CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

A COUNSELOR'S HANDBOOK
ON PREGNANCY

A project submitted in partial satisfaction of the requirements for the degree of Master of Arts in

Education,
Educational Psychology,
Counseling and Guidance

by

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June, 1980
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ABSTRACT

A COUNSELOR'S HANDBOOK 
ON PREGNANCY

by

Elizabeth Maxine Smith

Master of Arts in Educational Psychology
Counseling and Guidance

June, 1980

I have written A Counselor's Handbook on Pregnancy for the purpose of providing a ready compendium of the basic nature and stages of pregnancy. There are many resource books available on the physiological and psychological characteristics of pregnancy but not one concise book combining both areas and geared towards the counselor working therapeutically with a client who is pregnant.

It is my hope that this Handbook will enable the reader to appreciate the scale and depth of the changes pregnancy brings into the life of a woman. The changes include both very specific changes to the pregnant woman's body as well as to her emotional and psychological life. It is a time when she may re-evaluate important relationships in her life; when she may re-examine prior relationships and conflicts in her life; and when she may incorporate new concepts of herself as a woman, a mother and an adult.
I have organized the Handbook in eight chapters. Chapter One is an introduction to the Handbook. Chapters Two, Three and Four cover the physiological and psychological characteristics of the first, second and third trimesters of pregnancy. In Chapter Five I discuss the decision-making involved in the pregnancy experience, including the choice of birth style, physician and whether or not to breast feed. In Chapter Six I provide an overview of the nutritional and exercise needs of the pregnant woman so that the counselor is aware of the total care needs of the client. Chapter Seven discusses the impact of pregnancy on the husband and the relationship of husband and wife. Chapter Eight highlights the fundamental issues of pregnancy and offers support and suggestions to the counselor.
CHAPTER ONE: INTRODUCTION

I have a dual interest in the experience of pregnancy. I am pregnant for the first time and I am in training to become a counselor. I find myself devouring information, learning at an enormous rate and feeling as though I have been suddenly thrust into a world I have never really been aware of, nor taken an interest in before. As a counselor, I am keenly aware of the total impact this pregnancy is having on my state of being; my body is changing, my feelings are exaggerated and heightened and altered in many ways by the biological and emotional influences of pregnancy. I have taken a great interest in my changes and in the way the people in my world relate to me now that I am pregnant. Some of the experiences have been startling; from the beautiful to the cruel.

I think of other pregnant women, and how the experience may be for each of them. While it is a unique experience for each woman and her man, there are similarities in what pregnant women and their men encounter. It has been a great comfort to me personally to have talked with or read of someone who shared the same feelings I may be having, or the same concerns as I may feel.

I had the choice to write a handbook directly for the pregnant woman or, as I have chosen to do, to
write it directly for you, the counselor. Basically, I want you to have a concise book filled with fundamental information about pregnancy. I do this because a strongly motivated pregnant woman will probably manage to get through the multitude of books available in local bookstores on various aspects of the pregnancy experience, but I don't think you will. And you may be the first or among the first people with whom a woman will have contact when she initially learns she is pregnant. It is my strong belief that that is the point a pregnant woman most needs information, support, understanding and fellowship.

Much of the community of childbirth interests focuses on the needs of the mother after her 6th or 7th month of pregnancy. I believe that those early months; 2, 3, 4 and 5 are extremely important months for therapeutic intervention; be it information gathering, decision making, active listening, empathy, self disclosure or referrals to community resources. You, the counselor I am writing to, are the person I want to reach with this information so that you will be able to address the special needs of your pregnant client. I am thinking both of a woman who may come into counseling because of pregnancy and the woman who is in counseling for other issues and then becomes pregnant. I believe the impact on the latter's life of the pregnancy will change the
focus of therapy and may crystallize fundamental issues. This may be a time to bring in a mate for couple counseling or the whole family if there are other children. Pregnancy presents an opportunity to focus on important life issues.

