



Doulas: An Alternative Yet Complementary Addition to Care During Childbirth

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The doula has evolved in recent years as a welcome and sometimes necessary addition to the health care team. Cost-cutting measures have increased provider-to-patient ratios, and perinatal technology has distanced nurses from the bedside of women in labor. Nurses rarely have the opportunity to stay with one woman throughout labor and birth. On the contrary, a laboring woman is the doula's sole responsibility. The word "doula" is defined as a person who is "in the service of" the woman in labor. Usually, a doula is self-employed and is hired by the laboring woman. As such, she is not restricted by allegiances to a facility or the medical establishment. Doulas are usually women who have had a baby and are able to empathize with another woman in labor.

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They understand the intimate nature of birth and provide the "softer, quieter, gentler, more sensitive nurturing qualities of 'mothering the mother'."¹ Most important, the doula stays with the woman throughout labor, beyond the confines of any shift, making the woman and her family feel cared for and never alone. Regardless of the response of the mother to labor, the doula is encouraging, provides comfort measures, and responds to each of the mother's differing needs. She explains and clarifies medical interventions, thereby decreasing the laboring family's anxiety. By her presence and comforting touch, the doula creates calmness and the essence of safety.¹

Historical Perspective

Historically, other women have attended expectant mothers at birth. Typically, it was one's mother and/or other older female relative who were present to assist. Studies by

anthropologists have found that in 98% of observed societies, an older woman was the birth companion.² Women have nurtured, comforted, and advised each other and have applied skills learned from their own birth experiences. Men were rarely a part of childbirth.

In the early 1900s in Europe and North America, birth moved from the home to the hospital, and many of these skills and techniques were lost in the medicalization of childbirth. Family members were barred from attending births. The traditional role of women at birth disappeared, and men, in their role as physicians, took over. Additionally, pain relief in the form of pharmacologic analgesia/anesthesia removed the laboring woman from the picture by leaving her asleep or out of control. Hours after birth, a nurse would bring a newborn that the mother could not remember delivering. The role of nurses had shifted from providing nurturing care to performing more highly valued medical tasks, often for more than one woman in labor.

The natural childbirth movement of the 1950s and 1960s resurrected interest in natural childbirth and the desire for a supportive companion during labor. With extended families no longer a key part of Western life, a nurturing female family member was unavailable, and women from the mother's community did not have the knowledge and experience of their own mothers. Grantley Dick-Read,³ one of the earliest proponents of childbirth education, wrote about effective ways to minimize childbirth pain. It was through his principle of the fear-tension-pain cycle that the benefits of preparatory education and support during labor gained interest. The father-to-be was advocated as the likely choice to provide this support.

In the 1960s, hospital policies did not routinely permit laboring women a companion. However, by the late 1970s, the concept of family-centered care was established, and an emphasis was placed on keeping a family together during the labor and delivery process. This meant that fathers were allowed in the

birthroom and, in some cases, even thrust into the role of "labor coach." Fathers began playing a major role in directing the laboring woman's "behavior." Experiencing the satisfaction of birth became a goal in itself for many families. It became apparent that father-supported childbirth, rather than being a negative event for hospitals and physicians who feared increased scrutiny, was actually positive—on the labor itself and on the remembrance of childbirth for the parents. In 1973, only 27% of hospitals were permitting fathers in the delivery room; by 1983, 79% of these hospitals encouraged fathers to participate in labor and delivery.¹

Though men have been increasingly present during childbirth, their role as the primary support person has been criticized. Research has shown that today, too much is expected of men at childbirth.^{4,5} Fathers find it difficult to be objective. The stress of seeing a loved partner in pain, anxious, making unaccustomed sounds, and exhibiting dramatic behaviors can be overwhelming. Anticipation, excitement, concern, anxiety, and fear all intermingle so that the father cannot remain emotionally detached enough to meet his own and the mother's needs.⁴ However, the father's presence is important for the emotional connection of the couple to each other and to the baby. Involvement of a doula can enhance the father's role during birth.^{1,6} The father is never left as the sole, isolated, responsible person caring for the laboring woman, a role he is sometimes ill-equipped to perform.^{4,7} Recognition and validation of the father's right and need to be present at the birth of his infant is not only compatible with but also enhanced by the presence of a doula.^{6,8} The doula provides support, reassurance, comfort, and information not only to the laboring woman but also to her partner, improving the birth experience for all involved.

