

ONLINE NIGHT 2 · 5-30 PM: 8-00 PM CST

Labor, Birth & When Things Get Complex

Mary's Hands Network

*ICEA Certified Birth Doula
Hybrid Training*

Learning Objectives

- Know the stages and phases of labor
- How your calm helps labor hormones
- The Six P's: what moves labor along
- Why doctors start or speed up labor
- Your role when she gets an epidural
- How to show up when birth becomes loss

SECTION ONE

Stages & Phases of Labor

*Birth doesn't unfold in neat boxes: it flows like a river.
Our job is to help families navigate it.*

Four Stages. Three Phases. One Common Confusion.

This distinction is tested on the ICEA certification exam, and it matters in the clinical setting.

Four Stages of Birth

- Stage 1: Labor (0-10 cm dilation)
- Stage 2: Pushing & birth (10 cm to baby born)
- Stage 3: Placenta delivery
- Stage 4: Recovery: the Golden Hour

Stages have distinct start/end points. Clinical language.

Three Phases of Stage 1

- Early/Latent phase (roughly 0-6 cm)
- Active phase (roughly 6-8 cm)
- Transition phase (8-10 cm)

Phases flow into each other gradually: like a dimmer switch, not on/off.

Early / Latent Labor

The longest phase, and often the hardest to support because it can last hours or days.

What's happening

- Cervix softens, thins, opens
- Dilation: 0-6 cm
- Contractions: 30-45 sec, 5-20 min apart
- Manageable at home
- Nesting burst common
- Duration: 8-24 hrs (first babies)

Early / Latent Labor

The longest phase, and often the hardest to support because it can last hours or days.

Doula Script

You're in early labor: this is the real deal. Best thing now: rest, eat something light, let your body work. Don't time every contraction yet. Sleep if you can. Call me when they're regular and you have to focus through them.

Your job: save her energy. Keep her home as long as it's safe. The wait is normal.

Prodromal Labor

Real contractions. Real pain. No measurable cervical progress: yet. One of the hardest things to support.

What It Is

- Real painful contractions, but the cervix isn't changing
- Hospital may send her home: that's hard
- Baby may need to move. Cervix may need more time.
- Sometimes fear is holding labor back

Doula Script

I know this is so frustrating. These contractions are real. They hurt. You've been at this for hours. But your body IS doing the work: softening your cervix, helping baby move. Every contraction matters. Let's focus on rest.

Active Labor: When Things Get Real

She can no longer talk through contractions. This is when she needs you most.

What's happening

- Dilation: 6-8 cm
- Contractions every 3-5 min
- Talking stops, coping begins
- Hospital typically admits now
- Average 1-2 cm/hour
- Client turns inward

Active Labor: When Things Get Real

She can no longer talk through contractions. This is when she needs you most.

Clinical Note: The ACOG 2014 Update

Active labor starts at 6 cm: not 4 cm like the old rule. ACOG changed this in 2014 to cut down on unneeded C-sections. If a doctor says she's 'not in active labor,' ask: is the cervix changing at all?

Your doula role

- Continuous presence: don't leave the room
- Breathe and move with her
- Counter-pressure. Change positions every 20-30 min.
- Coach the partner: quiet, calm, hands-on

Transition: The Peak

Shortest phase. Most intense. Your anchor matters more here than anywhere else.

What it looks like

- Dilation: 8-10 cm
- Contractions every 1-3 min
- Shaking, nausea, vomiting
- "Labor land": altered state
- Duration: 20-90 minutes
- "I can't do this" = almost there

Transition: The Peak

Shortest phase. Most intense. Your anchor matters more here than anywhere else.

Doula Scripts: The Transition Anchor

You ARE doing it. Right now. This is the hardest part, and you're already in it. Look at me. Breathe with me. One contraction at a time. Just this one.

When she says “I can’t do this”:

I hear you. And you ARE doing it. This is transition: which means you're almost there. Your baby is almost here.

Stage 2: Pushing & Birth

10 cm to baby in arms. A rush of relief or the hardest work yet.

What's happening

- Full dilation → baby born
- Duration: 30 min: 2 hrs
- Urge to push = intense pressure
- Fetal ejection reflex may occur
- "Ring of fire" at crowning
- Many positions valid

Stage 2: Pushing & Birth

10 cm to baby in arms. A rush of relief or the hardest work yet.