The Handbook contains eight chapters and a selected Bibliography.

Let me briefly go over the scope of the Handbook with you. Chapter One is the introductory material you are now reading. Chapters Two, Three and Four deal with the first, second and third trimesters of pregnancy. The medical community commonly groups the first, second and third months; the fourth, fifth and sixth months; the seventh, eighth and ninth months into three categories. The sensibility of the arrangement becomes clear as you read the material. Each chapter has two sections, the first covers the physiological changes in the mother and the fetus during each trimester and the second concerns the psychological and emotional experiences of that trimester. I chose this arrangement because it helps to see the patterns in the stages of pregnancy and it also allows me to discuss the individual variations that occur for many women.

In Chapter Five I will address the kinds of questions and decisions a pregnant woman will have to confront. "What kind of birth do I want?" "How do I select a doctor?" "Do I want to have the amniocentesis test?"
"Shall I see a genetic counselor?" "What support groups are available in the community?" "Do I need a birth class?" "Will I breast feed?"

Chapter Six includes information on the nutritional and exercise needs of the pregnant woman. Chapter Seven is devoted to issues facing the couple together, including what the experience of pregnancy is like for the husband, what changes the couple may experience in their sexual life and how communication may help them during the course of the pregnancy.

Chapter Eight is a recapitulation of the issues of the pregnancy experience along with suggestions as to how you as a counselor can support and facilitate your client on her passage towards childbirth and motherhood.
CHAPTER TWO: THE FIRST TRIMESTER

A. PHYSIOLOGICAL

The impact of pregnancy may make the first few months of the experience very difficult for your pregnant client. Many women experience what is known as "morning sickness." Morning sickness, in reality, can last all day, have peaks in the morning, afternoon and/or evening. It can vary in degree from mild to severe and, when severe, may cause vomiting. It's an awful feeling--I thought I was hit with the stomach flu the first day, and for the following five weeks felt I was living on a ship in rough seas. It made it very difficult for me to feel good about being pregnant.

The medical community is not certain what causes nausea and there are various theories. At the present time the greatest consensus is that the release of hormones early in pregnancy have an adverse effect on the digestive processes. There have been theories that nausea reflects emotional immaturity and instability on the part of the woman but physiological causes are considered to be the more likely.

Nausea may begin two weeks after conception (when the embryo attaches to the uterus) and generally does not last longer than 12-13 weeks. Unfortunately, some women experience it for a longer time, some even throughout
their pregnancy, but the majority find that it is gone after the third month when the fetus is fully formed. It is important for you and your client to realize that her experience is unique and individual and it's okay not to fit a stereotyped timetable.

It was an enormous relief to me when the symptoms left. I also felt an important function of the nausea for me was to enable me to stop eating certain things, such as coffee, alcohol, spicy foods, during that critical first three months of pregnancy when the embryo is very vulnerable and to confine myself—out of necessity—to simple, nourishing foods such as eggs, cottage cheese, baked potatoes and milk. I also found that eating starches and carbohydrates relieved the nausea but put weight on fast and I had to put some discipline to work. A friend of mine put on 15 pounds the first three months from just that kind of eating.

There isn't any natural treatment that completely eliminates the nausea, but some things do help. Basically it is best if the pregnant woman's stomach is never too full nor too empty. Six small meals a day work much better to relieve the symptoms than do three. I always found the nausea increased when I was hungry. Many women carry soda crackers with them and have them by their beds to nibble on before they get up in the morning.

There are anti-nausea drugs. It is my own bias to avoid any medicine during pregnancy, especially the first
three months, but if a woman feels the need for more than home remedies, perhaps she and her doctor can work out a treatment that satisfies her needs for comfort and safety.