STRESS PHYSIOLOGY

Whereas the physiologic changes and complications of pregnancy have been studied extensively, less attention has been directed

toward the impact of emotional stress on the mother and the outcome of pregnancy. The available evidence suggests that uncompensated stress may be linked with adverse birth outcomes.

The childbirth environment itself is stressful and elicits the stress response in the mother. Multiple factors contribute to creating stress, such as the unfamiliar hospital setting and staff. Two studies, reported by Keirse et al,⁹ found that a woman giving birth encountered an average of 6.4 unfamiliar professionals during labor; in a teaching hospital, as many as 16 people during 6 hours of labor were reported. In an environment like this, no one person can connect with the mother and provide the emotional stability necessary to cope with labor.

Common policies and procedures such as insertion of intravenous lines, restriction of fluid and foods, vaginal examinations, restriction of movement, fetal monitoring, augmentation of labor, epidural analgesia, and the possibility of an operative outcome all contribute to the stress response. The laboring woman is often left alone to deal with the fear and pain of labor and the anxiety induced by a mechanized clinical environment and multiple unknown attendants.⁹

The association between acute maternal anxiety and disturbances in the progress of labor has been suggested in studies of human and animal mothers.¹⁰⁻¹⁵ Circulating catecholamines may be the mechanism by which fear and anxiety influence the course of labor. The cycle of fear leading to increased myometrial tension and pain, thus creating more fear, was the basis of Dr. Grantley Dick-Read's childbirth education philosophy, and its alleviation is a major goal to help achieve a successful birth. Largely empirical at the time, his thesis has been used to explain the cause of conditions characterized by undesirable uterine activity.

Cortical arousal, hypothalamic activity, muscle tension, and endocrine functions are all closely correlated and are in a constant state of dynamic interaction to maintain or

restore equilibrium. Fear and stress cause the adrenal medulla to secrete epinephrine and norepinephrine. Kelly¹⁰ determined that these hormones, especially epinephrine, influence uterine activity in response to fear. Zuspan¹¹ advanced this work by finding that norepinephrine caused uncoordinated and ineffectual uterine activity, and epinephrine diminished uterine activity during both spontaneous and oxytocin-induced labor. Lederman et al¹⁴ found that women in active labor who reported anxiety had significantly increased levels of endogenous epinephrine, and these were associated with decreased contractile activity and longer labors. Further research found a relationship between measures of epinephrine, observed stress and anxiety scores, and fetal heart rate patterns, thus demonstrating the link to human fetal well-being.¹⁵

Pain and anxiety have been proven to be among the several influences that lead to endogenous release of catecholamines. A moderate amount of maternal stress during labor is desirable to stimulate the appropriate maternal and fetal adrenal cortical and adrenergic responses.¹⁴ In animal studies, the extent to which stress states during pregnancy or labor could lead to sufficient catecholamine release to reduce intervillous space perfusion is unclear. Lederman's findings support the hypothesis that under normal clinical conditions, several types of patient anxiety/stress are associated with increased catecholamine levels and that excessive anxiety and epinephrine are related to the increased duration of labor and adverse fetal conditions in the human mother. Use of stress-reduction techniques and modification of the childbirth environment could obviate the need for certain childbirth interventions, such as augmentation of slow labor. The doula, whose primary function is to decrease anxiety, create an environment of safety, and provide physical comfort measures during labor, may reduce catecholamine levels and, thus, facilitate normal uterine contractile activity, uterine blood flow, and fetal well-being. The

extent to which a supportive companion in labor can improve obstetric outcomes is seen in the studies described in this chapter.

RESEARCH: LABOR AND BIRTH OUTCOMES

In the 1970s, data on the beneficial effects of continuous labor support came from randomized, controlled trials of intermittent auscultation versus continuous fetal heart rate monitoring. The intermittent auscultation group required the nearly continuous presence of a project nurse, because fetal heart tones were auscultated every 15 minutes during the first stage of labor and every 5 minutes during the second stage of labor. Whereas there were no differences in infant outcomes between the two groups, the intermittent auscultation group had significantly fewer cesarean sections for fetal distress. Haverkamp et al^{16,17} postulated that the personalized nursing attention might have had a significant impact on the fetus.