Your doula role

- Hold her leg or support her position
- Breathe with her if she panic-pushes
- Coach the partner: where to stand, what to say
- Dim the lights. Keep it quiet.

Doula Script: At Crowning

You're almost there. Baby's head is right here. Slow breath: just breathe your baby out. A few more pushes and you'll meet them.

Stage 3: The Placenta

The only organ the body grows for nine months, and then releases.

What's happening

- Birth → placenta delivery
- Duration: 5-30 minutes
- Uterus expels placenta
- Signs: blood gush, cord lengthens
- Physiological or active management
- Retained >30 min → alert provider

Stage 3: The Placenta

The only organ the body grows for nine months, and then releases.

Clinical Note: Delayed Cord Clamping

Wait 30-60 seconds (or until cord stops pulsing: 3-5 min) before clamping. Gives baby up to 30% more blood. Lowers anemia risk. Push for this in the birth plan.

Your doula role

- Mom is focused on baby: YOU watch for bleeding
- Remind her: a few more pushes
- Speak up about cord clamping timing
- Start protecting the Golden Hour now

Stage 4: The Golden Hour

You are the guardian of this time. Your job is to protect it.

Why it matters

- First 1-2 hours: bonding window
- Oxytocin floods from skin-to-skin
- Prolactin → milk production
- Endorphins → "birth high"
- Stabilizes baby temp + HR
- Don't interrupt the physiology

Stage 4: The Golden Hour

You are the guardian of this time. Your job is to protect it.

Doula Scripts: Protecting the Hour

To staff: 'Anything that HAS to happen right now? Or can we give them uninterrupted time first?'

Routine procedures that CAN wait

- Weight and measurements: 1-2 hrs
- First bath: up to 24 hrs (vernix protects skin)
- Eye ointment & Vitamin K: up to 1 hr
- Newborn exam: can be done on parent's chest

Doula Task Mapping

In the chat, drop your answer: You've just arrived at the hospital with your client. She's 5 cm. Thirty minutes later she's still 5 cm. Two hours after that she's 7 cm and shaking. What's your doula role at each of those three moments, and what changes?

Discuss with your group:

- What changes about your role from early labor through transition?
- What does “continuous support” actually look like hour by hour?
- When is silence more supportive than talking?

SECTION TWO

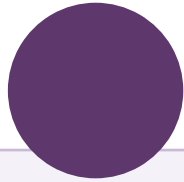
The Hormonal Symphony of Labor

Labor doesn't start in the uterus. It starts in the brain.

The body releases hormones only when it feels safe, supported, and undisturbed.

The Labor Hormones: An Overview

Your calm presence isn't just emotional support: it is hormonal support.



Oxytocin

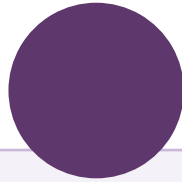
The Love Hormone

Triggers and sustains contractions.

Released by touch, warmth, and safety.

Pitocin is its synthetic

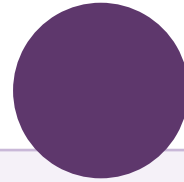
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Endorphins

Natural Pain Relief

Rise with contraction intensity. Create “labor land.” Blocked when adrenaline rises.

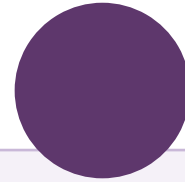


Adrenaline

The Fear Response

Slows labor when threat is perceived.

Cold, bright lights, fear trigger it. Your job: keep it low.



Prolactin

The Mothering Hormone

Spikes in the Golden Hour. Prepares for milk production and shapes the transition into parenthood.

Oxytocin: “The Love Hormone”

Your calm, warm, reassuring presence is not just emotional support: it is hormonal support.

- Triggers and sustains uterine contractions throughout labor
- Released in response to touch, eye contact, warm skin contact, dim lights, and feeling emotionally safe
- Pitocin is synthetic oxytocin: same molecule, but without the endorphin co-release or physiological feedback loop
- Drops sharply when a person feels afraid, observed, or unsafe: labor can stall or slow
- Floods the body during skin-to-skin after birth: drives bonding and helps the uterus contract to reduce bleeding

Clinical Note: What This Means for Your Role

A big 2017 review found doula shorten labors and lower C-section rates. How? You make her feel safe → adrenaline drops → oxytocin can do its job. That's the science behind your presence.