It may help your client to know that nausea is a very common experience of pregnancy and research shows that women who experience morning sickness tend to have healthier pregnancies, with fewer miscarriages, premature deliveries and underweight babies, than do those who suffer no nausea. (Fleming: 1972)

Along with early pregnancy and the changes and increased activities in the body, comes a feeling of lethargy, fatigue and exhaustion I have heard referred to as the "blahs". It's a very common and normal feeling and it does help a pregnant woman to know that she is not alone in feeling awful. It helps to know that this, too, as the morning sickness, is on its way out or gone by the end of the first trimester for most women. In the meantime, it's important for her to rest, to follow the message her body is sending her to take it easier than usual. It's important to get lots of sleep and to rest during the day.

Along with these two major symptoms of nausea and fatigue come a number of associated problems, such as irritability, inability to concentrate, impatience, loss of interest in sex, foul moods, discouragement and anxiety. The first three months are not an easy time for many
women, and for others they may be much more pleasant. My emphasis in this Handbook is to help you with women for whom pregnancy is a crisis time—a turning point in their lives.

The body is going through rapid changes. Breasts increase in size and become tender and the nipples and area around them may become darker in color during this period.

The blood supply gets richer and larger and it causes mucous membranes throughout the body to swell. There is an increase in vaginal discharge which may lead to irritations or infections. These are very common during pregnancy, not much talked about I have found, and can cause very annoying symptoms as well as interfering with sexual activities. I personally have had bouts of irritating vaginal discharge and it took some probing of the literature and my doctor to find out that it is an ordinary occurrence of pregnancy. Once I understood that it was not unusual and nothing to worry about I found it easier to live with. So I hope it will be for your pregnant client when she discovers many of her discomforts are perfectly natural and nothing to fear.

Frequent urination is another common occurrence in early pregnancy. It is believed that hormones are responsible for this in the first trimester, whereas the enlarging uterus pressing on the bladder causes the same
symptoms in the last trimester. It's a nuisance at times--
public bathrooms suddenly seem very scarce--but otherwise
not anything to be concerned about.

There is also a change in the water balance in the
body during this first trimester and your client may retain
more body water. Swelling is a normal symptom of preg-
nancy that is also the signal of problems, generally
 toxemia, the most common complication arising during
pregnancy. I found reading the descriptions of complica-
tions of pregnancy to be very alarming during the first
trimester and felt that if anything unusual appeared
I would consult with my doctor. I feel the same way now
and so will not include in this Handbook the serious ail-
ments that do sometimes occur in pregnancy. Great in-
creases of weight, blood pressure, protein or albumin in
the urine reveal themselves at the time of office visits
and your client's doctor will tell her to call in the
event of vaginal bleeding, severe headaches or other
specific symptoms that may be indications of something
serious.

Along with the commonly occurring side effects of
pregnancy, constipation, hemorrhoids and varicose veins
can be included. The latter two may not prove to be a
problem until the second or third trimester when increased
blood flow and pressure of the fetus may cause blood
vessels to swell. With constipation, drinking lots of
water, eating lots of vegetables, fruit, whole grains,
and practicing relaxation exercises do help. I found that two tablespoons of bran in yogurt every day plus six to eight glasses of water worked for me.

It is also not uncommon during the early months to feel dizzy, faint and headachy. Here these can be entirely innocent symptoms or indicate a problem, so it is important for your client to discuss these with her doctor. I will discuss the issue of selecting a doctor in Chapter Five but I want to mention here that the great value in selecting a doctor early is having the comfort and reassurance of being able to discuss the physical changes with someone who has the requisite medical information. I felt great relief once I selected a doctor as I knew there were people who knew me and my body to whom I could direct specific questions.

I want to change focus for a moment to look briefly at the development of the embryo which is causing any number of the symptoms your pregnant client is or has been experiencing.

The first three months are the most crucial in the formation and development of the fetus. Most of the organs are formed in this period. Most miscarriages occur in this trimester as nature usually causes fetuses where anything has gone awry to be discarded. The fetus becomes implanted in the womb about seven days after fertilization. The woman may bleed a little at this time. Any bleeding
should always be reported to her doctor. The uterus grows from about the size of two thumbs held together to the size of two fists during the first three months.

