 6 hours
  - Subsequent labors – 1 to 3 hours

- **TRANSITION**
  - First labor – 10 minutes to 2 hours
  - Subsequent labors – 10 minutes to 2 hours

### POSSIBLE PHYSICAL CHANGES:
- **EARLY PHASE**
  - Contractions are becoming longer, stronger, more frequent
  - Bloody show

- **ACTIVE PHASE**
  - Increase in bloody show
  - Discomfort in back, hips and legs
  - Cramping in feet and legs

- **TRANSITION**
  - Pelvic and rectal pressure
  - Hot flashes/cold chills
  - Cold feet
  - Burping
  - Nausea/vomiting

### MOTHER’S ROLE:
- **EARLY PHASE**
  - Maintain regular activities; ignore contractions as long as possible
  - Take a warm shower
  - Rest; conserve energy
  - Eat light energy food
  - Take a walk
  - Empty bladder every hour

- **ACTIVE PHASE**
  - Continue using relaxation and breathing techniques
  - Concentrate on resting between the contractions
  - Change position every half hour
  - Empty your bladder every hour
  - Tell you coach where you want massage

- **TRANSITION**
  - Take one contraction at a time
  - Focus on relaxation, remember tension can prolong labor
  - Listen to coach’s directions
  - Remember this is the shortest phase of labor

### MOTHER’S EMOTIONS:
- **EARLY PHASE**
  - Excited
  - Apprehensive
  - Confident
  - Sociable

- **ACTIVE PHASE**
  - Becomes more serious and quiet
  - Apprehensive – may doubt ability to handle labor
  - Attention turned inward
  - Less sociable; not as talkative
  - May become tired toward end
  - Resents distractions
  - Doesn’t want to be left alone

- **TRANSITION**
  - Overwhelmed
  - Irritable
  - Fatigued
  - Discouraged

### TECHNIQUES FREQUENTLY USED:
- **EARLY PHASE**
  - Active relaxation
  - Begin slow paced breathing when necessary

- **ACTIVE PHASE**
  - Relaxation techniques of visualization, touch, focal points and music
  - Slow-paced breathing to normal-paced breathing

- **TRANSITION**
  - Relaxation techniques
  - Patterned breathing or variable paced breathing
  - Eliminate cleansing breath if contractions peak immediately
  - Blow out with premature urge to push

### COACH’S ROLE:
- **EARLY PHASE**
  - Moral support
  - Provide a calm atmosphere
  - Encourage walking
  - Assess contractions
  - Remind her to urinate
  - Prepare for transportation to the hospital

- **ACTIVE PHASE**
  - Continue timing contractions
  - Reassurance and support
  - Watch for tension, use massage techniques
  - Offer ice chips and chapstick
  - Comfort measures – adjust pillows, cool washcloth
  - Remind her to change her position and to urinate
  - Assist in breathing techniques
  - Use your eyes for her focal point
  - Suggest changing techniques when they appear ineffective

- **TRANSITION**
  - Remain confident
  - Continue constant reassurance
  - Use eye contact
  - Use a firm voice when necessary
  - Give directions on what relaxation and breathing techniques to try
  - Do breathing techniques with partner

Ketchikan General Hospital New Beginnings Birthing Center: Childbirth Education 23
**LABOR SUMMARY**

<table>
<thead>
<tr>
<th>STAGE TWO</th>
<th>STAGE THREE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DELIVERY OF BABY</strong></td>
<td><strong>PLACENTAL EXPULSION</strong></td>
</tr>
<tr>
<td><strong>PROGRESS:</strong></td>
<td></td>
</tr>
<tr>
<td>• Cervical Dilatation: 10cms (complete)</td>
<td>• Placenta is expelled</td>
</tr>
<tr>
<td>• Baby moves down through the birth canal and</td>
<td>• Episiotomy or laceration is repaired, if</td>
</tr>
<tr>
<td>the baby’s head appears on the perineum and is</td>
<td>necessary</td>
</tr>
<tr>
<td>born</td>
<td></td>
</tr>
<tr>
<td><strong>CONTRACTIONS:</strong></td>
<td></td>
</tr>
<tr>
<td>• Intensity – Strong</td>
<td>• Intensity – Mild</td>
</tr>
<tr>
<td>• Length – 60 seconds</td>
<td>• Length – Variable</td>
</tr>
<tr>
<td>• Intervals – 5 to 3 minutes apart</td>
<td>• Intervals – Variable</td>
</tr>
<tr>
<td><strong>DURATION:</strong></td>
<td></td>
</tr>
<tr>
<td>• First Labor – 1 to 2 hours</td>
<td>• First Labor – 1 to 20 minutes</td>
</tr>
<tr>
<td>• Subsequent Labors – 15 to 30 minutes</td>
<td>• Subsequent Labors – 1 to 20 minutes</td>
</tr>
<tr>
<td><strong>POSSIBLE PHYSICAL CHANGES:</strong></td>
<td></td>
</tr>
<tr>
<td>• Rectal and perineal pressure</td>
<td>• Chills or trembling</td>
</tr>
<tr>
<td>• Increased bloody show</td>
<td></td>
</tr>
<tr>
<td>• Burning sensations</td>
<td></td>
</tr>
<tr>
<td>• Strong urge to push</td>
<td></td>
</tr>
<tr>
<td><strong>MOTHER’S ROLE:</strong></td>
<td></td>
</tr>
<tr>
<td>• Concentrate on pushing baby down and out</td>
<td>• Push as directed to deliver the placenta</td>
</tr>
<tr>
<td>• Try different pushing positions</td>
<td></td>
</tr>
<tr>
<td>• Relax in between contractions</td>
<td></td>
</tr>
<tr>
<td><strong>MOTHER’S EMOTIONS:</strong></td>
<td></td>
</tr>
<tr>
<td>• May experience renewed energy</td>
<td>• Relieved</td>
</tr>
<tr>
<td>• Is sociable again between contractions</td>
<td>• Excited, may cry with happiness</td>
</tr>
<tr>
<td>• Fatigued</td>
<td>• May feel some discomfort from repair of</td>
</tr>
<tr>
<td></td>
<td>episiotomy or vaginal exam</td>
</tr>
<tr>
<td><strong>TECHNIQUES FREQUENTLY USED:</strong></td>
<td></td>
</tr>
<tr>
<td>• Pushing techniques</td>
<td>• Slow paced breathing</td>
</tr>
<tr>
<td>• Relaxation between contractions to conserve</td>
<td>• Relax perineum</td>
</tr>
<tr>
<td>energy</td>
<td></td>
</tr>
<tr>
<td>• Pushing with contractions as directed</td>
<td></td>
</tr>
<tr>
<td><strong>COACH’S ROLE:</strong></td>
<td></td>
</tr>
<tr>
<td>• Be sure partner is in a comfortable position</td>
<td>• Share in the joy and excitement of the baby’s</td>
</tr>
<tr>
<td>• Initiate pushing with verbal cues</td>
<td>birth</td>
</tr>
<tr>
<td>• Remind partner to take cleansing breaths</td>
<td></td>
</tr>
<tr>
<td>• Suggest changing pushing positions</td>
<td></td>
</tr>
<tr>
<td>• Help her relax between contractions</td>
<td></td>
</tr>
</tbody>
</table>