The positive effect of labor support has also been noted in trials of active management of labor. The principles of active management were introduced in the late 1960s and include a definitive diagnosis of labor, early amniotomy and use of oxytocin if labor does not progress according to a predetermined schedule, and using one-to-one care with midwives. Of all the components in active management, continuous professional support is considered the most effective in reducing operative deliveries.^{1,18,19}

RESEARCH FROM GUATEMALA

The first randomized, controlled trial examining the effect of continuous labor support occurred in a busy, urban, Guatemalan hospital where women routinely labored alone.²⁰ In the study, primigravid women in early labor (cervix dilated 1–2 cm) and with no known medical problems were randomized to a control group or experimental group. The control group underwent the usual hospital routines of infrequent vaginal examinations, auscultation of fetal heart tones, and assistance for delivery. The experimental group underwent the usual hospital rou-

tines and, in addition, had the continuous support from admission to delivery of an untrained lay woman.

Support consisted of hand-holding, back rubs, conversation, and the presence of a friendly companion whom the mother had never met before. Women were removed from the study if any problem developed during labor, during delivery, or with the neonate, ie, need for oxytocin, operative delivery, meconium staining, or low Apgar score. To obtain 20 women in each group, 103 mothers had to be admitted to the control group, and 33 had to be admitted to the experimental group. Sosa et al concluded that significantly fewer problems occurred during labor, during delivery, and with the neonate when a supportive companion accompanied a woman in labor. They also found the mean length of labor was reduced by half when compared with the control group (8.7 hours vs 19.3 hours, respectively).

A second randomized, controlled trial was conducted at the same hospital using similar clinical conditions, with 249 women in the control group and 168 in the supported group.²¹ The duration of labor, need for analgesia, use of oxytocin, operative delivery, and neonatal problems were recorded. As in the previous study, Klaus et al found that fewer mothers in the supported group (27%) than in the control group (59%) had problems during labor, and the length of labor was 50% shorter (7.7 hours vs 15.5 hours, $P < 0.001$). There was also a significant difference in the use of oxytocin (13% vs 2%, $P < 0.001$) and the cesarean section rate (17% vs 7%, $P < 0.01$) between the control and supported groups. There was no significant difference in the incidence of meconium staining, low Apgar scores, use of analgesia, or operative vaginal delivery.

RESEARCH FROM HOUSTON

After the Guatemalan studies, questions remained about whether the positive effects of continuous labor support could be replicated in a United States hospital where electronic

fetal monitoring was used routinely and where epidural analgesia, artificial rupture of membranes, and oxytocin augmentation were frequently practiced. This led to the third randomized trial of continuous labor support conducted at Jefferson Davis Hospital in Houston, Texas, a public hospital that provides care for low-income patients.⁶ Companions were not routinely allowed during labor or delivery because privacy was problematic in a 12-bed labor ward. Furthermore, continuous labor support from staff was not possible because of the demanding obstetric caseload.

Nulliparous women with singleton, uncomplicated pregnancies who had a cervical dilatation of 3 to 4 cm were randomly assigned to a support group (n = 212) or observed group (n = 200). In the support group, trained doulas who were unknown to the laboring woman, were fluent in Spanish and English, and had themselves experienced a normal labor and vaginal birth, provided continuous labor support from admission through delivery. Women in the observed group received routine hospital care. The observer sat in the room, never spoke to the woman, and remained as inconspicuous as possible. After delivery, patients were asked to be in a control group (n = 204) if they had been admitted on days that doulas were at the hospital and if the chart indicated they met all enrollment criteria.

In this large teaching facility, residents used established obstetric protocols for medical interventions. All patients had an intravenous line and were confined to bed after admission to permit electronic fetal monitoring. Artificial rupture of membranes was performed after 5-cm cervical dilatation so that internal monitors could be placed if needed, and oxytocin was initiated after 1½ hours of stalled labor if uterine inertia was considered the cause or after 12 hours of ruptured membranes if cervical dilatation was less than 5 cm. Stadol or epidural analgesia was provided at the patient's request or if the medical or nursing staff thought the patient was unable to deal with pain as evi-

denced by vocalization, restlessness, or lack of cooperation between contractions.