Endorphins: The Body's Own Pain Relief

“Labor land” is endorphins doing exactly what they’re supposed to do.

- Beta-endorphins are natural opioids produced by the brain: structurally similar to morphine
- Rise progressively with contraction intensity: the body self-medicates as labor gets harder
- Create the dissociative, time-altered state known as “labor land”: this is protective, not pathological
- Responsible for the “birth high”: the wave of euphoria that floods the body immediately after birth
- Suppressed when adrenaline is high: fear, cold, bright lights, and feeling observed block endorphin action
- Epidurals block the pain but also block the endorphin rise: your emotional role remains essential

Adrenaline: The Fear Response

A late-labor surge of adrenaline is normal and gives energy to push. Chronic fear-driven elevation stalls labor.

What it does

- Body's threat-response hormone
- Triggers fight-or-flight
- Suppresses oxytocin directly
- Blocks endorphins → pain up
- Late-labor surge is normal
- Chronic fear stalls labor

Adrenaline: The Fear Response

A late-labor surge of adrenaline is normal and gives energy to push. Chronic fear-driven elevation stalls labor.

What Triggers Adrenaline in Labor

- Bright lights and cold rooms
- Loud voices, too many people, lack of privacy
- Fear of birth, of pain, or of the unknown
- Prior birth trauma or medical trauma
- Being observed or interrupted while coping
- Feeling that something is wrong or is being hidden

Doula intervention: Dim the lights. Lower your voice. Reduce foot traffic. Create safety. Every environmental adjustment you make is a hormonal adjustment.

Prolactin: The Mothering Hormone

Prolactin thrives in quiet, undisturbed bonding time. Protect it.

- Primary function: initiates and sustains milk production after birth
- Spikes dramatically in the first hour after birth: highest levels occur during the Golden Hour
- Stimulated by nipple stimulation and skin-to-skin contact with the baby
- Also plays a role in shaping the transition into parenthood: drives attentiveness and responsiveness to baby's cues
- Disrupted by formula supplementation without medical necessity in the early hours
- Thrives in the same conditions as oxytocin: dim light, quiet, undisturbed skin-to-skin

Clinical Note: Your Role in the Golden Hour

Every routine procedure you delay, every visitor you redirect, every quiet moment you protect is directly supporting prolactin. You are not being difficult. You are protecting physiology.

BREAK

6-20 PM: 6-30 PM · 10 minutes

*Step away, stretch, hydrate, reset.
Back at 6-30 PM: Six P's and Induction.*

SECTION THREE

The Six P's of Labor

Labor progress depends on six factors working together.

Think of them as gears in a machine: if one is off, all of them feel it.

The Six P's: What Drives Labor Progress

Your continuous presence addresses all six simultaneously.

Powers

Strength, frequency & coordination of contractions. Involuntary in Stage 1; voluntary pushing added in Stage 2.

Position

The birthing person's position during labor. Upright and mobile positions optimize all other P's.

Passage

The bony pelvis and soft tissues (cervix, vagina). Shape, size, and opening all matter.

Psyche

Emotional state. Fear slows labor. Safety speeds it. This P responds most directly to your presence.

Passenger

The baby: size, position, and how well the head can flex and rotate to navigate the pelvis.

Provider

The support team dynamic. Communication, trust, and shared decision-making all affect progress.

Powers: The Contractions That Drive Labor

You cannot make contractions happen. You can only create the conditions that allow them to work.

Stage 1: Cervical dilation

- Involuntary: uterus self-contracts
- Frequency, duration, intensity
- Goal: 0 → 10 cm
- Adequate: every 2-3 min, 60-90 sec

Stage 2: Pushing

- Voluntary bearing-down effort added to involuntary contractions
- Fetal ejection reflex: body pushes spontaneously: support this when possible
- Evidence favors waiting for the urge vs. directed “purple pushing”

Powers: The Contractions That Drive Labor

You cannot make contractions happen. You can only create the conditions that allow them to work.

Clinical Note: Inadequate Powers

When contractions are too weak, too far apart, or poorly coordinated, the cervix may not dilate despite hours of effort. This is one reason augmentation with Pitocin is recommended. As a doula, you may notice this before anyone says anything: contractions you can barely see from across the room, long gaps, no reported progress.

