The Birth of a Prenatal Class

at the Antepartal Clinic

An Honors Project (ID 499)

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Introduction

So far as I know we did not set sail to look for things useful but to seek honour and adventures. And here is as great an adventure as ever I heard of...

C.S. Lewis, *Voyage of the Dawn Treader*

The latter portion of the above statement might be concluded with "creating a senior honors project," although the person from whom this purposeful declaration is quoted has gotten the words "useful" and "honour" confused. While my project was certainly an adventure, I have always viewed my quest as being one of practical usefulness with little regard for "honour."

Because of my exposure to community health nursing and my enthusiasm and love for maternity nursing, I decided to combine the two for the development of my senior honors project. My first inclination was to locate a married couple in a lower income bracket and to formulate an in-depth, community-based nursing care plan with emphasis upon the teaching and resource needs of that early-childbearing family.

The resources that I utilized for locating such a couple included the Antepartal Clinic and the Family Practice Clinic which are both located in Maria Bingham Hall next to Ball Memorial Hospital (BMH). The Antepartal Clinic is supervised by the Coordinator of the Parent-Child Area at BMH, Mrs. Florence Brumley. The Family Practice Clinic is headed by Mrs. Betty Hale.
After countless meetings with my advisor and Mrs. Brumley, I found myself examining files of patients trying to detect clues that would tell me that a particular client would need and appreciate what I had to offer. Mrs. Brumley helped me narrow my decision to four or five patients that were affiliated with the Antepartal (prenatal) Clinic. Mrs. Hale also helped me search through charts and decide with which patients I might meet in order to locate a couple who would be accepting of me on "their turf." I wanted a couple I could work with closely to help make their birthing experience less mysterious and frightening and more fulfilling.

The following are notes pertaining to my interactions with Mrs. Brumley and Mrs. Hale:

Both Betty Hale and Florence Brumley were supportive of me and my proposed project. I met with Mrs. Brumley first at Ball Memorial Hospital. We looked through charts of women who would be delivering in late January or early February and eliminated those who were unmarried. We narrowed the choice from four to five possibilities to one woman who was married, was a gravida II para I, and had an estimated date of confinement (EDC) in mid-January.

Mrs. Brumley telephoned Mrs. Hale at the Family Practice Clinic and communicated my quest to her. I proceeded there to investigate other possible candidates. We again examined files looking for a married, pregnant woman and found two potential clients. I planned to attend their next clinic appointment after receiving permission from their physicians.
to introduce myself and my project. One of the appointments, though, was one that I could not make because of my class schedule. That appointment was one which Mrs. Hale and the woman's physician later tried to encourage me to attend because she seemed to be a "problem patient." Their statements about her included, "She has a lot of hostility." It is interesting to note that the community agency was anxious to meet the clinic's needs first and that my learning needs were not necessarily their primary concern.

Evaluation of Interview #1:

On a Tuesday morning I met with R.S. at the Family Practice Clinic while she was in an examining room waiting for the doctor. Mrs. Hale had earlier inquired if it would be permissible for me to meet with R.S. She was sitting in a chair and as I walked in, she smiled. There was another chair beside a small table and I sat in it. I introduced myself, explained my project, and we talked for a few minutes. She was excited about the pregnancy and I discovered that she had recently
Her attitude appeared positive and enthusiastic toward having someone available to answer questions and to teach her about infant care. She admitted she knew nothing of taking care of a baby. [Need #3: preparation for infant's arrival and teaching on infant care]

We concluded the interview. I told her I would phone her the next week to learn of her husband's reaction and of the role she might want me to take.

Evaluation of Interview #2:

The next Tuesday morning, I met with P.J. at the Antepartal Clinic. Our initial introduction was quite awkward because the nurses introduced me by saying, "This is a Ball State student who will be working with you." Two other patients were present and I was not even sure who P.J. was. Then I said, after I realized which mother-to-be I was to talk to, "I just wanted to introduce myself to you this morning and to discuss what I hope to be doing." Our talk was delayed while she was weighed and until we were able to locate a place to sit and converse.

I again introduced myself and told her of my project. I asked her if she had any names chosen and she responded, "'Joshua' for a boy, and 'Autumn' for a girl." I asked her if her husband was going to be present in the delivery room and she said, almost aghast, "Oh, no!" I also inquired if she was attending any prenatal classes and she responded,
pain and I just want to be out of it." Needs #1 and #2: possible intervention for increased father participation; parental education concerning "natural" childbirth, what prenatal classes offer, and defining the use of pain medication and anesthesia during labor and delivery.

We continued to talk for a few minutes and I said I would phone her to inquire about her husband's reaction and to discuss my role as a resource person. The interview ended.