Kennell et al⁶ found that the mean duration of labor was significantly shorter for the support group (7.4 hours) than for the observed (8.4 hours) and control (9.4 hours) groups. Among patients who had a spontaneous vaginal delivery, epidural analgesia was used significantly less frequently in the support group (7.8%) than in the observed (22.6%) and control (55.3%) groups. The control group also received the epidural earlier in labor than the support group did (6.2 hours vs 9.5 hours after admission). There was no difference across groups in the use of Stadol. Fourteen percent of women who had a spontaneous vaginal delivery in the support group required oxytocin compared with 37.4% of women in the control group. Significant differences also occurred with operative deliveries. In the support group, 8% of patients needed a cesarean section, whereas 13% of patients in the observed group and 18% of patients in the control group required the operation. The support group had significantly fewer forceps deliveries (8.2%) than either the observed (21.3%) or the control group (26.3%). This study was touted as the first demonstration in a technologically sophisticated United States hospital of a behavioral intervention that significantly reduced cesarean section rates, forceps deliveries, and need for oxytocin and epidurals.

OTHER STUDIES ON LABOR SUPPORT

The only other study to demonstrate such significant differences in obstetric outcomes took place in Botswana.²² In this setting, hospital policy prohibited companions during labor, and the shortage of midwives often resulted in laboring women being left alone for long periods of time.

Trials involving middle-class women^{23,24} who attended childbirth preparation classes and were accompanied during labor by family or friends did not demonstrate significant differences in length of labor or operative delivery rates. However, women in sup-

ported groups were significantly more likely to give birth without analgesia or anesthesia. Better staffing patterns, high intrapartum intervention rates (oxytocin and epidurals), and doula intervention occurring too late in labor may have confounded results.

Kennell and McGrath²⁵ found that middle-income women who were supported by a doula during labor had significantly decreased rates of cesarean section when compared with the control group. Among low-income women, there was no significant difference in cesarean section rates between the doula-supported and control group. In two other studies^{26,27} in which support was provided on an intermittent basis, companionship had no measurable effect on obstetric outcomes.

RESULTS OF META-ANALYSES

Three meta-analyses²⁸⁻³⁰ have evaluated the effects of labor support on obstetric outcomes. Findings indicate that continuous support significantly decreases the use of analgesia and oxytocin, shortens the length of labor, and decreases operative births. Scott clarifies that these outcomes are confined to studies in which the provision of continuous labor support is compared with no labor support. In trials in which intermittent labor support is provided, there are no significant differences in obstetric outcomes when compared with the controls with no support.

SUMMARY OF THE RESEARCH

The most positive effects of labor support on obstetric outcomes were observed in the Guatemala, Houston, and Botswana studies. In each of these trials, the clientele were young, nulliparous, disadvantaged, urban women whose labor and birth took place in crowded labor and delivery units that lacked privacy and restricted visitors. Women were often left alone for long periods of time because of the demands of the obstetric caseload. The fear associated with labor in a first-time mother cannot be underestimated. The presence of a continuous supportive com-

panion appears to make the hospital environment less stressful, and decreasing maternal anxiety and catecholamine levels promote more efficient labor. In hospitals where women are generally accompanied during labor by family and/or friends, the benefits of labor support may not be as striking.

Whether it is the role of the support person as comforter or protector that leads to better obstetric outcomes is still unanswered. The mere presence of a support person or an observer may encourage less medical intervention by altering staff behaviors.^{6,22,31}

Scott's meta-analysis highlights the importance of continuous support in labor, but this support does not need to be provided by medicine or nursing. The cost alone would be prohibitive. Several studies have shown that the partner, family members, and doulas can all provide the support necessary to lead to better or equivalent obstetric outcomes.²²⁻²⁴

Perhaps the greatest lesson to be learned from these studies is that the laboring woman, not hospital policy, should decide who should be present for labor support. It is possible that a combination of people may be best. Ultimately, it should be left up to each woman as to who, when, and how much support is needed.³²

Doulas and Their Support Techniques

The key components of support in labor have been variously described and are applicable to any labor attendant.^{9,34-40} Doulas use these components to the largest extent because they are continuously present and have no other responsibility to the labor and delivery unit. Support techniques are placed into four major categories:

1. Emotional support: constant physical presence, words of affirmation, calm reassurance, encouragement and praise, eye contact, mental distraction, role modeling for the father/significant others.