Doula role

Optimize the environment for oxytocin. Position changes to encourage descent.

Emotional support to keep adrenaline low.

Passage & Passenger: Pelvis & Baby

The passage is the road. The passenger is who's traveling. Both have to cooperate.

Passage: The Bony Pelvis

- Multiple pelvic diameters to navigate
- Gynecoid shape most favorable
- Soft tissues must soften
- Position optimizes entry angle
- Squatting opens outlet up to 28%

Passage & Passenger: Pelvis & Baby

The passage is the road. The passenger is who's traveling. Both have to cooperate.

Passenger: The Baby

- Baby's size, position, and ability to flex and rotate affect progress
- Ideal position: occiput anterior (OA): baby faces mother's back
- Baby must flex chin to chest, rotate, and extend to emerge
- Cardinal movements: engagement, descent, flexion, internal rotation, extension, external rotation
- Baby is not passive: position changes help baby find the optimal path

Position & Psyche: The Two You Control Most

Of all six P's, position and psyche respond most directly to what a doula does.

Position: The Birthing Person

- Most modifiable P: change every 20-30 min
- Upright uses gravity
- Hands-knees relieves back labor
- Side-lying conserves energy
- Walking, swaying, stairs
- Movement matters most

Position & Psyche: The Two You Control Most

Of all six P's, position and psyche respond most directly to what a doula does.

Psyche: The Emotional State

- Fear, anxiety, and trauma history directly affect hormone balance
- The fear-tension-pain cycle: fear → tension → more pain → more fear
- Your presence, voice, and calm lower adrenaline
- Informed clients cope better: knowledge reduces fear

Doula Script: Psyche Check-In

"I'm right here. You're doing great. Tell me what you need right now."

Provider: The Team Dynamic

The quality of the birth team relationship is a clinical variable.

How Provider affects labor

- Trusted team → less fear
- Clear communication → less adrenaline
- Rushed care → cortisol up
- Supportive nurse = force multiplier
- Bridge: never undermine

Provider: The Team Dynamic

The quality of the birth team relationship is a clinical variable.

Cochrane Review: All Six P's Connected

The 2017 Cochrane Review: continuous support leads to 25% fewer cesareans, 10% less pain medication use, and labors averaging 41 minutes shorter. The mechanism: doulas address all Six P's simultaneously.

How doulas address all Six P's

- Powers: optimize the hormonal environment
- Passage: encourage position changes and relaxation
- Passenger: use positions to help baby navigate
- Position: continuous, frequent movement
- Psyche: your entire presence addresses this
- Provider: bridge communication, foster collaboration

SECTION FOUR

Induction & Augmentation

Induction starts labor. Augmentation speeds it up.

Your job is to help families make informed decisions: not to make the decision for them.

Induction vs. Augmentation

Think breast augmentation: you already have some, now you have more. Labor augmentation is the same idea.

Induction: Starting Labor

- Body is not yet in labor
- Methods used to GET labor started
- Going from zero contractions to active labor
- Requires cervical readiness (Bishop Score)
- May need ripening before Pitocin can work

Augmentation: Strengthening Labor

- Labor has already started
- Contractions are too weak, too far apart, or stalled
- Methods used to strengthen or speed up what's there
- Most common: Pitocin drip or AROM
- Does NOT mean something is wrong: often a normal part of labor

Why Induction Is Recommended

Medical and elective inductions require very different preparation conversations.

Medical Indications

- Pregnancy past 41-42 weeks (post-dates)
- Water broke but labor hasn't started (PROM)
- Preeclampsia or dangerous blood pressure
- Baby not growing adequately (IUGR)
- Gestational diabetes with concerns
- Other health concerns for birthing person or baby

Elective Induction

- Scheduling or partner availability
- Distance from hospital
- History of fast labors
- Not recommended before 39 weeks without medical reason

Clinical Note: The Bishop Score

Providers assess cervical readiness with the Bishop Score (dilation, effacement, consistency, position, station). Score 8+ = favorable for induction. Lower = cervical ripening first, and induction may take 12-24

hours before active labor begins

Induction Methods: At a Glance

Cervical ripening comes first if the cervix isn't ready. Pitocin cannot do its job on an unripe cervix.