At three weeks the embryo is about 1/12th of an inch long. The backbone and the spinal canal are forming. By four weeks the head is forming and the heart is visible and beating. The beginnings of arms and legs are discernible. At five weeks the chest and abdomen are formed and the fingers and toes are beginning to take shape. The eyes are developing. The embryo is now about 1/2 inch long. By six weeks the ears are developing as well as the facial features. At two months the face is completely formed. The arms, legs, hands, feet, toes and fingers are in the process of taking shape. The embryo is over one inch in length and weighs 2 or 3 grams. By the 12th week of pregnancy the arms, legs, feet, toes, hands and ears are fully formed. The nails are beginning to appear and external genital organs are beginning to show differences in shape. The fetus is now three inches long and weighs an ounce.

The fetus is completely surrounded by amniotic fluid which cushions it from shock. The fetus draws its life support systems from the umbilical cord and the placenta. They are part of the fetus' biological system; they are connected to the fetus, not the mother. The placenta is like a root system of blood vessels which draws nutrients and oxygen from the mother's blood stream and exchanges
carbon dioxide and wastes. The placenta and the fetus share the same blood; the mother and the baby do not share blood supplies, their sharing is indirect.

It is hard to predict precisely how long the full term of pregnancy will last for any one woman but generally the due date is calculated by adding forty weeks to the first day of the woman's last menstrual period. Give or take two weeks from this date is considered full-term pregnancy. Pregnancy can be detected as early as three weeks after conception; when a woman chooses to go for a pregnancy test is very individual and I find very different advice in the books I have read. One suggested waiting until two periods have been missed, while others emphasized going as soon as the woman suspects, or soon after a missed period. I went to my internist for a pregnancy test two weeks after a missed period. It then took me three weeks of research to locate an obstetrician I felt comfortable with and in whom I felt trust.

In summary, the first trimester of pregnancy may affect your client's physical state in many ways. She may experience nausea, fatigue, irritability, anxiety, sore breasts, vaginal discharge, frequent urination, heaviness and lethargy due to increased body fluids, constipation, hemorrhoids, varicose veins, dizziness, fainting, headaches and may generally feel lousy. She may also feel very few symptoms and generally feel well; the range of experience is enormous and within the realm of normal.
However your client feels, she needs supportive information and reassurance.

The changes in her body are in response to the development of the embryo from a single cell organism to a fully formed fetus at 12 weeks. All the major organs of the body are formed in those three months.
B. PSYCHOLOGICAL

Pregnancy may be a time of considerable emotional turmoil for your client. This is a turning point in her life, whether it's her first, second or successive child.

The physiological changes in her body lead to a lowering of her psychological defenses, emotional vulnerability and for questioning of herself as a woman, as a potential mother, of her relationship with her man, her mother--it is a time laying the groundwork for change. The depth and scope of this experience of course depends on the personality and individual character of each woman, and yet for each woman there is life business to be worked through during her pregnancy. It may be hard to uncover, but stirrings are there, however quietly.

Self-questioning may begin very early in pregnancy. It is not uncommon for women, even those who strongly wanted and chose to have a baby, to have considerable doubt once they find themselves pregnant. Those reservations and second-thoughts give rise to anxiety and that anxiety may take a long time to work through. Your client may discuss the possibility of having an abortion or may be thinking about it. Very often, like morning sickness, the anxiety leaves at a predictable time; in this case by the 4th or 5th months of pregnancy, especially when the mother feels the movements of the fetus.
Anxiety may be felt about the fetus; that it may be damaged; that it may miscarry; that there will be something wrong with the baby. These are very common and normal fears and, in fact, have been shown to indicate a facility to become attached to the baby once it is born. (Ballou: 1978)

The mixed emotions many woman may feel about pregnancy and childbirth in these early months are very normal, and in fact, the absence of any doubts or misgivings is something that ought to be explored by you and your client. Pregnancy is a time of heightened emotionality and greater vulnerability. It is a real phenomenon that I look upon as laying the foundation for a major life change. It is one of the few times in a woman's life when she undergoes a major physiological and psychological upheaval, as with the onset of menstruation and menopause. I believe it is an opportunity for her to reevaluate her life at its most fundamental and I am glad she has you, her counselor, to help her focus on important issues.