“Labor Summary” chart from Prepared Childbirth Educators, Inc. for use in childbirth education classes
**Pain Medications Preference Scale (PMPS)**  
By Penny Simpkin

<table>
<thead>
<tr>
<th>Number</th>
<th>What it Means</th>
<th>Your Partner, Doula, Nurse or Caregiver Can Help You By</th>
</tr>
</thead>
<tbody>
<tr>
<td>+10</td>
<td>I want to be numb, to get anesthesia before labor begins. (An impossible extreme)</td>
<td>• Explaining that you will have some pain, even with anesthesia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Discussing your wishes and fears with you</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Promising to help you get medication as soon as possible in labor</td>
</tr>
<tr>
<td>+9</td>
<td>I have great fear of labor pain; and believe I cannot cope. I have to depend on the staff to take away my pain.</td>
<td>• Doing the same for +10 above</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Teaching you some simple comfort techniques for early labor.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Reassuring you that someone will always be there to help you</td>
</tr>
<tr>
<td>+7</td>
<td>I want anesthesia as soon in labor as the doctor will allow it, or before labor becomes painful.</td>
<td>• Doing the same for +9 above</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Making sure the staff knows that you want early anesthesia.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Making sure you know the procedures and the potential risks.</td>
</tr>
<tr>
<td>+5</td>
<td>I want epidural anesthesia in active labor (4-5cm). I am willing to try to cope until then, perhaps with narcotic medications.</td>
<td>• Encouraging you in your breathing and relaxation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Knowing and using other comfort measures.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Suggesting medications when you are in active labor.</td>
</tr>
<tr>
<td>+3</td>
<td>I want to use some medication, but as little as possible. I plan to use self-help comfort measures for part of labor.</td>
<td>• Doing the same for +5 above</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Committing themselves to helping you to reduce medication use.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Helping you get medications when you decide you want them.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Suggesting half doses of narcotics or “light and late” epidural.</td>
</tr>
<tr>
<td>0</td>
<td>I have no opinion or preference. I will wait and see. (A rare attitude among pregnant women.)</td>
<td>• Helping you to become informed about labor pain, comfort measures, and medications.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Following your wishes during labor.</td>
</tr>
<tr>
<td>-3</td>
<td>I would like to avoid pain medications if I can, but if coping becomes difficult, I’d feel like a &quot;martyr&quot; if I did not get them.</td>
<td>• Emphasizing coping techniques.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Not suggesting that you take pain medications.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Not trying to talk you out of pain medications if you request them.</td>
</tr>
<tr>
<td>-5</td>
<td>I have a strong desire to avoid pain medications, mainly to avoid the side effects on me, my labor, or my baby. I will accept medications for difficult or long labor.</td>
<td>• Preparing for a very active support role.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Practicing comfort measures with you in class and at home.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Getting a doula (labor support person) to help for both you and your partner.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Not suggesting medications. If you ask, suggesting different comfort measures and more intense emotional support first.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Helping you accept pain medications if you become exhausted or cannot benefit from support techniques and comfort measures.</td>
</tr>
<tr>
<td>-7</td>
<td>I have a very strong desire for a natural birth, for personal gratification along with the benefits to my baby and my labor. I will be disappointed if I use medication.</td>
<td>• Doing the same as for -5 above.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Encouraging you to enlist the support of your caregiver.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Requesting a supportive nurse who can help with natural birth.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Planning and rehearsing ways to get through painful or discouraging periods in labor.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Prearranging a plan (e.g. a “last resort” code work) for letting them know if you have had enough and truly want medication.</td>
</tr>
<tr>
<td>-9</td>
<td>I want medication to be denied by my support team and the staff, even if I beg for it.</td>
<td>• Exploring with you the reasons for your feelings.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Helping you see that they cannot take that responsibility.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Promising to help all they can, but the final decision must be yours.</td>
</tr>
<tr>
<td>-10</td>
<td>I want to avoid medication, even for a cesarean delivery. (An impossible extreme.)</td>
<td>• Doing the same as for -9 above.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Helping you gain a realistic understanding of risks and benefits of pain medications.</td>
</tr>
</tbody>
</table>