As I was walking out, though, I passed her sitting on the stairs with a cigarette in her hand. [Need #3: health education and information about the effects of cigarette smoking during pregnancy]

The week following the two interviews, I attempted to reach the women that I had interviewed, but without success. I did speak with both of their mothers, either because their daughters lived with their parents, or because the mothers were visiting. Both mothers took messages the first time I phoned. Yet, upon subsequent conversations, both mothers stated their daughters were not interested in having me help them through their pregnancy. While this occurrence was discouraging for me, I was able to make some noteworthy observations. First, I must have appeared to the mothers, and possibly to the pregnant women, as a threat. My presence in their homes and talking with them about their own personal bodies and lives was not acceptable to them. Furthermore, because the mothers were the persons to actually say "no"
their daughters and helping them through their pregnancy was their job as a mother and grandmother-to-be. I was probably seen as a threat to what they must have considered was their obligation and duty.

While I had started on this journey with the above intentions, I was determined not to be shipwrecked and stranded without some sort of project to carry out. So, I patched my battered ego and set out for a new course full speed ahead. This new course I steered for is the focus of the remainder of the paper. With priceless advice from my guide and more help from Mrs. Brumley, I decided to develop an educational program in the form of prenatal classes at the antepartal clinic.

Because the foundation for all nursing actions lies in the utilization of the nursing process, the following description and account of my project will be mapped out in the form of assessment, planning, implementation, and evaluation. While the individual teaching projects that I presented at the clinic include sections of planning, implementation, and evaluation, this is a microcosmic form of the nursing process in comparison to the project as a whole.

In order to have a clear definition of the four steps in the nursing process, one must understand the individual tasks involved in assessment, planning, implementation, and evaluation.

A nursing assessment focuses on determining the physical, psychological and social status of families or clients. The assessment identifies strengths, weaknesses, potential or
actual problems, and coping mechanisms. To expand this definition, one can replace "family" or "client" with "groups of individuals," or "institutions."

Planning involves formulating goals and writing objectives for overcoming those obstacles found in the nursing assessment and for maximizing those assets which are also described in the assessment. Friedman states:

Planning means determining what needs to be accomplished... This involves the mutual setting of goals, identifying possible resources, delineating alternative approaches to meet goals, selecting specific nursing interventions, mobilizing resources, and operationalizing the plan (setting of priorities and phasing plan in).

Therefore, a goal supplies direction and purpose to one's interventions and actions.

Implementation is putting the plan into action. Yet, during implementation, new data and feedback are processed back to the nurse so that her assessment and planning are continuous. Furthermore, barriers to implementation must be dealt with and implementation strategies altered and molded to fit individual situations.

Evaluation is an assessment of the effectiveness of the actions and how they met the need. Furthermore, evaluation is not necessarily based on the performance of the nurse, but on the responses that are received from the client. The crux of evaluation is that it is an ongoing process and answers the question, "were the goals and objectives fulfilled?"
Assessment

Through discussions with Mrs. Brumley, the need for patient education dealing with aspects of pregnancy, labor, and delivery for the women at the Antepartal Clinic was recognized. She particularly pointed out the need for the emphasis of relaxation and breathing exercises. Because many of the clinic patients do not attend prenatal classes elsewhere, Mrs. Brumley felt that if we could hold information sessions at the clinic, more women could be reached. Unfortunately, from Mrs. Brumley's observations, many of the mothers-to-be attend the clinic for their appointments but express urgency to leave the clinic as soon as possible. Many of the clinic patients must be firmly encouraged to speak to the nutritionists whom they are required to see following their appointments. The explanation for such unwillingness to spend extra time at the clinic is obscure and bears no relationship to whether or not they are married, have other children, or are employed.

In order for the women to be accepted as clinic patients, their annual income must be below a specified level. A large number of the women are unmarried and have not planned their pregnancy. Of the women at the clinic who are married, their husbands are often unemployed.

The age of the women attending the clinic varies, but there is a large percentage between the ages of fifteen and twenty-one. The educational level of these women is relatively low. Most have attended senior high school, but
there are many with a low reading ability.

By being in a low income group, patients at the Antepartal Clinic are more likely to present high risk factors. Olds and London report that "...high risk mothers deliver high risk newborns." Other risk factors include:

...mothers who are younger than 16 or older than 35 years of age, who are over gravida 4, who are classified as overweight or underweight, or who smoke. Women who have an Rh-negative blood type, who received transfusions at one time, or who had a pregnancy loss should also be considered at high risk...mothers with less than a high school education, who are in the poverty-level income group, who are unmarried, who have an unplanned pregnancy, and who have had little or no antepartal care. 5

The factors in the above list incorporate many characteristics that are prominent in the Antepartal Clinic's patient population. While there may be many weaknesses identified in this group as a whole, the women at the Antepartal Clinic share a crucial and monumental strength--they have sought and are receiving antepartal care. This strength must be maximized in order to minimize their high risk factors.