One of those issues will undoubtedly be her feelings for her own mother. It is very likely that during the first three months, those feelings will be largely critical and resentful and there may be bad feelings between the pregnant woman and her mother. It is invaluable for her to deal with them in counseling. She may find resentment that her mother gave her very little honest information about her own childbearing experiences
and your client may be left with a lot of fear at the approach of childbirth. Many women in our Western culture have little information about childbirth and much dread at the approach of what seems to be a terrible ordeal.

It is also confusing during these first three months when your client's abdomen does not yet show the signs of the fetus, especially if this is her first pregnancy, for her to believe that she is pregnant, that she will be a mother. It is a task of the first trimester for your client to come to believe that the fetus is a part of her.

Sexuality may also be an important issue for your client in this first trimester. If she feels exhausted and/or nauseous she may have no desire for sex. If she has had a history of miscarriage her doctor may have suggested no sex for the first three months or not at the time she would have expected her period.

There may be fears on the part of her husband that sex will hurt the embryo. There may be a host of emotions both your client and her man may be feeling that will affect their sexuality and their relationship. It is important for them to talk them over and work them through.

This may also be a time of great increase and renewal in sex between them and all sorts of possibilities in between.

The first trimester may also be a time your client
is given a lot of advice from people in her world. However well meaning that advice may be, it may be very anxiety provoking for your client to hear how her pregnancy should be progressing. I found this onslaught of advice very difficult to accept; I felt raw and vulnerable and sometimes under attack. What was the most comforting was a good listener who also shared her own experience of pregnancy, keeping very clear that it was her experience she was referring to.

I believe that the emotional upheaval of pregnancy, particularly the first trimester, is harder to accept and live with than the physical changes. Most of all I want to convey to you how thorough a time of turmoil this trimester may be for your client. She is thrown into chaos, her defenses are lowered, her sensitivity is heightened and she is vulnerable. She may reexamine many areas of her world; her sense of herself, her sexuality, her important relationships, her feelings about herself as a mother, her encounters with other people. During this first trimester your client may embark on a period of tremendous self-examination and growth. She needs to be with supportive people. You can help a great deal.
CHAPTER THREE: THE SECOND TRIMESTER

A. PHYSIOLOGICAL

The second trimester, months 4, 5, and 6, is often the trimester when women feel their best. They are generally the safest months and the most pleasant. By four months the nausea should be gone as well as the extreme fatigue and the depression and irritability that accompany them.

During this second trimester the pregnant woman's body undergoes its greatest physical changes. By 4 or 5 months it is likely that her abdomen has grown so large that her clothes no longer fit. This is generally the trimester of greatest weight gain in pregnancy, although this of course varies from individual to individual. The pregnant woman's total circulating blood volume increases by about forty percent and there is an increase in the fluid bathing her tissues.

She also first begins to feel the movements of the fetus in this trimester. The fetus has been moving from the beginning but the pregnant woman cannot feel the movements until it has grown in size. This movement, called "quickening" generally is perceptible at 18 or 20 weeks, or thereabouts. There is a lot of individual variation in when it occurs and how strong it feels but the usual description is of a fluttering feeling, like intestinal movement or gas bubbles.
Towards the end of the second trimester, your client may begin to experience heartburn, a burning sensation in the pit of the stomach and lower chest. The cause seems to be connected with the stomach cavity being pushed up and out of its usual position thus causing gastric juices to be pushed up into the esophagus. Drinking a lot of water and having small frequent meals seems to help. I personally find it much easier to live with heartburn than the nausea of the first trimester.

