Hospital-based Birth Support for Women with Trauma: A Pilot Study of a Clinical Doula Program in the Netherlands

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Translated by Margie Franzen from the Dutch, "Hoe ervaren getraumatiseerde zwangeren de aangeboden zorg van een bevallingscoach? "

Abstract: Pregnancy and childbirth rank among life's most important events for both women and men. It can also be a stressful experience for women for whom birth in a teaching hospital is indicated, given existing risk factors. A history of trauma may be one of these risk factors. Women generally receive excellent information about medical conditions and their consequences in an academic hospital, but are often not kept abreast of standard hospital protocols. They must also negotiate the hospital's organizational structure and the frequent shift rotation of providers. Consequently, a busy obstetric unit is challenged to provide a woman and her partner with sufficient opportunity for

Catharina Ooijens is the first clinical doula in the Netherlands. Trained as a pregnancy yoga teacher and as a postural integration therapist with Jack Painter in the early 90's, she understood that emotional and complementary practice was needed in an academic center in addition to expected high-quality medical care. Her training with internationally approved Dona teacher Debra Pascali-Bonaro in 2009 inspired her to write a proposal in 2010 for the implementation of doula care in a hospital setting. Prof. dr. J.A.M van der Post, head of OBGYN at the Academic Medical Center in Amsterdam understood the value of doula research in the Dutch patient population. After being published in the Dutch Journal for Obstetrics and Gynecology in 2015, she was offered a full-time position as part of their obstetric team. She is a member and chairman of the accreditation commission of the Dutch Association for Doulas (NBvD). **Jannet Bakker** graduated as a midwife in 1979. During 18 years she worked as an independent midwife in a practice with mainly home deliveries in the Netherlands. There she developed interest in the physiology of childbirth and motivation to advocate the right of every woman to make autonomous decisions. She obtained a doctorate in the Faculty of Medicine of Amsterdam in 2013 with a thesis titled "studies on induced labor". At this moment she works as a clinical midwife and researcher, her main subject in research is prevention of unnecessary medical interventions. **Irene de Graaf** obtained a doctorate at the university of Amsterdam in 1999 with a thesis entitled " on first trimester Down syndrome screening". She graduated as gynecologist in 2005. She worked for 7 years as a general gynecologist. In 2012 she switched to the Academic Medical Center in Amsterdam to become a perinatologist. Her approach towards teaching resulted in an appointment as principal educator. Fields of interest are perinatology, pregnancy and psychiatry. She is a strong advocate of autonomy in childbirth and shared decision making.

individual personal and continuous support. A pilot study of continuous doula support within a high-risk obstetric unit in an academic hospital in Amsterdam, the Netherlands, examined how a doula might fulfill this need.

Keywords: birth support, doula, high-risk birth

A Cochrane review (Hodnett, Gates, Hofmeyr, Sakala, & Weston, 2011) comparing continuous support against standard care during labor resulted in 21 randomized trials spread over 11 countries and with a total of 15,061 women participants. In these studies, continuous labor support was provided by nurses, obstetricians, or birth doulas. Experience, qualifications, and relationship between support persons and the birthing woman varied, as did other aspects of the birthing environment. The review showed increased satisfaction in women after receiving continuous labor support as well as decreased use of pain medication and medical intervention. Such results indicate that continuous labor support should be the normal standard of care instead of the exception to the rule. It has been shown to be especially effective when provided by one person who is able to focus solely on the birthing woman and her partner.

Other studies have also advocated for continuous labor support. According to a satisfaction survey conducted by Marlies Rijnders (Rijnders et al, 2008), a researcher with the Netherlands Organization for Applied Scientific Research (TNO), one out of five have women — who were questioned shortly after their birth and who were in both low and high risk categories — remember their birth negatively. Like the Cochrane review, these results indicate both a need for clear language and transparency of how to deal with birth pain, with emphasis on the advantages of continuous support in labor.

The Project

The obstetric unit at the Academic Medical Centre (AMC), in Amsterdam, the Netherlands, provides high quality technical medical services for complicated pregnancies and deliveries, performed by professionals whose main focus is the standard care and medical management of potential problems. As such, the human aspect of birthing runs the risk of receiving less attention than what a *key life experience* deserves. In addition, women with a problematic health history or with a history of trauma (Emerson, 1998) often approach labor and birth tensely and fearfully.

In 2009, the AMC kicked off the initiative "What if It Were Your Mother? " Employees, hospital-wide, were able to submit proposals for how to improve the overall quality of care in the hospital. One proposal, by Catharina Ooijens (then employed as a secretary in obstetrics), suggested pairing a doula with women who had a history of trauma.