2. Advice and information: discussion of events as they unfold, explaining obstetric interventions, coaching in patterned breathing and relaxation techniques—neuromuscular dissociation or progressive relaxation, imagery, meditation, attention focusing.
3. Tangible assistance/physical comfort measures: hands-on activities such as deep or superficial touch (effleurage), massage to legs, feet, and hands, hydrotherapy—bath or shower, application of heat/cold, fluids and food, positioning and assistance with ambulation, provision of a comfortable environment—lighting, pillows, and room temperature, support during second-stage pushing efforts.
4. Advocacy: support of decisions, asking others to respect them, conveying to the woman the centrality of her role in decisions, encouragement for asking the “right” questions of care providers.

The initial support begins prenatally when the doula makes a home visit and learns what the expectant mother wants for her birth experience.⁴⁰ In preparation for labor, roles of the expectant father/primary support person or other family/friends are clarified. Stress-relieving measures are explored, and breathing and relaxation techniques learned in childbirth preparation classes are reviewed with the mother. If the first encounter with the woman is at the hospital during early labor, this same information is explored and helps establish rapport with the laboring woman and her partner. By learning the woman’s goals for the birth, the doula becomes her advocate, communicating and interpreting the mother’s desires to care providers during labor. Long-term satisfaction with the birth experience appears to be related to the fulfillment of these prelabor desires and goals.³⁵

Women respond differently to the process of birth. For some women, the challenge of birth is integrally related to their self-esteem and self-concept. They are able to trust their own bodies and allow the process of birth to unfold naturally. These women cope with pain as a natural part of birthing. This takes time, patience, and com-

mitment by the woman, her family, and her birthing attendant.^{34,39,40}

Other women find pain to be frightening or unbearable. Without adding her own agenda, the skilled doula assists parents in making informed decisions regarding pain-management options, and may also help the mother make adjustments to earlier goals if unexpected demands or complications arise. For an individual mother, prelabor decisions may include acceptance of an epidural analgesic.

When assisting the mother during difficult labor, confirming the reality of pain in labor and the difficulty of dealing with it may be more helpful than a suggestion of pain medication. This may be particularly important when the mother’s prelabor goals include an avoidance of pain medication if at all possible. Various manifestations of touch have been found to be particularly therapeutic as a comfort measure and as a way to transmit a sense of safety. Accelerating anxiety, such as that occurring during transition, seems to increase the need for physical contact. Touch can be effective in maintaining control during this time.^{39,41} Additional reassurance, a change in position or activity, and eye-to-eye contact with the doula may be enough to bring a woman who is reaching the limits of her control back to a place where she begins to feel more confidence in her ability to work through her labor. The provision of pharmacologic pain relief should be offered primarily based on prelabor wishes, the response of the mother to take-charge support techniques, and also on how much longer the labor is expected to take.³⁵

Support persons also need the benefit of doula support. Without encouragement, significant others, particularly fathers, have been shown to retreat. Bertsch⁴ found that as labor intensifies, the father touches the mother less and spends an increased amount of time out of the room. The doula increases her touching and massage, stroking, talking, and eye contact as labor intensifies (75% of the time vs 13% of the time for fathers). The

doula supports the partner by verbalizing what is happening, assuring the family of the normalcy of what they are witnessing, and encouraging positive support. By words and actions, the doula models behaviors and attitudes that can be replicated by the father and/or other support persons. In regard to the desire of the partner to “do something,” the doula suggests concrete supportive tasks that help the laboring woman.

Not all mothers are part of an intact nuclear family or have supportive extended family to attend them during labor. When a mother’s social structure does not include adequate supports, the beneficial effects of doula support may be especially important. The Guatemala and Houston studies demonstrated the positive effects of continuous support among indigent women who labor alone. More recently, the Chicago Health Connection Doula Project (1998) showed how support to minority, low-income, unwed, teenage mothers could achieve similar results of a decrease in cesarean section births, a decrease in the need for epidural analgesia, and an increase in the initiation and continuation of breast-feeding.⁴² This project demonstrated a team approach between medical personnel and doulas that resulted in successful birth outcomes in a group often classified as high-risk. Additionally, the SEAD Project (support, empowerment, advocacy, and doulas) has recently begun in the Albuquerque, New Mexico area. The focus of this project is to increase access to health care and to fill the need for quality medical interpreting, culturally competent health information on childbirth, breast-feeding, and early parenting issues, and emotional support during pregnancy, labor, and delivery for women with limited English-speaking capabilities. During the first year, the project will work with Vietnamese and Spanish-speaking women from the community who will be trained as both doulas and as medical interpreters. The goal is to increase the number of women with limited English-speaking capabilities receiving prenatal and parenting education and to increase the capacity of hospitals and health systems to have multilingual and