From previous experiences at the Antepartal Clinic, I have observed signs that would indicate that these women have a low self-esteem. One such indicator is poor personal hygiene. There are some women who have unpleasant body odors, whose hair is unkempt and who have slovenly appearances. Other nonverbal indicators include a lack of eye contact with the nurse, slumped shoulders, and resistance to communicate with health care personnel. Koziér and Erb state, "...all
people need to think well of themselves." However, it seems unlikely that without more care in their personal appearance, these clients will think well of themselves, or will have self-respect.

Furthermore, a person's level of dependence or independence is related to his self-concept. Limitations placed on an individual's level of independence can decrease his self-esteem. Pregnancy often poses limitations on activity if the patient is prescribed to bedrest or if the patient is experiencing discomforts associated with pregnancy. In addition, many women attending the Antepartal Clinic are dependent in other manners. Due to their low income level, clinic patients are dependent upon the government for meeting many of their physiological needs such as health, food and shelter. Often these women must also rely on their parents for the provision of these needs. While certainly not all of the Antepartal Clinic patients are assessed as having low self-esteem, there exist numerous possible reasons why some women do harbor low self-concepts.

With reference to Maslow's hierarchy of needs, self-esteem needs cannot be met without prior fulfillment of lower basic human requirements which include: physiological needs, safety and security, and love and belongingness. Abraham Maslow attempted to understand motivational factors responsible for human behavior. His hierarchy of needs arose from his conclusion that human beings have certain basic needs which must be met for survival. The attempt to fulfill these
needs dominates behavior. Consequently, higher level needs, such as self-esteem, self-respect, and self-actualization, can only be met after the needs for oxygen, fluids, food, shelter, sleep, safety, and love have been satisfied.  

The implications of Maslow's theories in relation to patient teaching are important for assessing an individual's readiness for learning. In the process of assessment, the nurse must identify at what level a particular patient has an unmet need before attempting to promote higher level needs. Therefore, prenatal classes aimed for decreasing knowledge deficits and for promoting self-esteem may not be the immediate priority needs of many clinic patients.
Planning

If one word had to be chosen to describe the planning process of my experience, that word would be "communication." The planning of five prenatal classes included meetings with Mrs. Brumley, my advisor, the clinic nurses, and countless interactions with other people so that such a program could blend into the routine of the Antepartal Clinic. In order to plan the classes, these questions had to be answered: when? where? what? how? and why?

Prenatal services are only offered on Tuesday mornings as the clinic facilities are utilized for other types of clinics during the week. Since the antepartal clinic patients would be present then, the logical time to hold the classes would be on Tuesday mornings, when they would be attending their appointments.

The question as to where these classes would be held did not have many alternatives. The six foot by six foot waiting room could have been used with difficulty. The other option was to try to obtain permission from the Practical Nurses' School, also located in Maria Bingham Hall, to utilize a room designated for their use. Through a short meeting with the director of the school, I obtained permission to use the back portion of their library which had tables and chairs for classes.

What facilities would I have to work with? To my surprise and delight, when she took me into the library, there was a stack of rolled-up carpet pieces from days gone by when an
obstetrician used to have prenatal classes there. In addition to the space and the carpets (I was already conjuring up images of my clients doing exercises on the floor together), there was a moveable self-standing bulletin board which I could use for posters. I could hardly believe my good fortune.

However, deciding how to coordinate the scheduling of appointments and my classes proved to be a dilemma. Appointments at the clinic are scheduled on the hour on a first come, first serve basis. Yet, in addition to working around appointments, there are nutrition classes which the women are required to attend. Therefore, if the patients have had to wait for an empty exam room, wait for the doctor, have their exam, schedule new appointments and see the nutritionist, would anyone want to spend extra time to attend a prenatal class too? That question could only be answered realistically at the time of beginning the classes.

Another nursing student, also at the Antepartal Clinic as part of her Community Nursing experience, did hand out questionnaires which delat with this question. A majority of patients at the clinic answered, "yes, I would attend a prenatal class." (The survey questionnaire is listed in the appendix). In addition, the majority of women were not attending parent education classes elsewhere. Although not all of the patients answered the questionnaire, we were encouraged about their expressed willingness for participation.

The next step in planning the classes was communicating to the nurses, doctors, and especially the patients that the
antepartal classes were going to be held. The nurses at the clinic were enthusiastic about such a plan for prenatal education and agreed that there was a great need for group teaching. They stated that they would be more than willing to encourage patients to attend my classes.

The antepartal clinic is staffed with two interns during their obstetric rotation. One of the interns who was assigned to the clinic happened to be an enthusiastic female who was more in favor of my presence and of my project than anyone I had yet met. The other intern happened to be a mellow doctor of the male gender who liked to come in to the clinic, put his feet on the desk and sip coffee. He also gave the impression that nursing students are worthless creatures whom he only tolerated. He, of course, did not particularly care whether or not my endeavors were successful. Unfortunately, he did not refer many patients to my classes. In fact, it was not unusual for him to say to a patient that she must go straight home to bed and not bother with the nutritionist or my classes.

