Doulas: Nurturing and Protecting Women's Memories of Their Birth Experiences

by Penny Simkin

ABSTRACT

This paper reviews research findings on psychosocial outcomes of childbirth, such as women's long-term memories and impressions; the effects of emotional distress on labor progress and fetal well-being; women's satisfaction with their childbirths; and Post-Traumatic Stress Disorder after childbirth. These outcomes are explored in terms of how they are influenced by doula care during childbirth. The conclusion is that the doula's simple intention of nurturing and protecting women's memories of their births addresses and improves psychosocial outcomes.

INTRODUCTION

Doulas, under a variety of names, entered maternity care in scattered parts of North America in the mid-1980s, and their influence and availability have grown continually. In a recent national survey (DeClerq et al. 2002), approximately 5% of the women reported having the help of a birth doula during the years 2000 to 2002. The increasing acceptance of doulas by the public stems from the desire by childbearing women to have their psychosocial needs met throughout labor by an experienced supportive person giving continuous reassurance, comfort, guidance, and encouragement. The context in which most childbirths occur does not accommodate these needs. Hospital staff cannot devote much attention to nonmedical matters, because they have enormous demands and other priorities, and women's loved ones often feel too anxious or do not know how to meet these needs.

In this paper, I review some recent research findings on psychosocial aspects of childbirth, such as women's long-term memories and impressions, physiological and behavioral responses to distress during labor, satisfaction with their births, and post-traumatic stress disorder after childbirth. I explore the influence of care received during birth on these outcomes. I hope to show that the doula's simple intention of nurturing and protecting the woman's memory of her child's birth addresses many of the woman's psychosocial needs and improves psychosocial outcomes.

A DAY SHE'LL NEVER FORGET

Women's memories of childbirth and their perceptions of its personal impact have been the subject of a number of investigations, most of which indicate that women have vivid memories of the events and strong feelings about their birth experiences (Hodnett 2002). Studies of long-term birth memories have found varying degrees of consistency (Bennett 1985; Simkin 1990; Simkin 1991; Waldenstrom 2003). Interestingly, the intensity of women's positive or negative feelings often changes over time, especially when compared to their feelings a day or two after birth. The "halo effect" — the immediate relief felt by parents when labor is over and their enchantment with their baby — lasts for a few weeks and often temporarily overrides negative aspects. Memories of the unpleasant aspects, such as complications, frightening events, or unexpected interventions, often emerge later as the "halo" wears off (Bennett 1985). On the other hand, women's impressions of the psychosocial care they received (i. e., sharing of information and decision-making, respectful treatment, attentiveness and emotional support, a welcoming environment, an opportunity to process the birth afterwards) seem to remain quite constant over time, and, when positive, may be associated with increasingly positive later overall impressions of their births (Simkin 1991; Waldenstrom 2004). In other words, a high degree of attention to women's psychosocial needs, which is a top priority among most doulas, has long-term positive effects on women's perceptions of their birth experiences.

My own research in this area consisted of following up with twenty women who had attended my childbirth classes between fifteen and twenty years earlier (Simkin 1991; Simkin 1992). I had their original birth stories, written within weeks after their first childbirth. As part of the study, they wrote another birth story from memory, and when I checked the two versions for consistency, they were very similar, despite the passage of years. I also interviewed the women, and discovered that their memories were vivid and poignant.

The women who rated their satisfaction high felt a sense of great accomplishment, and felt they were in control of what was done to them, and of their responses to their contractions. They also felt well-cared for by their doctors and nurses. Few of the less-satisfied women had any of those positive feelings. Some were still bitter after

continued on page 17

all those years had passed. All the women had clear memories of what their caregiver said, both positive and negative. Nine of the twenty women wept as they recalled the events of the birth — some out of joy, some out of remorse or anger. The interviews had a powerful effect on me, and led me to the conviction that all women deserve to be cared for and nurtured by a doula, and also by everyone involved in their care, during this vulnerable time. They will remember their childbirths for the rest of their lives. The memory should bring joy and fulfillment.

EMOTIONAL DISTRESS DURING LABOR

Unmanageable pain and emotional distress cause an outpouring of stress hormones (catecholamines). High levels of catecholamines result in the physiological response usually called the "fight or flight response." Because the body does not distinguish between physical danger and emotional distress, it reacts as if the distressed person is in danger of bodily harm. Blood flow to the uterus is diverted to the skeletal muscles (to enable fighting or fleeing), resulting in slowing of contractions and labor progress. Fetal movements and heart rate slow (to conserve oxygen for the fetal brain) in response to decreased blood flow to the placenta. This mechanism explains how maternal distress contributes to dysfunctional labor and fetal distress. It is therefore possible that some labor complications are preventable if excessive pain and maternal distress are avoided.

There is further relevant information about the fight or flight response in labor from recent research findings that women's psychological and behavioral responses to distress are different from men's (Taylor et al. 2000). The term "fight or flight" is more appropriately applied to the male survival response to threat or perceived threat (that is, either repelling the danger — "fighting" — or if the odds are too great — "fleeing"). The term "tend and befriend" more appropriately describes the female response to threat. The female's response is dictated by the biological need to protect the young and to survive in order to care for them. Thus her priorities are to protect her babies from harm — "tend" — and to reach out and join or form social groups — "befriend" — to reduce risk.