Also in this second trimester, leg cramps may begin to trouble the pregnant woman. It may be due to the sluggish circulation of blood in the legs and also due to calcium deficiency. It occurs most often at night. The problem may be helped by increasing calcium intake, massage, the application of heat and keeping the legs propped up whenever possible.

As in the first trimester, increased secretions to the mucous membranes leads to irritations of the vagina and to nosebleeds. Irritations of the vagina can lead to infections so it is important for your client to discuss any such condition with her doctor.

The increased blood supply I mentioned in the first trimester continues into the second. The blood supply is pooled in the abdomen and may cause deficiencies to the brain sometimes causing feelings of faintness and dizziness. Also, the heart is changing position and increasing slightly in size.
There may be changes in your client's skin, as well, some of which may be alarming if she does not know they are normal occurrences. A line of dark pigmentation may appear from the navel to the pubic region. Sometimes "maidens cap" appears; this is a darkening of pigmentation to the face that usually disappears after the birth of the baby. The nipples and areola darken and may remain that darker color. In some women "stretch marks" (striae) appear on the abdomen and/or on the breasts. They don't disappear after childbirth but become a whitish color. There is no sure way to prevent them but some people believe rubbing oil or cream on her body daily helps a pregnant woman avoid these marks.

During this trimester of abdominal enlargement many women feel pain in the lower abdomen. It's an achy, sore feeling that comes and goes. It is believed to be due to the stretching of the ligaments which support the uterus, one of which runs along each groin.

Along with vaginal irritations a symptom not often mentioned is gas caused probably by a combination of increased bloatedness, relaxation of the stomach and intestines, and sluggishness of the digestive system. Gas means farting and belching and can be embarrassing as well as annoying. If your client can discern which foods most aggravate the problem, she can eliminate them. She'll probably have to live with it however best she can.
By the beginning of the second trimester all the major organs of the fetus have been formed. By the sixteenth week it weighs about six ounces and the eyebrows and eyelashes appear. By this time the genital organs are differentiated as to sex. By the 20th week, or five months hair is beginning to appear on the head and the fetus weighs about one pound and is ten inches long. By the sixth month there is hair on the head, the eyes are open and the fetus weighs about two pounds. The top of the womb will be at about the level of the mother's navel, having grown up from its starting point low in the pelvic region.

The second trimester, in summary, is a much more pleasant three months than the first trimester. Although there are several very typical physical symptoms that are annoying and troublesome, such as heartburn, leg cramps, irritations of the mucous membranes, stretch marks, groin pains and gas, they are more isolated and infrequent in scale than the pervasiveness of exhaustion and nausea. Generally pregnant women in this trimester have the energy to go about their usual activities, feel much less anxiety than in the first trimester and feel much more accepting of their pregnancy.

The fetus has by this second trimester been largely fully formed. It has truly settled into its life in the uterus and danger of miscarriage has generally past. Now
is the time for the fetus to grow in length and weight and to continue its development and refinement of mature characteristics, such as hair on the head, eyebrows and eyelashes.
B. PSYCHOLOGICAL

During the second trimester much of the anxiety the pregnant woman has felt decreases. The fetus moves, the decision whether or not to keep the pregnancy has been largely resolved and the woman generally feels better physically and emotionally.

However the psychological impact of pregnancy continues and changes in direction and focus. There may be many indications of the increased psychic activity of the woman to be alert to. Many women dream about babies, a good proportion of the dreams representing danger to the baby or the birth of a deformed baby. The dreams may focus on the husband and/or on the mother. This may also be a time when women's fantasy life of themselves as mothers, of their husbands, of the changes to come, are particularly active. These activities may be seen as the ways in which the woman comes to grip with the changes that await her.