If you find that the meaning of the numbers above do not reflect quite the way you feel, you might pick a number that falls between them (for example, +4 or –6).
Relaxation

**Active Relaxation: Ability to release tension; a total mind-body experience that involves thinking about the release of tension.**

Relaxation in labor is the single, most important thing a woman can do because it lets her uterus do it’s work unimpeded. It decreases stress and fatigue and helps conserve energy.

**Relaxation Basics**

- Comfortable position: Body well supported with pillows.
- Comfortable environment: Room temperature, lighting, quiet, presence of your choice of family and friends.

_The more comfortable you are, the more relaxed and tolerant of pain you will be._

**Guidelines**

- Relaxation techniques are used when you can no longer ignore the contraction.
- Both mother and her support person need to master the techniques.
- Playing music may enhance the relaxation experience.
- Change your relaxation technique during labor when it is no longer effective.
- Both progressive and selective relaxation may be practice as touch and relax methods. Your partner finds the tense muscle group and gentle touches it. This reminds you to that you are becoming tense and then you can consciously relax that area. This is very helpful in labor where repetitive phrases “you’re tense”, “you need to relax” can become irritating.

**Progressive Relaxation: Systematically contracting and releasing tension in specific muscle groups.**

Home practice:

1. Provide a comfortable place for practice. Set the atmosphere: music, aromatherapy, etc.). Take a cleansing breath and then continue to breathe in an easy and relaxed way as you tense and relax each area of your body: eyes, jaw, neck, shoulders, hands, abdomen, butt, pelvic floor, thigh, legs.
2. **Tense and relax**: face, shoulders, fists, pelvic floor, legs.

3. **Relax only**: face, upper body, lower body.

**SELECTIVE RELAXATION**

Consciously relaxing some muscles of your body while others remain tense. This practice simulates labor; one muscle (your uterus) is contracting while you consciously release muscle tension in the rest of your body.

Find a comfortable position. Breathe in through your nose and out through your mouth. Search for tension in your body and then release it.

*Practice: right arm, left arm, right leg, left leg.*

**MEDITATION**

Releasing tension by focusing on an object, picture, sound or activity and blocking out all other thoughts or concerns. You can achieve deeper levels of relaxation by focusing on something other than the discomfort of the contraction.

**TYPES OF FOCUS**

- **External focus**: Eyes open, choose an object or picture and concentrate on that object.

- **Internal focus**: Eyes closed, block out all distractions. You may use visualization as an internal focus – a beach or meadow, a happy memory, your cervix opening.

- **Auditory focus**: Concentrate on recorded music, your partner’s voice, or the sound of the fetal monitor.

- **Mental activities**: Recite a poem, song, or phrase, or use counting.

- **Physical activities**: Concentrate of performing a particular movement – walking, effleurage, pelvic rocking, or swaying.

**VISUALIZATION**

The mind creates a secure and restful scene while the body responds by releasing muscle tension. This helps the woman achieve a deeper level of relaxation by imaging a place of safety and comfort.
BREATHING TECHNIQUES

Breathing techniques are used in labor to enhance relaxation when relaxation alone is no longer adequate. They also provide a point of concentration and distraction. They ensure adequate oxygen intake.

Cleansing Breath

**Description:** Take a deep breath through your nose. As you exhale through your mouth, release all tension from your body. Use at the beginning and end of a contraction. Consider it a welcoming breath that brings a wave of relaxation. It also divides labor into smaller, manageable segments and reminds couples to take it one contraction at a time.

*Childbirth is something you do, not something that happens to you.* F. Lamaze

A special way of breathing is something you can do to help yourself and your baby during labor and birth. To become comfortable with the different types of breathing, practice often.

Slow-Paced Breathing

May be used through labor to help you stay relaxed. Relaxation is the key, allowing you to have control during labor and birth.

**Description:** Take air in slowly (either through your nose or mouth) and slowly let it out. You may have done this breathing before. It is simple and it is good for you and your baby.

Modified-paced Breathing

May be used as labor becomes stronger. Requires more thought and concentration and sense of control.

**Description:** This is a lighter and slightly faster breathing than slow-paced breathing. Inhale and exhale through your mouth or nose.

Patterned-paced breathing

May be used as labor becomes stronger and if you have been asked not to push. This requires more thought and aids your concentration and sense of control.