multicultural services available for women before, during, and after childbirth. The benefits of doula support in the United States may be most dramatic in these populations in which the comfort, support, and education that a doula can provide may be an important supplement to the medical and technical focus of care providers.

POSTPARTUM BENEFITS

The benefits of doula support extend beyond labor and birth to improved postpartum and neonatal outcomes. Support during labor has been associated with improved mother–infant attachment, successful breast-feeding, and decreased incidence of postpartum depression.^{29,40,43,44} The nurturing received during labor may be internalized by parents as a model for infant care.

Hodnett,²⁹ in a meta-analysis from the Cochrane Library, noted that supported mothers were more positive about their birth experiences and demonstrated more smiling, talking, and stroking behaviors towards their infants. Hofmeyr⁴⁰ found a higher proportion of breast-feeding in the doula-supported mothers that persisted to 6 weeks postpartum (51% vs 29% in the unsupported group). Supported mothers also reported fewer feeding problems (16% vs 63%). In mothers who were “mothered” by a doula during labor, emotional bond formation took 2.9 days versus 9.3 days in the unsupported group. These mothers were less anxious, had lower scores on a depression scale, and had higher levels of self-esteem. Further, these mothers felt more satisfied with their partners at 6 weeks postpartum (77% vs 30%). This has been called a “halo” effect.³⁷ With doula support, couples experience emotional success in birth and feel nurtured while learning to care for their new baby, building a foundation of confidence.

Wolman et al⁴³ found that doula-supported mothers “were more positive on all dimensions involving specialness, ease, attractiveness, and cleverness of their babies.” As op-

posed to women in the control groups, women supported by doulas felt that they could take care of their babies “better than anyone else.” Another study⁴⁴ confirmed that women supported by doulas during labor were less helpless in infant care-giving activities than those who had childbirth education classes alone. Orenstein observed that mothers showed less emotional distress, greater security and self-esteem, and also felt their babies were less fussy. “To explain the pronounced and persistent effects on feelings and actions of a relatively short-lived intervention, we need to accept the premise that labor is a time of unique sensitivity to environmental factors and that interactions in labor may have far reaching and profound psychological results.”⁴³

Breast-feeding success is another key outcome of doula support. Today, discharge from the hospital occurs even before the mother’s milk comes in. After the excitement of the birth, the trip home can be lonely, overwhelming, and exhausting. Traditionally, older, experienced female relatives provided support and practical assistance. The doula is in the unique position of providing continuing support for new mothers within the comfort of the home. Whether the doula performs these postpartum duties or the extended family and friends are mobilized to help, support in the early postpartum period can be a key factor in achieving a satisfying breast-feeding experience and a smooth transition to successful parenting.^{33,45}

The continuing nurturance of the doula in the postpartum period can offer more than the “how-tos” of breast-feeding. The doula can provide an opportunity for the mother to process a difficult childbirth experience, thereby improving her self-esteem. During home visits, anticipatory guidance regarding physical and emotional readjustment after the birth can be provided, as well as watchful attention for the signs of postpartum depression.³³ Some postpartum programs include massage, help with the dishes, and care of the infant while the mother takes a

much-needed nap. A range of activities can be performed by the doula so that the mother feels cared for and, in turn, can focus on the needs of her newborn.