In order to let the patients know about my classes, I designed a poster with pictures of mothers, fathers, and babies which stated that prenatal classes were going to begin in January. This poster was displayed in the waiting room one month before the classes actually began. I wanted a visual aid which would relay the information and at the same time create a positive attitude about babies, mothering and fathering. On the other hand, I did not want something too cheerful that would look like a commercial for "Pampers" with
a nanny, a happy baby and a "goody-goody" outlook on life. These women had tough lives with many problems and many did not plan on becoming pregnant. Therefore, I cut out color magazine pictures which elicited positive feelings. Then, I balanced those pictures with two black and white photographs, one of which was taken from an advertisement condemning smoking during pregnancy. While the woman pictured is not frowning or smiling, she does look thoughtful, and provides contrast to the color pictures. (A photograph of the poster is in the appendix).

Fliers were used as another mode of communication to inform the patients of the classes. They were distributed at the clinic by the nurses. The fliers indicated the dates, times and titles of the presentations. They also stated where the classes were to be held. (A copy of this flier is in the appendix). Thus, the groundwork was laid for launching my education classes.

However, in order to have a course of direction for my endeavor and to answer to question, "why?", goals had to be formulated to give purpose to teaching interventions. Through the conversations with Mrs. Brumley, teaching needs were assessed because of knowledge deficits about pregnancy, labor, delivery, and infant care. Furthermore, clinic patients were seen as having difficult labor and deliveries because of high anxiety levels which possibly could be alleviated through proper prenatal education. Goal #1: To increase knowledge bases about pregnancy, labor, delivery and infant care.
Goal #2: To decrease high anxiety levels related to hospitalization, labor, and delivery.

Because of their backgrounds, many of the clinic patients have higher prenatal risks for developing complications than pregnant women from higher income levels with more formal education. Goal #3: To decrease the potential for developing serious complications related to pregnancy, labor, delivery, and the newborn's well-being.

Finally, because of my observations at the Antepartal Clinic of low confidence levels and low self-esteem, the approach to my classes revolved around helping the women discover their abilities to learn and to view pregnancy as a positive experience. While this self-esteem need can only be fulfilled after lower needs have been met, I wanted to assist those women who were ready for developing more positive self-concepts, and to reinforce existing self-respect. In addition, for those women whose lower needs had not been met, I wanted to strive to promote an accepting attitude toward the pregnancy. Goal #4: To increase self-confidence and to increase patients' self-estees about giving birth.

In order to substantiate the implication that high anxiety states during pregnancy are related to knowledge deficits about pregnancy, labor and delivery, and may affect the outcome of pregnancy, researchers Standley, Soule, and Copans investigated concerns of pregnancy and pregnancy outcome. Their results and conclusions suggest that pregnancy holds specific concerns and anxieties.
Furthermore, these anxieties are significantly related to aspects of birth and infant well-being....timely and appropriate interventions directed toward the pregnant woman's concerns may lessen the need for extensive pain-relieving medications during labor and delivery. 10

This investigation identifies three main areas of anxiety of pregnant women and compares these three dimensions with background, education, maternal age, childbirth preparation, anesthesia administration during labor and the neonate's motor maturity. The three anxiety categories include: anxiety concerning being pregnant and the labor process, anxiety about caring for an infant, and "psychiatric symptomatology." The researchers of this longitudinal study interviewed seventy-three caucasion, married women with medically uncomplicated backgrounds and deliveries. Psychiatrists and psychologists coded their verbal responses according to a standardized, but flexible set of questions. 11

In looking at the outcomes of the pregnancy, age is correlated with anxiety. Younger women exhibit more worries about the birthing process. Furthermore, the authors point out a relationship between high anxiety in the ninth month and the administration of pain medications during labor and delivery. The authors also point out that a low educational level predisposes pregnant women to anxiety states. The investigators conclude:

Preparation for childbirth in the form of instructional classes seems to provide the expectant mother with skills of physiologic [al] and/or psychological coping which combat anxiety. 12
In another research article, the question, "'how do you feel about having a baby now?'" was posed to approximately 8000 pregnant caucasian women covering various socioeconomic levels. Their responses were categorized as either negative, ambivalent (including a change in attitude), or positive. Their answers were compared with prenatal, intrapartum, and postpartum complications, along with perinatal deaths. The purpose of the investigation was to explore the possibility that negative attitudes toward being pregnant can increase the fetal and obstetrical risks. 13