**Description:** Three or four breaths in and out followed by one blow. The blows should be like those used to cool a hot spoonful of soup. As the urge to bear down becomes stronger you may wish to use only blows. As the urge fades, try the three or four light breaths and blow pattern again.
Puff or blow breathing

May be used with pattern-paced breathing if you have an urge to push and have been asked not to.

**Description:** The blow should be like those used to cool a hot spoonful of soup or like trying to blow out a single candle.

No matter which breathing you choose to use, always try to do the following with each contraction:

- Use cleansing breaths at the beginning and end of each contraction. (Take a big deep breath in, let it all out, allowing the tightness to leave your body.)
- Focus your eyes and mind on something or someplace that feels safe to you or focus on a pleasant thought.
- Relax and let all your muscles go limp so that your uterus is the only muscle working.
- Change positions often.

Try to work with your mind and body and with the natural forces of birthing.

---

**Breathing Patterns**

**SLOW PACED BREATHING**

**TECHNIQUE:**
1. Comfortable position
2. Cleansing breath
3. Breathe in through your nose
4. Breathe out through your mouth
5. Repeat for approximately 8 to 10 breaths per minute
6. Cleansing breath
NORMAL PACED BREATHING

TECHNIQUE:
1. Comfortable position
2. Cleansing breath
3. Breathe in through your nose
4. Breath out through your mouth
5. Repeat for approximately 16-20 breaths per minutes
6. Cleansing breath

PATTERNED BREATHING

TECHNIQUE:
1. Comfortable position
2. Cleansing breath
3. Begin with normal paced breathing
4. Switch to shallow breathing in and out of mouth during the peak of the contraction
5. Return to normal paced breathing as the contraction subsides
6. Cleansing breath
VARIABLE PACED BREATHING

TECHNIQUE:
1. Comfortable position
2. Cleansing breath
3. Begin with normal paced breathing as the contraction peaks
4. Switch to 3 shallow breaths, inhale and then softly blow out through puffed cheeks; repeat until contraction starts to subside
5. Return to normal paced breathing
6. Cleansing breath

Breathing patterns from Prepared Childbirth Educators, Inc. for use in childbirth education classes
The sentences below should be completed by the woman and her coach. You will not be expected to share this information with the class.

1. The thing that I am most afraid of is...

2. I feel excited when I think of...

3. (Woman) When I am in labor, I wish you would...

   (Coach) When you are in labor, I wish you would...

4. The one thing about the labor and delivery which I have not told you is...

5. The idea of being with you during labor and delivery makes me feel...

Sentence Completion Exercise from Prepared Childbirth Educators, Inc. for use in childbirth education classes
Aromatherapy for Labor and Childbirth – by Francoise Rapp

With all the access we have to information about pregnancy—from websites, to books, to childbirth classes—labor itself remains a mystery in many ways. What we do know is that labor is likely the hardest work a woman will endure in her lifetime. It also holds all the beauty, magic and infinite power of life itself.

But it is the unknown that causes most expectant mothers to be scared and apprehensive as the due date nears. More and more women are turning to aromatherapy during their labor to help them cope with the emotional issues facing them.

Resources usually divide labor neatly into three phases, but it’s important to recognize that each childbirth experience is unique. Depending on your emotional needs, consider incorporating no more than two of the following aromatic blends into your childbirth plan.

*******
First Stage: Early Phase
*******

During the early phase of labor, contractions begin. While the intensity varies from woman to woman, you will begin to see a pattern in frequency emerging. You should take it easy, relax, take a bath, or even a nap if possible.

You may be feeling a little apprehensive, and the following aromatic blend can help you relax your mind and release your fears.

In a 10-ml bottle, pour the following essential oils and then add organic vegetable oil to fill:
- 4 drops Lavender
- 2 drops Neroli

Massage your temples, forehead, chest and solar plexus. Take deep breaths.

*******
First Stage: Active Phase
*******

During the active phase, contractions become more intense and frequent. It is at this point that your doctors will likely tell you to go to the hospital. The key is to relax in order to gain enough strength for the delivery. A good birth coach is essential to help you with your breathing and relaxation exercises. Try the following aromatherapy blend to bring you peace and harmony.

In a 10-ml bottle, pour the following essential oils and then add organic vegetable oil to fill:
- 6 drops Lavender
- 1 drop Neroli
- 1 drop Rose
Massage your solar plexus, heart chakra, chest and neck. Inhale the blend deeply while resting.

*******

First Stage: Transitional Phase
*******

During this phase, contractions will come hard and fast, and symptoms might include shaking, shivering, and nausea. It is important that your birth coach provide you with all the emotional care and attention you need. Once you are done with this phase, you will be fully dilated and ready to begin pushing.

You may be feeling scared and exhausted. Inhale the following blend between the contractions to help you endure this phase, and give you an added boost of strength for the delivery.

In a 10-ml bottle, pour the following essential oils and then add organic vegetable oil to fill:
- 4 drops Lavender
- 4 drops Sage
- 4 drops Peppermint

Massage the lower back, with emphasis on the sacrum.

*******

Second Stage
*******

Now that your body has prepared itself for childbirth, you're likely feeling relieved that the end is finally in sight. And yet you still have a big job ahead of you. Pushing is an exhaustive process, and during this stage you will use all your reserved energy and strength. Many women feel the desire to give up, as the labor thus far has left them emotionally drained.

Inhale the following aromatic blend before you begin pushing to help you to gain the needed courage and emotional strength for this stage.