Method	What It Does	Your Doula Role
Cervidil / Cytotec	Prostaglandins soften & thin the cervix. Cervidil = removable insert. Cytotec = pill. Usually overnight.	Normalize the long wait. Keep her comfortable. Encourage rest: this phase can take 12+ hours before Pitocin even starts.
Foley Bulb	Balloon inflated on both sides of cervix to press it open. No medication. Falls out around 3-4 cm.	Warn her it feels like strong pressure. Help her breathe through insertion. Once placed she can usually walk.
Pitocin (IV)	Synthetic oxytocin IV drip. Starts low, increases until contractions every 2-3 min. Continuous monitoring.	Pitocin contractions can be stronger than natural ones. All comfort measures still apply. Use the bed and peanut ball strategically.
AROM	Amniotomy: provider uses a small hook to rupture membranes. Speeds labor in active phase.	Reassure her the warm gush is normal. Fluid keeps coming. Help her change pads as needed.

The ARRIVE Trial: What the Evidence Actually Says

Clients will ask you about this. Know it cold. Then help them ask their own questions.

What the ARRIVE Trial Found (2018)

2018 study: elective induction at 39 weeks vs. waiting.

Key finding: induction did NOT raise C-section rates.

Slightly fewer perinatal complications.

This challenged the old belief that induction = more C-sections.

What this means

- 39-week elective induction is now common
- Not automatically harmful
- Individual risk + context still matter

Doula Language: When Asked About ARRIVE

“Have you asked your provider about the benefits and risks for your specific situation? Would it help to write down your questions before that appointment?”

BRAIN Framework Practice

The Scenario:

A client texts you at 40+1 weeks: “My doctor wants to induce next week. Should I do it? I was really hoping to go into labor on my own.”

In the chat: type your word-for-word response. Then discuss:

- **B: Benefits of induction now?**
- **R: Risks?**
- **A: Alternatives?**
- **I: What does her intuition say?**
- **N: What if we did Nothing? Wait?**

Scope reminder: Help her think through the decision using BRAIN: never steer it. You may not change the intervention, but you can change her experience of making the decision.

BREAK

7-20 PM: 7-30 PM · 10 minutes

Step away, stretch, hydrate, reset.

Back at 7-30 PM: When Birth Needs Help.

SECTION FIVE

Pain Relief in Labor

There is no wrong choice. There is only the informed choice that is right for this person, in this moment, in this labor.

The Spectrum of Pain Relief

Pain relief is not binary. It exists on a spectrum, and your doula role is constant across all of it.

Non-Pharmacological

- Breathing & vocalization
- Hydrotherapy (shower/tub)
- Counter-pressure & massage
- Movement & position changes
- Heat & cold therapy
- Acupressure

Nitrous Oxide

- Inhaled at contraction onset
- Reduces pain perception: doesn't eliminate it
- Client holds the mask (self-administered)
- Wears off immediately between contractions
- Not available at all facilities

IV Opioids

- Fentanyl or morphine via IV
- Takes the edge off without full numbness
- Causes drowsiness: allows rest
- Wears off in 1-4 hours
- Not given when pushing is close
- Doula: your presence more

Epidural / Spinal

- Most effective option available
- Complete numbness below waist
- Placed by anesthesiologist
- Requires continuous monitoring
- Client cannot move independently
- Doula role SHIFTS: does not

The Epidural: What It Is & How You Show Up

Your work doesn't stop when the epidural goes in. It shifts.

What happens

- Catheter in epidural space
- Continuous medication
- 15-20 min to full effect
- Stay still during placement
- Continuous monitoring + IV
- BP may drop initially

The Epidural: What It Is & How You Show Up

Your work doesn't stop when the epidural goes in. It shifts.

How your role shifts

- Physical comfort → positioning becomes your primary work
- Peanut ball + position changes every 20-30 min
- Emotional support matters more: not less: with reduced sensation
- Help client stay connected to her baby and her body

Safety: Moving an Epiduralized Client

- Always use two people to reposition: legs may be numb
- Lift completely off the bed, never drag across sheets
- Dragging can dislodge the catheter (held by tape only)
- Sweep IV lines, monitor cords before every move

Spinal Block & Combined Spinal-Epidural (CSE)

Spinals are fast, complete, and temporary. Most often used for cesarean birth.