The findings of this study appear to be significant in supporting the hypothesis. Of the entire group of women, 56.4% had a strongly favorable attitude, 15% showed a moderately favorable attitude, 22.4% showed an ambivalent attitude, and 6.2% had negative feelings. The statistical data indicate that perinatal death and congenital abnormalities occurred proportionately more often in pregnancies that were unwanted and under more anxiety than in pregnancies where positive maternal attitudes were more prevalent. Furthermore, this same trend carried over into postpartal complications where 80.3 per 1000 women in the negative attitude group developed hemorrhage or infection as opposed to 40 to 50 per 1000 women in the other categories. In conclusion, the findings of this large-scale investigation do lead to the assumption that consideration of maternal attitude during pregnancy must be taken into account "...as a clinically meaningful risk factor in regard to fetal outcome." 14
Another study, involving thirty-two married women in their last trimester of pregnancy, investigated psychological and anxiety factors in relation to epinephrine levels, uterine activity, and labor length. The hypothesis states that there is a relationship between the maternal psychological condition and the outcome of labor. During three interviews held in the last three months of pregnancy, the psychological variables as related to pregnancy and labor include:

...quality of relationship with husband, with mother, and with father; acceptance of pregnancy; identification of a motherhood role; amount of preparation for labor; fears in labor of pain, helplessness, loss of control, loss of self-esteem, reproductive adequacy, and injury and death.

A limitation of the study's validity is the lack of a defined control group.

However, findings and implications of the study prove to be thought-provoking. Of all of the above psychological factors, acceptance to pregnancy was the variable with the most significant relationship to phase two stage of labor (defined as three to ten centimeter cervical dilatation) involving anxiety, epinephrine levels, length of labor, and uterine activity. Those women not readily accepting their pregnancies did appear to have higher anxiety levels, a harder labor and a longer labor period. Identification to the motherhood role also had a statistically significant relationship. The results are supported with tabular data. The study concludes by stating that the relationship between labor progress and
the psychological state and stress level is a positive one and that more studies are needed to investigate if the fetus and neonate are also affected. 16

The implications for prenatal education that have been alluded to in the previous research studies are explicit. Their conclusions indicate the importance of reducing anxiety and stress levels in pregnant women. Furthermore, antepartal education should aid a woman's acceptance of the pregnancy and help her to adjust to the motherhood role. Future research studies might look at methods to maximally promote a healthy pregnancy and delivery and focus on specific educational techniques and calming influences.

The planning process of my development of prenatal education classes at the Antepartal Clinic answers the questions of when? where? what? how? and why? Consequently, after plotting my course of direction and pooling the available, bountiful resources I found at my disposal, I plunged directly into the implementation of my project unsure of what obstacles might arise and what I might have to overcome.
Implementation

A large part of the implementation process was confronting many mothers-to-be, introducing myself, and telling them that the nurses and I would like them to attend the prenatal classes. After the first rejection, who happened to be the first woman I approached, I learned quickly not to offer a choice. I made sure that I did not ask them if they "would come," but I would say, "Come on down to the library for our parent education classes. We want you to be there with us." I often extended my arm around the woman's shoulders and led her down the hall to the library. While many women had replied on the questionnaire, "yes, I will attend a prenatal class," I received many excuses why they urgently had to leave. However, those women who did come, appeared more comfortable and became active participants after the class began.

To encourage attendance, Mrs. Brumley and the clinic nurses declared that if husbands and mothers would attend two of my classes, they would be permitted to be present in the delivery room. Normally, hospital personnel only allow the husband or "significant other" to enter the delivery area after completing certified classes. Thus, this motivational factor encouraged at least one couple to attend the classes.

For the implementation of teaching the classes to be successful, I had to consider the clients to whom the teaching would be aimed. The women at the antepartal clinic are adults. As one author points out, adults are self-directed and must be given the consideration of being capable of applying a
problem-solving approach to controlling their own lives. Therefore, in order to be an effective teacher, characteristics of the adult learner must be understood. 17

Paramount to approaching the adult learner is respect. "Respect includes establishing a mutually acceptable learning climate." 18 If unconditional trust and respect are incorporated into the nurse-teacher's approach, then the patient's self-concept can allow him the courage to practice the desired behavior. 19 That "behavior" in my classes was relaxation and breathing exercises.

Another aspect that the nurse must not disregard is the client's own previous experiences. Part of a patient's self-identity are his experiences. The nurse must be careful not to downplay that which is part of the individual's identity, or she will be showing rejection of the patient as a person. However, if previous experiences are a hindrance to the present learning situation, then the nurse needs to assist the patient in looking objectively at unrealistic preconceptions. 20

Through my experience as nurse-teacher, I strived to maintain the client's dignity and to help raise her self-esteem. Hopefully, unconditioned acceptance and respect were continuously communicated to those who participated in the prenatal classes and to those who seemed uncomfortable with the idea of participating. I attempted to create an atmosphere that would foster mutual sharing of patient's experiences and I helped clarify questions or misconceptions.
The following pages include the teaching projects which I presented at the clinic. While "Preparing for the Hospital Experience" was led by another nursing student, I formulated a teaching plan similar to what she presented. Each week "Relaxation and Breathing Exercises" were reviewed before I introduced a new topic.
Preparing for the Hospital Experience

Objectives: Upon completion of this presentation, the learner will:

1. Describe those items that she will need to take with her to the hospital.
2. Distinguish between false and true labor by naming five out of seven characteristics that differentiate false labor from true labor.
3. Describe four suggestions to help prepare for the hospital experience.