This behavioral response to stress is evident during labor. When a woman fears for her baby's well-being, she will do whatever it takes to protect her child — consenting to a cesarean, accepting any suggested course of treatment if she believes it will benefit her child (and resisting treatment if she believes it will harm her child). When she is frightened, anxious, or unable to cope with her pain, she reaches out for help and reassurance from a trusted person.

Another manifestation of the survival response that pertains to labor is the tendency to interpret events in the most negative or pessimistic way possible. In the wild,

continued on page 18

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 from page 17

when one is in mortal danger and survival depends on the ability to detect danger in time to avoid it, this tendency is invaluable; but in labor, it is not. For example, if a woman is checked and found not to have progressed in dilation since her previous exam, she is likely to believe that labor will not progress and to quickly become discouraged. If the nurse has difficulty locating the fetal heart tones, the mother may jump to the conclusion that her baby is in trouble.

If the people caring for laboring women understand and respond appropriately to manifestations of the stress response, they may be able to ease emotional distress and prevent the surge of catecholamines that can interfere with normal labor progress. Doulas give this a high priority. Note: this effect of catecholamines applies only to the first stage of labor. A catecholamine surge in the second stage is physiological and gives the woman the strength to deliver her baby (Odent 1999).

WOMEN'S SATISFACTION WITH CHILDBIRTH

A recent systematic review examined factors that influence women's reported satisfaction with their childbirth experiences (Hodnett 2002). From the 137 studies reviewed, several factors emerged as being more powerful in influencing satisfaction than pain, pain relief, use of medical interventions, and demographic characteristics (e. g., age, education, socioeconomic status, etc.), including these psychosocial factors:

Personal expectations. If high expectations were met, or if the birth experience was better than expected, satisfaction was high.

Caregivers' attitudes and behavior. High levels of support from caregivers, along with rapport and good communication, were strongly predictive of satisfaction.

Personal control and involvement in decision-making. When present, these enhanced women's satisfaction.

An in-depth study (published since the systematic review described above) included sixty women with normal births. It examined multiple factors for their association with childbirth satisfaction (Goodman, Mackey, and Tavakoli 2004). The authors found that personal control during labor and having expectations met were statistically significant predictors of overall satisfaction with childbirth.

The doula's defined role is to assist women with those factors that have been found to increase childbirth satisfaction — meeting their expectations, providing support, enhancing communication, and increasing the woman's sense of control and involvement in decision-making. All trials that compared birth satisfaction among women with doula care versus those with usual care, found increased satisfaction in the doula care groups (Hodnett et al. 2004; Simkin and O'Hara 2002).

TRAUMATIC BIRTH AND POST-TRAUMATIC STRESS DISORDER (PTSD)

"Birth trauma is an event occurring during the labor and delivery process that involves actual or threatened serious injury or death to the mother or her infant. The birthing mother experiences intense fear, helplessness, loss of control, and horror" (Beck 2004a, 28). This definition of "birth trauma" is consistent with the definition of "trauma" that applies to any life event, as described in the authoritative *Diagnostic and Statistical Manual of Mental Disorders (ADA 1994)*.

An extensive literature review reports that many studies have surveyed pregnant and/or postpartum women to determine the incidence and causes of birth trauma and PTSD (Beck 2004a). Even though traumatic births (reported in some studies as high as 33% to 34%) are very troubling in themselves, and women require time and support to process and resolve them, most women with birth trauma do not go on to develop the full syndrome of PTSD, which is a serious long-term reaction to trauma (Creedy, Shochet, and Horsfall 2000; Soet, Brack, and Dilorio 2003). In fact, estimates of PTSD after childbirth range between 1.5% and 5.6% (Beck 2004a).

The diagnosis of PTSD includes at least three symptoms from any of these three "clusters": 1.) intrusive thoughts (e. g., nightmares, flashbacks, preoccupation); 2.) avoidance of reminders (e. g., detouring to avoid going near the hospital, not returning for postpartum appointments, avoiding discussions about the birth, emotional numbness, avoiding a future pregnancy); and 3.) hyperarousal (e. g., panic attacks, sleeplessness, anxiety, crying, anger). These symptoms must persist for at least one month to meet the criteria for PTSD (ADA 2004).

Why do some women who have traumatic births go on to develop PTSD while others do not? Preexisting factors (e. g., previous unresolved trauma or a mental health problem) are major contributors, but a discussion of these is beyond the scope of this paper. A review of numerous studies identified a number of PTSD-associated factors that occurred during the birth and that are preventable, such as lack of support, not being listened to, lack of communication, being ignored, insensitive care, negative contacts with staff, and lack of control (Beck 2004b). PTSD can occur, even when labor is normal. One study reported an incidence of 3% among 274 women who had normal births; that is, they included no obvious physical trauma (Czarnocka and Slade 2000).

There are no studies specifically investigating the impact of the doula on birth trauma and PTSD. The top priority of doula care, however, is to provide those elements that were almost always missing for women who have PTSD after childbirth — reassurance, expression of needs and feelings, continuing and undivided attention, and a sense of control. The doula supplies the kind care that may prevent many traumatic births from progressing to PTSD. *continued on page 19*

CONCLUSION

The doula plays an essential role in maintaining the psychological and physical well-being of laboring women. There are several possible avenues through which a doula can improve short- and long-term birth outcomes — reducing catecholamine production in the first stage of labor, constantly striving to bring about a positive long-term memory, increasing birth satisfaction, and preventing PTSD.

Human caring and support through this challenging transition is a scarce feature of conventional maternity care. The doula, in pursuing her objective of nurturing and protecting women's memories of their birth experiences, can fill this gap.

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