Spinal Block

- Single injection into spinal fluid
- 1-5 min onset, complete numbness
- Lasts 1.5-3 hours
- Standard for planned cesarean
- Stay still during injection
- Sensation returns top down

Spinal Block & Combined Spinal-Epidural (CSE)

Spinals are fast, complete, and temporary. Most often used for cesarean birth.

Combined Spinal-Epidural (CSE)

- Spinal for fast relief + epidural catheter left in place
- Fast onset + ability to extend or top up
- Common for long labors where epidural is desired
- Sometimes called a 'walking epidural': mobility varies

Clinical Note: Supporting Placement

During placement she must hold still through contractions. Position her sitting on the bed edge, feet on a stool, chin to chest. Stand in front, hold her hands or forearms. Say: "Breathe with me. You just need to hold still for the next two minutes. I've got you."

Doula Dos and Donts in Medicated Labor

An epiduralized client needs you just as much. Your role adapts: it doesn't disappear.

DO	DON'T
Reposition with the nurse every 20-30 min (peanut ball, side-lying, semi-reclined)	Leave her alone because she's comfortable now
Use peanut ball to open the pelvis and encourage baby's descent	Skip positioning because she can't feel it: she still needs it
Provide continuous emotional support and narrate what's happening	Assume pain relief = emotional relief: anxiety often surfaces now
Help her stay connected: hand on belly, talk to baby, partner time	Check out and scroll your phone while she rests
Coach partner: how to help, what to say, how to be present	Take over the partner's role entirely
Always use two people to reposition: never drag across the sheets	Push her before the urge arrives without the nurse's input
Advocate for laboring down if she feels no urge (delayed pushing)	Move her alone or drag: this can dislodge the epidural catheter

The Peanut Ball: Use It Every Time

The peanut ball creates the pelvic opening that walking and squatting would provide. Use it every time.

What it does

- Peanut-shaped ball between knees
- Holds pelvis open & asymmetrical
- Mimics squatting & walking
- Reduces labor + cesarean rate
- Rotate sides every 20-30 min

The Peanut Ball: Use It Every Time

The peanut ball creates the pelvic opening that walking and squatting would provide. Use it every time.

How to use it

- Smaller end between the knees, larger end behind the hips
- Top knee rests over the ball, not hanging off it
- Switch sides every 20-30 minutes with nurse assistance
- Reposition the whole body: don't just flip the ball

Clinical Note: Peanut Ball & Outcomes

A 2020 systematic review found peanut ball use reduced Stage 1 labor by 90 minutes on average and lowered cesarean rates in epiduralized clients. One of the most impactful tools in your kit, and it costs nothing.

SECTION SIX

When Birth Needs Help

Your job isn't to prevent all interventions.

It's to help families navigate them with dignity and agency.

Normal Variations vs. True Complications

Not everything that deviates from textbook labor is a complication. Some are variations.

Normal Variations

Common: often resolve with position changes, patience, and support:

- Posterior positioning (sunny-side up)
- Nuchal cord (cord around the neck)
- Slow early labor or prolonged latent phase
- Brief fetal heart rate decelerations that resolve quickly
- Asynclitic presentation (head tilted to one side)

True Complications

Require provider involvement: sometimes urgently:

- Fetal distress: persistent concerning heart rate patterns
- Maternal hemorrhage: excessive bleeding
- Prolapsed cord: cord slips through cervix before baby
- Placental abruption: placenta separates prematurely
- Shoulder dystocia: shoulders stuck after head delivers
- Uterine rupture: rare but catastrophic

OP Position: Back Labor

15-30% of babies start labor posterior. Most rotate. Your positioning work matters.

What's happening

- OP: baby faces front
- Skull presses on sacrum
- Intense, unrelenting back pain
- Labor often longer
- Only 5-8% remain OP at delivery

OP Position: Back Labor

15-30% of babies start labor posterior. Most rotate. Your positioning work matters.

Positions that encourage rotation

- Hands-and-knees: opens back of pelvis, best for 30+ min
- Side-lying on the side OPPOSITE baby's back
- Lunge (one foot on a chair) to open one side of pelvis
- Rocking on hands and knees or birth ball
- Avoid reclining: gravity works against rotation

Doula Script: Back Labor

"This pain is real and it's intense. Baby is in a position that's making labor harder. Let's try some positions to help baby rotate. You are doing exactly the right things."