I. What to Take to the Hospital

A. You will probably want to take some personal things to the hospital. Little items such as your own toothbrush or hairbrush may provide security.

B. Since the onset of labor can be unpredictable, it is recommended that you have your suitcase packed two to three weeks prior to your due date.

C. Some articles that you might want to take with you include:
   1. your own lotion in case you want a backrub during labor
   2. your bathrobe
   3. a nightgown (although for the first day, you will be wearing a hospital gown)
   4. slippers or socks
   5. a support bra (At Ball Memorial, even if you have never worn a bra or are not planning to breast
feed, your breasts need some support. If you do not have a bra, the hospital will supply you with what is called a "breast binder."

6. a toothbrush, comb, hairbrush, or cosmetics
7. magazines or books

D. The hospital furnishes sanitary napkins and belts for your stay at the hospital. For the first few weeks following delivery, you will have a bloody vaginal discharge called lochia. Therefore, you will need sanitary supplies ready at home for when you are discharged.

II. How to Tell if You are Experiencing True Labor

A. A "due date" is a date that many women think will be the last possible day for the infant's birth. In actuality, the due date, or "estimated date of confinement," is only an estimate. Birth will occur upon maturation of your baby and when your body is ready to begin labor. The onset of labor may vary two weeks prior to or following the due date.

B. One change which signals that delivery may be imminent is the appearance of "mini" contractions called Braxton-Hicks contractions. These are irregular tightening episodes that are similar to menstrual cramps. These contractions turn into "priming" contractions, where the cervix and uterus are preparing for true labor.

C. This type of pre-labor contractions may be confusing, but there exist significant differences between false and true labor pains.
D. False labor can be distinguished from true labor pains by the following characteristics:

1. In false labor the uterus may remain hard for two to three minutes. In true labor, the uterus is hard for only thirty to sixty seconds.

2. In false labor the contractions are irregular, whereas in true labor, contractions are evenly spaced.

3. The intervals, or time periods between contractions, become progressively shorter with true labor.

4. In false labor, if you change your position by standing up, shifting weight, or moving, the contractions will end. In true labor, the contraction will continue.

5. False labor pains are usually uncomfortable but not painful. Although mild at first, the pains become progressively more severe in true labor.

6. In true labor you may also have a "show" of blood or a discharge from the vagina. This is a mucous plug that drops from the cervix because the cervix is beginning to dilate (or open). There is no change in vaginal discharge with false labor.

7. False labor pains are located in the lower abdomen and groin area. The discomfort and pain of true labor occurs in the back and abdomen.

K. If you are unsure of whether you are experiencing true or false labor pains, the safe thing to do is call your physician and notify the hospital that you will
be arriving. There are situations in which the only method of verifying true labor is by a vaginal exam to determine how far the cervix has dilated (opened).

F. The doctors and nurses here at the clinic often recommend, if you are pregnant with your first child, that you go to the hospital when contractions are regular and approximately four to five minutes apart. If this is not your first term pregnancy, they recommend that you arrive at the hospital when contractions are farther apart, such as seven to eight minutes apart. Usually, the more babies you have had, the shorter labor time you will experience.

G. Sometime during labor, you may have a sudden gush of fluid from the vagina. If and when it does occur, you need to go directly to the hospital. You may hear this called "your water breaking," although actually, it is the rupture of the amniotic membranes surrounding the infant.

H. Suggestions for preparing to go to the hospital
1. If you have other children, make previous arrangements to have someone care for them while you are enroute to the hospital.
2. If your husband works or is away frequently, have an alternate plan for obtaining transportation to the hospital.
3. Do not allow your automobile gasoline tank reach empty as the time to give birth draws near.
4. If your water has not broken before you leave for
the hospital, protect the car seat with a plastic bag and a towel. It is not advisable to wear a sanitary pad as it may contribute to a vaginal infection.

III. Evaluation

A. What are you going to plan to take with you to the hospital?
B. When are you going to pack?
C. What are the characteristics of false labor and true labor?
D. If you cannot decide which is occurring, what should you do?
E. What are some suggestions to remember in preparing to go to the hospital?

Bibliography:


2. You can have control over what your body is doing and what you are feeling.

3. Even if you are planning on having anesthesia, the breathing and relaxation techniques that we will be doing will help you to experience less pain during labor. Anesthesia can only be administered immediately before delivery because the medication may have a harmful effect upon your baby. Therefore, you will probably be awake during some stages of labor and will experience some labor pain.