Though funding was too tight to support this particular initiative, the obstetric floor did recognize the importance of continuous and supplementary care for women and decided to move forward with a pilot study. The AMC funded the pilot study in order to gauge the effectiveness on women's satisfaction with their quality of care provided by the hospital. No study of the effectiveness of a doula for pregnant women with a traumatic background had ever been conducted in the Netherlands. We researched not only whether the doula is valuable to women, but also whether the doula is valuable to the obstetric team — specifically as a catalyst and model of client-centered care within an academic training environment.

Study Design

A pilot study design was chosen over a randomized-trial study due to financial limitations. Women with a history of trauma, a poor social-support network and an above-average fear for birth were selected to participate. Selection was based on the assessment of these criteria in conversation with the clinical obstetrician or gynecologist during the patient intake. The women were then referred to the pilot study.

For this pilot study, continuous labor support was provided by a doula. Catharina Ooijens, initiator of the pilot study, was also the person to provide doula care for the participants. She is a registered doula with the Netherlands Professional Association for Doulas (NBvD).

After the initial intake, each woman was offered two, two-hour consults at home or in the hospital in order to document her needs and wishes. The degree to which her requests could be accommodated was then examined and discussed. A summary of each conversation was documented in the birth plan and patient's file after the consultation with the care provider.

The consults promoted family-centered care, a model where a woman's closest support persons were involved directly in aid and support she received. During labor and birth, one of the doula's functions was to encourage and facilitate, where possible, active family participation so as to provide optimal support to the birthing woman. A birth doula imparts specific skills important for the one-to-one attention a woman receives during labor and birth. She listens empathetically to the patient's experience and fears, consoles and reassures the patient during the labor process and encourages a woman to believe and trust in herself. Other emotionally intelligent and empathetic skills are also important and include: caring for and helping others, safe-guarding a woman's birth space, and exploring the birth experience.

During the dilation phase of labor, a doula helps with breathing and relaxation techniques, physical comfort measures and pain management. Massage and touch, for example, relax tensed muscles after a contraction

and are known to increase oxytocin (Lund et al, 2002). The doula also ensures the birthing woman eats lightly and drinks periodically. She encourages her to change positions, reminds her regularly to empty her bladder and, if necessary, to use the shower as a muscle relaxer. During the entire labor a doula's choice of uplifting words verbally taps into a woman's confidence in her core strength. If needed, she verbalizes specific wishes that the mother has for care professionals and provides supplemental explanation to the parents about procedures or medically-indicated management of the birth.

Continuous support was also provided for the postpartum period during which the doula met with the woman at least once, though often several times. Goals for the postpartum visits included continuation of support and evaluation of the doula's presence during labor and birth.

Educational Goals

The pilot study project also included an educational component for medical students completing a two-week internship rotation in the obstetric unit. The doula held educational sessions for medical students, during which she communicated a clear image of what supplementary care is during birth. She also explained how they could facilitate elements of supplementary care within a standard care model. As a result, medical students felt they had concrete ideas for how better to support birthing women and were themselves better prepared for attending births in the delivery room. Insight into what students' learning and comprehension after the course was assessed by a short report in which each student was asked to explain to the training program coordinator what it means to "attend birth. "

Quote from an assistant's written report:

> Now that I've been with the woman in labor "as a person, " I felt like it was enough to just be there. Just being there, quietly holding her hand, chatting a bit and bringing her a glass of water. I feel a lot "better " as a person. After all was said and done, my power wasn't in my role as a "doctor-in-training, " but actually in the strength I have as the person I am. A person, who, coincidentally, is learning what you need to know in order to be a doctor. For me, I realize that personal care isn't only important for when I'm at birth in the future; it's also an insight that will help me for my entire career - to just be myself and to safeguard the calm every patient deserves.

Data collection

A questionnaire, developed jointly by the TNO and the NBvD, was send electronically to women six weeks postpartum. The questionnaire asked about the: progression of the pregnancy, background information (country of origin, age, educational level), the safety of mother and child during the birth, and the satisfaction with the doula's continuous supportive presence.

Space was left after each question for women's personal comments and explanation. Caregivers, doctors, nurses and obstetricians were also sent a questionnaire about what it had been like to work with a doula.

Results

From April, 2011, to April, 2013, 81 women received continuous care provided by a doula. Seventy-two women were sent the questionnaire; 67 responded.