In a 10-ml bottle, pour the following essential oils and then add organic vegetable oil to fill:
- 4 drops Peppermint
- 4 drops Rosemary

Visit www.aromalchemy.com/aromatherapy/ouroils.html to learn more about the essential oils used in these blends.

Check out our Starters Kit for Pregnancy at

In Good Health,
Francoise Rapp
www.aromalchemy.com

This article was originally published by Francoise Rapp in "The Arom'Alchemy Newsletter," a weekly ezine dedicated to healthy mind, body and soul through the use of aromatherapy. Join her for many aromatic moments to come by subscribing at www.aromalchemy.com/education.

Author's Bio
Internationally renowned aromatherapist and alchemist Francoise Rapp was trained in the sacred ancient arts of anointing and practicing alchemy by priests and alchemists in France more than 10 years ago. She now lives in San Diego where she holds an International License in Aromatherapy. Her talents have been featured in many national media outlets, including RedBook Magazine, New Age Journal, Self.Com, and the nationally televised program "Men are from Mars, Women are from Venus." Visit her on the web at www.aromalchemy.com.
**PAIN RELIEF FOR BACK PAIN**

1. **Counterpressure/Rolling pressure**
The laboring woman should have her hips flexed either while standing, kneeling, sitting or side-lying. Her partner applies steady one-handed pressure to one spot on the lower back throughout the contraction. Tennis balls, wooden massager and fleece paint rollers can be used for rolling pressure.

2. **Double hip squeeze**
The support person places his/her hands on the sides of the buttocks of the laboring woman and presses toward the center. Pressure should be steady and firm throughout the contraction.

3. **Knee press**
The laboring woman sits upright with her lower back against the chair. During contractions, the support person’s hands cup both knees and press straight back toward the hip joints applying steady pressure to both knees.

**TECHNIQUE TO ROTATE BABY / PAIN RELIEF FOR BACK PAIN**

**Lunge**
The woman stands, facing forward with the chair at her side. She raises one foot, places it on the chair seat, and rotates her raised knee and foot to a right angle from the direction in which she is facing. Keeping her body upright, she shifts her weight sideways, bending her raised knee. She remains in that position for a few seconds, then returns to upright. She repeats this throughout several contractions in a row. The lunge can also be done on a bed in the kneeling position. This can be especially helpful with side pain.
Remember: Practice techniques in class. Also, practice switching roles so the birth coach understands better how the technique works.

**COMFORT MEASURES**

**MOVEMENT/POSITIONS FOR LABOR**
Change positions every 30 minutes
Free movement: The laboring woman should be able to choose the most comfortable position for herself
Different positions in labor can include a birth ball

**KEEPING THE BLADDER EMPTY**
- A full bladder impedes labor and can cause more pain
- The support person should remind the laboring mom to void every hour

**HEAT**
- Application of heat from moist compresses or heated rice bags to lower abdomen, back, or shoulders can be helpful

**COLD**
- Application of cold packs to the mom’s forehead or lower back

**HYDROTHERAPY**
- Baths, whirlpools and showers reduce pain, relieve stress and promote relaxation

*Pain Relief and Comfort Measures adapted from Prepared Childbirth Educators, Inc. for use in childbirth education classes*
**VARIATIONS OF STAGE ONE: DEFINITIONS**

**Induction:** Beginning of the childbirth process through artificially rupturing of the bag of water, or with medications which begin uterine contractions – ie, pitocin, prostin, cervidil, or cytotec.

**Augmentation:** the process of supplementing ones existing contractions with medication or rupturing of the membranes to enhance the strength and/or frequency of contractions to further promote cervical changes and labor progress.

**Monitoring:** The tracing of fetal heart rate and uterine contractions through external or internal means to evaluate fetal well being and uterine contraction frequency, duration, and strength (internal monitor only).

**IPUC (Intrauterine Pressure Catheter):** A device placed internally (into the uterus) to provide accurate information about the patient’s uterine contractions; an IPUC may also be used to transfer fluid back into the uterus.

**Fetal Intolerance of Labor:** An indication through internal/external fetal monitoring that the fetus is not showing reassuring signs through the labor process.

**Back Labor:** Extreme discomfort in the lower back, usually due to the fetal position known as “occiput posterior.”

**Prodromal Labor:** A lengthy period of time with uterine contractions which are not strong or frequent enough to promote maternal cervical change, yet are uncomfortable for the woman and may reduce her ability to attain adequate rest.

**Anesthesia:** Medication provided by the anesthesiologist, doctor, or CRNA theoretically relieving all or most of the discomfort. This can be achieved through general, spinal, intrathecal, epidural, and/or local anesthesia.

**Analgesia:** Medications assisting in comfort; they may be given by an RN and usually require an IV site, but may be given intramuscularly.
Positions for Second Stage

For second stage, an ideal position involves opening the pelvic outlet as widely as possible, providing a smooth path for the baby to descend through the birth canal, using the advantages of gravity to help the baby move down, and giving the mother a sense of being safe and in control of the process.

Try out a position for a few contractions. If it works, stay with it. If not, switch to a new position in-between contractions. Depending on the obstetric caregiver, you may be asked to move to a specific position just prior to your baby’s birth.

“Standard” Positions
These can be done by anyone. These are the positions in which most OB providers are used to delivering babies.