Prolonged Labor: When Exhaustion Becomes the Risk

Prolonged labor is defined as >20 hrs for first-time moms, >14 hrs for subsequent births.

Why it matters

- Uterus exhausts after hours
- Exhaustion → hemorrhage risk
- Infection risk rises after ROM
- Baby tolerates less well
- Intervention can be mercy

Prolonged Labor: When Exhaustion Becomes the Risk

Prolonged labor is defined as >20 hrs for first-time moms, >14 hrs for subsequent births.

Clinical Note: When Intervention Becomes Necessary

A client who has labored for 40+ hours without adequate rest, who cannot eat or drink, and whose cervix has stopped progressing is not “failing.” Her body is working beyond its sustainable limit. Epidural for rest, Pitocin augmentation, or cesarean birth may be the kindest, most evidence-based choice available to her.

Doula Script: When Intervention Is Recommended

“Your body has worked so hard for so long. Choosing to rest or accept support right now is not giving up. It’s wisdom. You are still doing this. You are still the one having this baby.”

Shoulder Dystocia: Get Out of the Way

0.5-1.5% of vaginal births. Rare, but not so rare that you won't encounter it.

What it is

- Head delivers, shoulders stuck
- Cord compressed: baby cannot breathe
- Must be delivered within 4-5 min
- "Turtle sign": head retracts
- Providers act in seconds

Shoulder Dystocia: Get Out of the Way

0.5-1.5% of vaginal births. Rare, but not so rare that you won't encounter it.

Your role: Four things only

- Move out of the way: providers need space immediately
- Stay calm: your client feels your energy
- Support the partner briefly: "The team has this"
- Stay present but silent until baby is delivered

After Birth: What Families Need

"That was scary. You did nothing wrong. The medical team acted quickly, and your baby is here.

Let's take a breath together."

Shoulder dystocia is traumatic even when baby is fine. They need validation, explanation if they

want it, and permission to feel shaken.

Cesarean Birth: Planned vs. Emergent

A cesarean birth with dignity and agency is a better outcome than a vaginal birth filled with fear.

Planned Cesarean

- Scheduled in advance
- Client arrives calm + prepared
- Pre-plan your role & preferences
- Family-centered C-section possible
- Confirm OR access in advance
- Support partner coaching

Cesarean Birth: Planned vs. Emergent

A cesarean birth with dignity and agency is a better outcome than a vaginal birth filled with fear.

Emergent Cesarean

- Happens fast: client may not have time to process
- You may not be allowed in the OR
- Stay with the partner if you're separated from the client
- Keep partner calm and informed
- When she returns, she may need to process what happened
- Your presence in recovery is critical: don't leave early

VBAC: Vaginal Birth After Cesarean

72-75% success rate. Your role is informed support: not steering the decision.

Key Facts

- 72-75% of VBAC attempts result in vaginal birth · 0.5-1% risk of uterine rupture (rare but serious)
- Best candidates: one prior cesarean, low transverse incision, supportive provider, hospital equipped for emergency

VBAC

72-75% success rate

Shorter recovery if successful

Increases chance of future vaginal births

Requires labor and continuous monitoring

Elective Repeat Cesarean

Known birth date, planned recovery

No risk of rupture during birth

Longer initial recovery

Future births likely also cesarean

What Would You Do?

The Scenario:

Your client has been in labor for 34 hours. She planned an unmedicated birth and has been doing beautifully. But for the last 6 hours, her cervix hasn't changed. The provider is now recommending a cesarean. She's sobbing. Her partner looks panicked.

Discuss with your group:

- What do you say to her in this moment: word for word?
- What do you say to the partner?
- If she asks "Should I do it?": how do you respond without answering the medical question?
- How does your support look different in the OR waiting room vs. in recovery?

SECTION SEVEN

Perinatal Loss: An Introduction

Your doula work doesn't end when hope shatters.

In the moments when words fail, presence becomes your most powerful tool.

Why We Cover This, and What It Includes

Grief is not proportional to the size of the baby or length of pregnancy. Every loss is profound.