II. Relaxation

A. Relaxation is defined as the absence of tension.

B. If you already have your own methods of relaxing, of getting tension out of your muscles, then use them. The final goal is relaxation.

C. Basic principles of relaxation include:
   1. Support of all body parts in a comfortable position is necessary.
   2. All joints must be flexed (or bent), including your elbows, knees, and hips. Joints cannot be relaxed if they are straight.
   3. You need to have a peace of mind and to be free of worry.

D. Assume a comfortable position.
   1. Usually side-lying is most comfortable.
   2. Arrange the pillow for your head so that the upper arm can rest on the pillow also.
3. Try to have your lower arm behind you.

4. Have the upper leg in front of the other leg and resting on a second pillow if one is available.

5. Have all parts of your body flexed (bent).

E. This exercise is basic and is called Tension-Release. There are two purposes to this exercise:

1) to recognize the state of tension
2) to be able to release that tension

F. This exercise focuses on tensing one area of the body at one time and then relaxing that area. Try to feel the difference between muscle tension and muscle relaxation.

G. Exercise Procedure:


2. Think about how your body feels with each step and think of the difference between tension and relaxation.


6. Turn your head to one side. Release. Turn your head to the other side. Release.
11. Steps 8 through 10 are repeated for the right arm.
13. Take a deep breath and slowly exhale, pulling in your abdominal muscles.
14. Take a deep breath and slowly exhale, releasing your abdominal muscles.
15. Tighten your buttocks and pelvis. Release.
19. Steps 16 through 18 are repeated for the right leg.
20. Go over your entire body and feel that all the tension is released.

G. Evaluation
1. What are the steps of relaxing your face?
2. What are the steps of relaxing your arms?

3. What are the steps of relaxing your legs?

III. Breathing Exercises

A. Practicing breathing may sound strange since you have been breathing all of your life, but breathing properly can help in relaxing your body and in controlling labor pain.

B. During pregnancy, the oxygen need of your body increases.

C. During labor, you and your baby's need for oxygen increases even more because of the great amount of energy you are expending. Labor is hard work.

D. Therefore, it is important to understand how to control your breathing so that you will have enough oxygen supplied to the baby and to your body's tissues.

E. Four points to remember include:

1. Breathe through your nose as much as possible.
   The nostrils warm and moisten the air.

2. Never hold your breath.

3. Practice before labor begins so that you will become better conditioned to the breathing patterns.

4. Use relaxation along with controlled breathing.

F. Abdominal breathing:

1. When you are relaxed, you are usually performing abdominal breathing.

2. Place your hand on your stomach and feel your abdomen rise as you inhale and lower as you exhale.
3. During labor, as a contraction begins, always take what is called a cleansing breath. Inhale deeply, letting your abdomen rise, and exhale completely and relax. Do this type of breathing pattern at the end of a contraction also.

4. As labor accelerates and your contraction is becoming harder, you may begin to breathe faster. It is important to continue to breathe through your nose taking a slow, deep abdominal breath when the contraction begins. Allow your breathing to become faster and more shallow with the peak of the contraction.

5. Think of the rhythm that you are breathing because concentration can help block your pain.

* 6. Do not use abdominal breathing when you feel the urge to push before it is time to push. This would be the time to pant which will be another breathing pattern we will practice.

G. Deep chest breathing:

1. This type of breathing decreases pressure from the diaphragm on the uterus. It can be used as a substitute for abdominal breathing.

2. To learn to expand the ribs, firmly place your hands on each side of the rib cage. Attempt to expand your ribs outward against this pressure as you inhale.

3. Perform these two types of breathing patterns we have just practiced for as long as you can while
labor progresses. The needs of the uterus for an adequate oxygen supply are better met.

H. Candle-Blowing:
1. Inhale through the nose on the count of one and exhale through the mouth on the counts of two, three, four, and five, while pursing your lips. Imagine that you are holding a candle six to eight inches from your mouth. Blow just hard enough to bend the flame but not to extinguish it.

I. Panting:
1. Place your hand on your breastbone where your collar bones meet so that your hand rises as you inhale, and lowers as you exhale. Keep your breathing light and shallow as in a slow pant. This type of breathing can be done through the mouth or nose.
2. Perform panting when you must control the urge to push.

J. Pant-Blow:
1. This type of breathing is similar to panting but upon exhaling, you blow out at regular intervals.
2. For instance, you may take four panting breaths and then after the fifth inhalation, purse your lips and blow out for a longer count. You may use any comfortable rhythm.

K. Panting, if not done correctly will lead to hyperventilation. Hyperventilation is overbreathing and
is characterized by the feeling that you simply cannot catch your breath. It may be caused by panic. Also, you could be breathing harder than you need to be. If hyperventilation occurs, cover your mouth with cupped hands and breathe back your carbon dioxide.