<table>
<thead>
<tr>
<th>Semi-sitting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use pillows underneath knees, arms, and back. During contractions, wrap hands around knees and pull knees up toward shoulders (as in squatting). Most common in hospital setting. For mom and baby: some help from gravity moving the baby down; mom feels more in control than in lithotomy position. Benefits for caregivers: good view of perineum, easy access to perineum.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Lateral / Side-Lying</th>
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</thead>
<tbody>
<tr>
<td>Back curved, upper leg supported by partner. Gravity neutral, good for fast second stage. May be a comfort position for mom.</td>
</tr>
</tbody>
</table>
**Kneeling Positions**
These positions work fine if you have no pain medication, or narcotics only. These *may* be possible with a light epidural. You can ask your caregiver if it would be possible to try these positions, but you will need assistance. (Moving the IV tubing, catheter tube, monitor wires and so on to keep them from tangling around you can be a production in and of itself!). Once you are in these positions, you would need to be “spotted” (have one person on each side of you, making sure you stay balanced and stable).

<table>
<thead>
<tr>
<th><strong>Kneeling</strong></th>
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</thead>
<tbody>
<tr>
<td>Hands on the bed, and knees comfortably apart. Or one knee up. Good for reducing tears and episiotomies. May be restful for mom.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Hands and knees</strong></th>
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</thead>
<tbody>
<tr>
<td>Arch back occasionally for increased comfort. Great for back labor, big babies, and posterior babies. Many find it most comfortable.</td>
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</tbody>
</table>

**Upright positions / Squatting**
These will not be possible if you have had an epidural, because with an epidural, you typically cannot get up out of bed.

<table>
<thead>
<tr>
<th><strong>Sitting</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>On the toilet, on thighs of support person, on birthing stool/chair, on partner’s lap. Opens pelvis, gravity enhancing, natural pushing position.</td>
</tr>
</tbody>
</table>
During your pregnancy you probably read one of the many books available on the subject of breastfeeding. Once your baby arrives, you may find it difficult to remember helpful information you will need to know to succeed in breastfeeding. Below is an easy-to-follow guild to help you through the first two weeks. I hope these suggestions will assist you in your new job of feeding your infant.

❖ Your Baby’s Birthday - Nursing Day 1
Nurse the baby as soon after delivery as possible. Most babies are eager and interested in nursing soon after birth. If you wait a few hours, your infant may fall to sleep and be less interested in nursing. You already have early milk...colostrum. Your baby can begin attaining the benefits of your early milk immediately. The colostrum will protect your infant from many diseases and illness.

Your nurse will be happy to help you. If you prefer to attempt breastfeeding without assistance, tell your nurse. Place a pillow on your lap and put the baby on top of it. This will bring your baby up to the same level as your breast and make it easier for him/her to feed. The infant’s nose and tummy should be facing directly into your chest or “tummy to tummy.” Be sure the baby does not have to turn his head to the side just to “latch on” to your breast.

Baby may seem frantic and upset when he/she fails to latch on immediately. This is normal. You may have to comfort and quiet your baby before trying again. Remember it’s a learning process for both of you. It may take several attempts before a successful “latch on” occurs.

After-pains are contractions that feel similar to early labor. You may notice nursing the baby causes the after pains to be stronger during the first few days. This is normal. The same hormones that deliver early milk to your baby...
also cause your uterus to contract. Each contraction helps your body return to its normal shape. With first babies, these contractions are usually mild. With each additional baby, the after-pains may get more severe. Ask your doctor about pain medication approved for breast-feeding mothers.

_Your routine for the first week should be:_
- Resting or napping while baby sleeps
- Checking the baby’s diaper upon waking
- Putting the baby to the breast as often as possible
- Cuddling and getting acquainted with your baby

Do not give water or artificial baby milk (Formula) if you are planning to breastfeed. Rooming-in is the norm here at KGH. However, if you would like your infant to go to the nursery to allow you uninterrupted rest, the nurses will bring your infant back to you for all feedings.

- **Day 2**
Some babies will be alert, but others will seem a little disinterested in nursing. If your baby is one of these “sleepy” babies, you may have to work at getting him/her interested in nursing. Stimulate the baby by unwrapping the blankets and rubbing his/her arms, legs, and back. A cool cloth placed gently on the face and chest works well to wake a sleepy baby for nursing.

Put the baby to the breast every 1.5 to 2 hours. The early milk is very valuable to him/her. Some babies would rather sleep all day. You may need to be persistent. This is only the first of many times when you will make a decision that benefits your child, even though he/she may not agree with you.

Nursing frequently may help you avoid engorgement and discomfort when your mature milk comes in.

You may not feel like napping today. Having a baby is exciting. It is common to feel a burst of energy following the dramatic decrease in weight and pressure from pregnancy. Avoid overexertion. Remember, you have just had a baby Give your body a chance to recover. _Rest while your baby sleeps!_

- **Day 3 & 4**
Under normal circumstances, your mature milk will come in today or tomorrow. You may notice a change in the color of the slightly yellow early milk to the pale white color of mature milk. Don’t be alarmed if your milk looks different than you expected. It may look watery and thin. Some foods will cause your milk to appear light blue or green. This is normal.