Doula Training and Certification

By its very nature, the training of a doula draws on the individual’s own experiences and expands on these with additional skills to enable support of a childbearing woman. At the present time, no consensus exists on the specifics of training. Most basically, doula training focuses on the provision of physical and emotional support, and also the basics of pregnancy, childbirth, and the postpartum period. Training generally has a didactic component and an apprenticeship with an experienced doula. Most doulas-in-training are also required to attend a series of childbirth education and lactation classes.^{37,46}

Various organizations have evolved to support and monitor doula services. The oldest national program that trains and certifies doulas is the National Association of Childbirth Assistants located in San Jose, California. This organization also supports women who wish to create doula training programs in their own community, and it also has a national referral system. Doulas of North America is a relatively new (1992) international umbrella organization based in Seattle, Washington. Its purposes are to certify doulas from diverse backgrounds and to establish standards of safe, responsible labor support and care. It also seeks to promote and publicize the concept of labor support to both the medical profession and the public. In addition, the International Childbirth Education Association provides for doula certification as one of its many programs. These and other organizations may be reached through the Internet, where more than 500 other resources exist for doula information and referral. Doulas can be con-

tacted through childbirth education programs, obstetric providers, or prenatal care organizations. Women who seek training find it to be a satisfying addition to their lives, because they are able to contribute to a positive experience of another woman. The next section is an example of a doula training program.

Pam England in Albuquerque, New Mexico started the Art of Birthing Doula Training program in 1993. She has published a book, *Birthing From Within*,³⁷ which advocates a different method of childbirth preparation from traditional approaches that focus on the process of labor and delivery and breathing/relaxation techniques. The concepts of this preparation are beyond the scope of this chapter, but it was through her unusual focus that she found doula support to be so vital to success in achieving a satisfying childbirth experience. The doula program involves 4 months of training, extensive reading, and it begins with 3 days of education in prenatal, labor and delivery, and postpartum topics. This is followed-up by six seminars, each 3 to 4 hours in duration, in which the participants select and present topics thought to contribute to their effectiveness as doulas. Student doulas attend a series of childbirth education classes and a breastfeeding course. Each student apprentices with an experienced doula for 10 births and attends six prenatal and six postpartum visits. Additionally, each student is required to present three community talks to increase awareness of doula services and to complete a project that will have practical value to other doulas or expectant/postpartum mothers. Doulas have been accepted wholeheartedly by area hospitals because they are on-call at a moment's notice. Doulas have been especially helpful to women who are alone or who find labor extremely difficult to cope with. The extensive training model from Pam England is being adopted elsewhere. Through this program, an interested mother can preselect a certified doula by attending an introductory tea or by contracting with a doula through the Art of Birthing Center.

Services include a prenatal visit, support during an entire labor and delivery, and postpartum visits.

Across the country, programs have evolved with diverse approaches to doula preparation, methods by which expectant mothers can contract with a doula, ways to handle payment for services, and connections with hospitals and care providers. Compensation for doula services by Health Maintenance Organizations and other insurance plans may be a future consideration as the positive benefits become more widely recognized. The basic function of the doula, however, remains the support of the mother, regardless of her personal circumstances or those of the care setting. "The doula starts out developing a trusting relationship. Soon she becomes a quiet and calming presence. As labor progresses, she moves to a more intense, stronger, nurturing role, pacing herself according to the mother's needs and the power of the birth process itself. Her own role with each mother has a developmental aspect and ends with a close tie—a shared moment in a woman's and a family's life."¹

Conclusions

The concept of support in labor is not a new one. During the past century, the practices surrounding childbirth have changed dramatically from woman-supported birth in the home to a highly medicalized process in a hospital setting. The needs of women, however, have not changed. They still need a sense of safety, acceptance, freedom from fear, and the presence of a supportive companion throughout labor and birth. The nurse, midwife, and physician are often unable to be that support person. Fathers/partners or family members may not be equipped to provide this essential support. The doula has been introduced as an answer to this need. Studies from hospitals in developing countries that have restrictive visitation policies, crowded labor wards, and poor staffing have demonstrated significant physical and psychologic benefits of doula support. Many of the same results, al-

though less dramatic, have been achieved in Europe and North America, where family visitation is more liberal and birth environments are less stressful. Whether hospitals implement a doula program or make adjustments in how nursing care is provided during labor, it is clear that human companionship has beneficial effects on the outcome of labor and early parenting. In the words of Marshall Klaus, "... if I had told you today about a new medication or a new electronic device that would reduce problems of fetal asphyxia and the progress of labor by two-thirds, cut labor length by one-half, and enhance mother-infant interaction after delivery, I expect that there would be a stampede to obtain this new medication or device in every obstetric unit in the United States, no matter what the cost. Just because the supportive companion makes good sense does not decrease its importance."⁴⁷

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