Responders were of Dutch (65.7%), Suriname (22.4%), Moroccan (6%) or East-European (4.5%) descent. The women generally had a high level of education. Many had scientific training (22.6%). Women had higher professional education (48.4%) or a mid-level, applied education (24.2%). Only 3.2% had a lower professional educational level.

Women participants also had a history of trauma in their medical history (53.1%) or current social problems and/or a poor social network (18.5%). Women also had an above-average fear of birth (27.2%) and one woman was referred to the pilot program because of a maternal pathology and contraindications for pain medicine.

The questionnaire asked women about fear they had during birth. Most (73.1%) did not fear for baby's safety during birth. The remaining women (26.9%) felt fearful when they saw amniotic fluid with meconium, experienced decelerations of the baby's heart rate or when they felt the urge to push. Most women (85%) replied that they had not feared for themselves. The others (15%) admitted to fearing the possibility that the bladder might tear or that they might have intense nausea. Fear of pushing was also mentioned.

Most women (86.6%) agreed with the statement that every woman should have a doula with her during labor. The benefits of one-to-one, continuous care — rest and relaxation, reassurance, and better pain management (van der Gucht & Lewis, 2015) — were offered in support of this statement. Indeed, the participants' questionnaire answers valued how a doula provided for their care, protection and emotional wellbeing, otherwise known as *mothering the mother*. That said, women who agreed to have a doula present thought that this was a personal choice made based on the informative conversation that had taken place beforehand. Five women had no opinion on that matter. Out of the 67 respondents, 63

would use a doula again. The remaining four women were not satisfied with the doula and would not choose to have a doula again. One had a perinatal demise in her medical history that involved mourning and grieving that neither the referring provider nor the doula had accurately estimated. Two women had prepared for a VBAC and a normal physiological birth and were disappointed when a repeat cesarean section was performed. One other woman did not feel a comfortable personal connection with the birth doula and the decision for the doula to leave was mutually agreed upon.

Woman A

> When a hospital birth is obligatory because of a medical indication, it can lead to a lot of uncertainty and a whole lot of worry, first and foremost about the birth. I didn't have any idea about what to expect and I had the feeling I didn't have any control at all over the birth. I was under the care of various doctors, and a cardiologist, and an anesthesiologist, in the hospital. New developments kept coming up.
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> The doula's support let me see and trust that natural birth, without interventions, was indeed within my reach. It was definitely possible! That is what I had in the back of mind and it let me approach giving birth full of confidence.

Woman B

> We have quite a history (miscarriages, discontinued pregnancy after a diagnosis of Down's Syndrome) and the hospital staff doesn't always have enough time or space to devote attention to such things. That was especially evident with the medical students.

Woman C

> A doula is definitely not for everyone. In our case, though, it was good there was always someone there for us. But there were also times when the doula was more in the background, like when the doctors were making a decision that maybe didn't fit with one of the doula's ideas.

Multi-disciplinary Collaboration

A digital questionnaire was also sent to 50 randomly-selected care providers at the end of the pilot study. Of the nurses, obstetricians, gynecologists and medical students surveyed about "What went well and

what could go better? " Thirty employees who had worked with the doula were, in general, happy with the doula's care. Respondents remarked on how inspiring it was to see how the doula motivated the women to draw upon her own potential. A doula was also considered an additional asset to a busy obstetric unit in order to guarantee the continuity of personal care. Several care providers found that the doula shed light on another aspect of patient care. As such, there is staff that has started to think differently about the standard care provided.

In situations where an epidural was requested or where a woman's first cesarean section was performed, the patient had the option of using the doula and appeared to be satisfied with her care afterwards. From the staff's perspective, and in answer to the question of "What could be improved? " it was sometimes difficult for the doula to negotiate between medical indications and the client's wishes and needs. Some care providers' remarked on the questionnaire that they found it bothersome when the doula was involved in the medical care. Documentation in the medical chart was not always provided about which women had the doula or when to bring in the doula.

Conclusions and Recommendations

In conclusion, the doula, together with supplementary care, contributes to a more positive birthing experience for the client *and* those close to her. She also imparts a better understanding of patients' fears and needs during this vulnerable period to medical students completing a two-week rotation in the obstetric department.

Furthermore, a doula's continuous care is not only valuable to the birthing woman but also to a sometimes inherently busy and stressful environment in the high-risk obstetric unit. A point to consider here is documentation and delineation of professional roles.

Given the level of satisfaction (63 out of the 67 women participants would use a doula again), the obstetric unit has turned the doula into a fixed staff position. Considering high healthcare costs, it would be useful to perform a cost-benefit analysis of a clinical doula, in particular regarding the reduction of medical interventions and the mental health of mother and child.

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