Types of perinatal loss

- Miscarriage: before 20 weeks
- Stillbirth: 20+ weeks
- Neonatal death: within 28 days
- Life-limiting diagnosis
- TFMR: medical termination
- Loss of a twin / multiple

Why We Cover This, and What It Includes

Grief is not proportional to the size of the baby or length of pregnancy. Every loss is profound.

Why Doulas Need This Training

- You WILL encounter loss during your career: it is not rare
- Families remember forever how they were treated in these moments
- Your presence, language, and actions either help or cause harm
- You do not need to fix grief: you need to witness it
- Doulas who are unprepared often disappear when they're needed most
- This training protects your clients and protects you

Language: What Helps vs. What Harms

Families will remember what you said forever. Choose your words with that weight.

SAY THIS	NEVER SAY THIS
<i>I'm so sorry.</i>	Everything happens for a reason.
<i>Your baby is beautiful.</i>	God needed another angel.
<i>There's nothing I can say. But I'm here.</i>	At least you can get pregnant again.
<i>Tell me about [baby's name].</i>	At least you have other children.
<i>It's okay to feel whatever you feel.</i>	I know how you feel.
<i>I'll stay as long as you need.</i>	They're in a better place now.
<i>What do you need right now?</i>	You'll get through this. You're strong.

Your Role: Bear Witness. Use the Name. Stay.

You don't need the perfect words. You need to show up and not disappear.

What your role looks like

- Use the baby's name: every time
- Sit quietly: be okay with silence
- Stay even when there's nothing to do
- No phone, no clock-watching
- Ask before touching
- They'll remember years later

Your Role: Bear Witness. Use the Name. Stay.

You don't need the perfect words. You need to show up and not disappear.

Memory-making: offer, don't push

- Photos: Now I Lay Me Down to Sleep (free professional photographers)
- Hand and footprints: ink impressions or clay castings
- Physical keepsakes: lock of hair, blanket, hat
- Time: uninterrupted time alone with their baby
- Naming and naming ceremonies if desired
- Memory box: many hospitals provide these

Doula Self-Care After Loss

You cannot pour from an empty vessel. The 24-hour rule exists to protect you.

The 24-hour protocol

- Don't process alone in first 24 hrs
- Don't reach to family to vent
- Journal privately: not social media
- Rest, eat, be cared for
- Debrief within the week

Doula Self-Care After Loss

You cannot pour from an empty vessel. The 24-hour rule exists to protect you.

What Not to Do Right After a Loss Birth

- Don't share the story publicly or on social media, ever
- Don't make the family's loss about your feelings
- Don't skip the debrief because you think you're fine
- Don't take on another birth immediately if you're not ready

Carry This Without Being Crushed

You are not required to be okay immediately. Grief is the appropriate response to witnessing grief. What you carry from this work is evidence that you were fully present for a family in the worst moment of their lives.

Take a breath.

*This material is heavy. That weight is appropriate.
It means you understand what is at stake.*

*Hold space for whatever this material brings up for you.
You do not have to perform okayness right now.*

This is why you're here.

What to Carry With You From Tonight

01

There are four stages of birth and three phases of Stage 1. Get the language right: it matters in the clinical setting.

03

Active labor doesn't reliably begin until 6 cm. The ACOG 2014 update exists to reduce unnecessary interventions.

05

An epiduralized client needs you just as much. Peanut ball, positioning, and emotional presence don't stop.

Key Takeaways: Night 2

02

Labor hormones respond to environment. Dim lights, privacy, warmth, and your calm presence are biological support.

04

Induction is common. Your role is to support informed decision-making using BRAIN: never to steer the decision.

06

When birth becomes loss, you stay. You say the baby's name. You do not look away. You bear witness.

Mary's Hands Network · ICBT Hybrid Training · Night 2

Before In-Person Day 1:

1. Stages of Labor Quiz

Complete and pass the quiz on Canvas (stages, phases, hormone functions, medication identification). You must pass to attend In-Person Day 1. Retakes are available.

2. Resource Guide: Keep Adding

Add at least 3 new entries covering labor support, birth trauma, and perinatal loss resources in your community. Guide must be complete by Day 1.

3. Reflection Journal

Ungraded. In Canvas, respond to: What came up for you during the perinatal loss section? What do you need to prepare yourself to support families through loss?