Put the baby to breast as often as he/she will nurse, or at least every 1½ to 2 hours. Your baby may wish to nurse again just a short time after finishing a feeding. Offer the baby your breast frequently. Nurse the baby whenever
he/she shows an interest by sucking on fingers or turning toward you with an open mouth.

When your mature milk comes in, your breasts will suddenly feel heavier. You may feel a slight tingling sensation. When your breasts are producing milk, they are about four times heavier than normal. After your mature milk comes in, you may hear more swallowing and gulping while your baby is feeding.

Count your baby’s wet diapers to be sure that he/she is getting enough milk. Most mothers produce much more milk than their babies need during the first week. You can be sure that your baby is getting plenty of nourishment if he/she has 6-8 wet diapers in a 24 hour period of time and is receiving no other feeding but breast milk.

Your milk production will match the amount your baby takes. Avoid giving supplementary bottles of formula, water or pumped breast milk during the first few weeks. There will be plenty of time later for family members to bottle feed your baby. Right now, missing a feeding and introducing a bottle may cause problems. Frequent nursing is essential for the first two weeks.

**Day 5**

Hopefully by now, your baby is latching on and nursing well. If not, you need to get help right away. Call your health care provider or the OB unit for assistance. Although many mothers never experience sore nipples, soreness is most common on the fifth day. If you have sore nipples ask yourself the following questions.

Are your nipples tender only when the baby latches on?

This is common. Many mothers experience minor discomfort for the first few seconds of the feeding. Breastfeeding is generally not a painful activity. This type of discomfort is only temporary.

Are your nipples so sore you dread the next nursing session?

If so, don’t give up on nursing because of the problem. Call your health care provider or the OB department for assistance. You may need to give your nipples a short “vacation” while they heal. Using a breast pump for a few feedings will allow you to heal and get the baby back to painless nursing.

**Days 6 - 9**

Your daily routine of feeding and caring for your baby is now established. Be careful about having too many visitors. If you are embarrassed to breastfeed in front of your friends, simply excuse yourself and go into another room. Many mothers learn to nurse their babies so discreetly that no one can tell the baby is feeding. This may take time. Don’t be afraid to tell friends and family that you and the baby are still a little tired. Keep visits short.
Continue taking naps or short rest periods while the baby sleeps. Continue with frequent feedings and wet diaper counts.

**Days 10-14**
Your breasts may suddenly feel softer now and not quite as full. You may worry that your milk is disappearing. **DON'T WORRY.** Continue to count the wet diapers to assure yourself of your milk supply. Unless it is time for a feeding your breasts will not be full and swollen like they were the first week. You may also notice your baby is more alert and isn't sleeping as much as he/she did previously. Your baby is more awake because he/she is becoming more aware and interested. Continue frequent feedings.

Call your doctor or clinic and ask about getting a weight check of the baby, if you do not have an appointment already scheduled. Breastfed babies gain weight a little slower the first weeks than do artificially fed infants. Knowing your baby is gaining adequate weight will help you relax. Most clinics will allow you to come in for a weight check.

Breastfeeding should not continue to be painful. If you have nipple soreness or pain that is not getting better, have your healthcare provider assess for potential problems.

*Breastfeeding is an experience you will always remember.*
*It is a wonderful part of being a mother and a good start for you baby’s health.*

♥ ♥ ♥ ♥ ♥
Sharing Books with Infants and Toddlers
From the Ketchikan Public Library

A lifelong love of books and reading begins with many shared experiences with good stories, beautiful pictures, and a loving adult. Let reading time be warm and relaxing for both of you: a quiet oasis in your day- and all the other benefits will come naturally, as by-products of your shared enjoyment.

2-6 months: Lullabies and Mother Goose. Babies at this age won’t be very interested in books as such, but your baby is passionately interested in you and the sound of your voice. This is a good time to sit the baby on your lap and store up songs, nursery rhymes and bits of poetry (good baby “small talk”). Your baby may also enjoy sitting on your lap looking at large colorful pictures while you slowly turn the pages.

6 months: Give your baby cloth or handmade books to play with and look at. Sturdy baby board books are ideal first reading or tasting for baby!

8 months: Try to establish a regular reading period: choose a quiet time when you’re both in the mood for snuggling.

12 months: Give your toddler old magazines and catalogs to practice turning pages.

14 months: Your child will probably begin to point to objects and ask you to name them. This is called “labeling” and is an important beginning to the ability to follow a story line. You can also point out interesting details in the story. Help your child to become observant in your own environment as well. Richard Scarry’s word books, among others are good for labeling.

18 months: Your child will enjoy simple, entertaining stories like Rosie’s Walk or Max’s Ride.
22 months: Relating objects and events in stories to everyday life helps to provide a framework for experience. Recalling the past is still difficult, but you can say, “Look at this yellow dump truck, we saw one on the way home, remember?”

24 months: Until about age five, your book lover will mostly enjoy stories about everyday things and simple fantasies. Here’s a good example; A five year old is excited at being told that Becky opened a door and there was a dragon behind it. A two year old is excited at being told that Becky opened a door.

Have fun reading together!!

Top Ten List for New Dads

1. Trust your instincts. A little experience will quickly turn you into the world’s leading expert on your own baby.

2. Learn from those with experience. Ask the hospital nursery personnel to show you how to change, swaddle, and bathe your baby. Ask other dads for suggestions.