L. Shelf breathing:
1. As the contraction begins, take a cleansing breath and exhale completely, ending with the abdomen low.
2. As the contraction starts to build, take a slow, deep abdominal breath, expanding the belly, raising abdominal wall as the uterus rises. You want to expand the abdomen slightly less than full expansion.
3. Keep the abdomen expanded for the remainder of the contraction and continue to breathe with the diaphragm or with the chest in slow easy breaths until the contraction ends.
4. At the end of the contraction, exhale completely to lower the abdominal wall.
5. Take another cleansing breath.

M. Evaluation
1. Demonstrate an abdominal breath.
2. Demonstrate a deep chest breath.
3. Demonstrate what candle blowing is.
4. What is panting and what complication do you need to avoid?
5. What is the importance of understanding proper breathing and relaxation patterns?
Bibliography:


Warning Signals - When to Call the Doctor
or Get to the Hospital

Objectives: Following this presentation, the participants will:

1. Name eight symptoms during pregnancy that indicate the need to obtain medical help.
2. Differentiate between common discomforts of pregnancy and physical conditions that warrant seeking medical advice.
3. Name relief measures that can be taken when experiencing the common discomforts of pregnancy.

I. Introduction

A. During pregnancy your body goes through many physical changes.

B. Sometimes these physical changes can be confusing. You may experience a symptom that you feel you should not be having and you may wonder if you should be concerned or call the doctor.

C. Today, we are going to discuss conditions that you need to be aware of so that if you do develop a complication, you will know to notify the physician. Seeking early medical treatment could help avoid a serious complication.

II. Symptoms to Watch For

A. Vaginal bleeding

1. Some women do experience light menstrual bleeding
during pregnancy. All pregnant women experience an increased amount of vaginal discharge, in addition to a change in discharge consistency. Yet, all obvious signs of vaginal bleeding during pregnancy should be checked and monitored especially if the bleeding occurs during the last trimester.

2. If bleeding occurs early in pregnancy, it may be a sign of spontaneous abortion (or miscarriage). It is important, therefore, to get to the hospital quickly if the bleeding is more than light spotting.

3. During the last trimester (or the final three months) if bleeding occurs, it could be due to placenta previa or abruptio placentae. These long words can be serious complications and both are characterized by vaginal bleeding. Placenta previa means that the placenta is lying near the opening of the cervix. Remember that the placenta is attached to the uterine wall and supplies oxygen and nutrients to the fetus (infant). Placenta previa will cause bright red bleeding.

4. Abruptio placentae is characterized by the placenta separating from the uterine wall before delivery. Consequently, nutrients and oxygen are interrupted for the baby. Severe abdominal pain also occurs with this complication.

B. Pain while urinating

1. Pain or burning while urinating could indicate bladder or kidney infections.
2. Because the uterus is growing larger and heavier, it can exert pressure on the bladder which can impair lymph drainage and blood supply, leading to an increased susceptibility to infections.

3. Infections are harder to treat during pregnancy because you cannot usually take medication, since the effects may transfer to the infant.

4. Drinking four to five glasses of water daily may help to prevent or minimize bladder and kidney infections.

C. Abdominal Cramps or Persistent Pain

1. Early in pregnancy abdominal cramping may be a warning sign of spontaneous abortion. Late in pregnancy, abdominal cramping could indicate abruptio placentae.

2. Leg cramps may occur and these are considered normal. They occur due to pressure on the nerves leading to the legs. Immediate relief may be obtained by putting pressure on the front of the knee and pushing the toes upward.

3. Backache may also occur as a result of the uterus increasing in size and creating more strain on the back muscles and ligaments. When lifting, use the leg muscles and bend the knees to decrease strain on your back. Wear low-heeled shoes and maintain straight posture by keeping your shoulders back.

4. Again, you should report any pain that is persistent to the doctor or to the clinic nurses.
D. Severe constipation
1. Some constipation in pregnancy is normal and is caused by decreased peristaltic motion of the intestines from the weight and pressure of the growing uterus.
2. A daily diet consisting of fluids, fruits and vegetables will help decrease constipation. Daily exercise such as walking will also help (if not restricted by your physician).
3. Do not use enemas or laxatives. Many laxative labels state that the laxative should not be taken during pregnancy.
4. If you are having severe constipation, contact the doctor or clinic nurses.

E. Infection, fever, chills
1. Any type of infection should be reported to the physician, especially if you are running a fever.
2. Do not take any cold medications including aspirin before checking with the doctor.

F. Persistent vomiting
1. The exact cause of nausea and vomiting associated with pregnancy is unknown. The changes in the body's hormones and the change in the uterus size may play a role.
2. Some nausea and vomiting is normal and is expected. Suggestions that might help to make you more comfortable include:
   a. Half an hour before getting out of bed eat a