3. When it comes to Mom, remember to be patient and positive. Communication and support are the key. She’ll love you for it!

4. Stand your ground. Let no one push you away from your baby- not your mother-in-law, your mate, your boss- no one.

5. Learn as a family, just the three of you. Keep “help” in the first weeks down to what is needed, lest it becomes interference.

6. Your baby is portable. You can take your baby just about anywhere. Don’t get caught up in fretting about what you can’t do, but enjoy all the things that you can do.

7. You will get frustrated (guaranteed). Step back. Think. Count to some high number (as high as needed!). Think again and then respond (don’t react).

8. Make eye contact. Babies talk with their eyes. You will see!

9. Relax and enjoy the ride. Make it a daily habit to play with your new baby. Check out her tiny little feet, have him fall asleep on your chest, etc. It’s the little things that count the most, and kiddos need their daddies to play with them!

10. When times are trying, remember they too will pass. Before you know it, you will have a teenager instead of a baby.
8 Ways to Be A Happier Mom (Parent) Overview

1. Admit when you’re stressed. You’re not a bad parent if motherhood doesn’t feel warm and fuzzy all of the time. “Kiss mommy guilt goodbye.”

2. Get enough sleep. A recent study showed that enough sleep has a greater effect on your daily happiness than a large annual income. Sleep when the baby sleeps, and support each other by giving breaks (i.e.- Dad, give Mom a break on the weekend when you have a little extra time home from work so she can sleep in a little; help by getting Baby and changing his/her diaper at that 2AM feeding time).

3. Reconsider your priorities. Focus on what really matters. Does the house have to be cleaned now? Can someone outside your home help, like a friend, family member, or hired person? The housecleaning will wait; your relationships won’t. At first, one task per day is plenty (laundry), and after a while you’ll start adding on to that. Focus on what really matters.

4. Go with the flow. “Time seems to slow down when you’re doing what you enjoy… Bringing more of your best qualities – your strengths – to the often mundane tasks of child rearing can also help you feel more engaged.”

5. Savor the moment. “One way to nourish positive emotions is to take time to appreciate, well, the moment. Just map out two- or three-minute activities that you can do that day to relish that time. In the morning, for instance, instead of trying to do ten things, take your cup of coffee to the window, and sip it while your child plays in an Exersaucer. Notice what’s going on. Will it change your life? No, but you’ll feel calmer.” Notice those sweet little details about your child- “…those chubby cheeks, that toothless smile…”

6. Take the long view. “Having a sense of perspective will also improve your attitude. If the drudgery is getting to you, think about life without children. …realize how empty your life would be without these people in it.” This too, shall pass!
7. **Reconnect with your spouse.** “…it’s so important to keep the lines of communication open, especially during the ‘diaper years’ – infancy to age 3 – that experts say are the most stressful on a marriage. ‘You can’t say, ‘I’ll handle the relationship later.’ A healthy and realistic goal is to ask, ‘What are some small, manageable things we can do to keep our connection strong during this rough time?’ It can be as easy as going food shopping together… once you make little steps, it’s easy to move on to bigger ones, like a night out. If you can both just say, ‘Raising a kid is hard,’ putting it out there diminishes the strain .’”

8. **Say thanks.** “Feeling grateful is a mood booster. Write the three best things that happened today. Of course, you’ll still have bad days. But at least you’ll be less likely to think there’s something wrong with you.”

*Excerpts from “8 Ways to Be a Happier Mom” by Robert Barnett
Used, with permission, from December/January 2007 issue of Parenting Magazine.*

- **Title:** “Good Night Sleep Tight: The Sleep Lady’s Gentle Guide to Helping Your Child Go to Sleep, Stay Asleep, and Wake Up Happy”
  - Author: Kim West with Joanne Kenen
  - Publisher: Vanguard Press, 2006
  - ISBN-10: 1593153562

- **Title:** “Love and Logic Magic® for Early Childhood: Practical Parenting from Birth to Six Years”
  - Author: Jim Fay & Charles Fay, Ph.D.
  - Publisher: Love and Logic Institute Inc, 2000

- **Title:** “On Becoming Baby Wise”
  - Author: Gary Ezzo and Dr. Robert Bucknam
  - Publisher: Multnomah Books, 1998
  - ISBN-10: 1576734587

- **Title:** “On Becoming Baby Wise: Book II (Parenting Your Pretoddler Five to Fifteen Months)”
  - Author: Gary Ezzo and Dr. Robert Bucknam
  - Publisher: Parent-Wise Solutions Inc, 2001
  - ISBN-10: 0971453217

- **Title:** “Signing Time” or “Baby Signing Time” DVDs
  - Creator: Rachel Coleman
  - Producer: Two Little Hands Productions
Website:  http://www.signingtime.com/

- **Title:** “The Happiest Baby on the Block”  
  **Author:** Harvey Karp, M.D.  
  **Publisher:** Bantam, 2003  
  **ISBN:** 0-553-38146-6  
  **Other:** Also available on DVD (highly recommended) “The Happiest Baby on the Block- The New Way to Calm Crying and Help Your Baby Sleep Longer”  
  **Website:** http://www.thehappiestbaby.com/

*The above listed resources do not necessarily reflect the views of the Peacehealth organization, Ketchikan General Hospital, or New Beginnings Birthing Center and its staff, but may be helpful to you as a parent.*