During the second trimester, you may see in your pregnant woman client a change in her attitude toward her own mother. She may begin to remember many supportive, loving acts her mother did for her, she may begin to remember her own childhood as a happy time. Her feelings towards her mother may soften a great deal from the anger of the first trimester. Part of this process seems to be a way in which the pregnant woman can come to some feeling
of having been well-mothered herself, of accepting her own needs to have been mothered before she can turn to the task of mothering her own child. (Ballou: 1978) Thus the second trimester may mark an improvement in the relationship of your pregnant client to her own mother.

I will focus on the relationship between the pregnant woman and her husband/mate in Chapter 7 but let me add for now that this is an important time for them to redefine and rework their relationship. The issue of the woman's changing body shape and physical characteristics affects them both.

As the second trimester marked an easing of physical discomforts, so it is characterized by an ease in psychic discomforts. The work of pregnancy continues; the internal adapting to shifting roles within the woman herself and with her family members continues but with less anxiety than in the first trimester. Your client's defenses are still low and she is vulnerable; her fantasy life may be richly active and her dream life indicates working through of many feelings. She is probably expressing positive feelings about her own mother during this time. She also has many issues to work through about her feelings regarding her changing body shape and may find she has much to deal with in her relationship with her man during this second trimester.
CHAPTER FOUR: THE THIRD TRIMESTER

A. PHYSIOLOGICAL

The third trimester includes months seven, eight and nine and concludes with birth. The last weeks may be the most difficult of the pregnancy period because they're a time of limbo, a time of waiting, and being very uncomfortable physically at the same time.

The third trimester carries with it many of the physical characteristics of the first and second trimesters as well as others unique to this last period.

Familiar problems may be varicose veins and hemorrhoids, both manifestations of poor circulation in the lower half of the body during pregnancy. Support stockings and keeping legs elevated help the varicose vein situation and good regular elimination aids the hemorrhoid situation (hemorrhoids are varicose veins of the rectum). Both of these problems tend to increase over the last trimester with the added weight of the baby.

Leg cramps may also be a continuing problem as well as constipation and heartburn. There may be some nausea from strain on the liver and sometimes itching over the whole body also due to changes in function of the liver.

In this third trimester the increasing weight of the growing fetus may bring about various physical consequences to the pregnant woman. She may find her ankles swelling because tissues of the body retain increasing
amounts of fluid toward the end of pregnancy. This swelling may be entirely innocent or it may indicate a condition which requires careful watching, especially if the swelling proceeds to the hands and face. In any case this is the kind of issue your client should be discussing with her doctor so that she knows what is going on in her body.

The added weight also may cause backaches in your pregnant client. The strain of bearing the unaccustomed weight of the fetus combined with the relaxation of the pelvic joints during pregnancy can result in an annoying ache in the lower back. Massage may help, or heating pads or regular exercise.

The enlarging uterus also presses up against the diaphragm, making it difficult for the diaphragm to move. This may cause the sensation of shortness of breath, very common to the later stages of pregnancy. It may help to sleep propped up on pillows so the shoulders are elevated, and in general, to take it easier when breathing is difficult. Breathing is more rapid in middle and late pregnancy than it is ordinarily. The rapid breathing causes the woman to lose fluids by evaporation and she will need to increase her intake of fluid. This will no doubt add to the annoyance of frequent urination but it seems to go with the territory of the third trimester.

Insomnia is a very common experience of the last weeks of pregnancy. It may come as a result of a combination of conditions. For one, with her large abdomen,
it may be difficult for the pregnant woman to find a comfortable position in which to fall asleep. For another, she may have to get up to urinate so often it disturbs her sleep. She may also be experiencing a lot of anxiety about childbirth and the consequences; Will she die? Will the baby be deformed? There may be many issues on her mind that make it difficult for her to relax and sleep. And, too, the movements of the baby may keep her awake. Although as the fetus nears term it has grown so large its movements in the uterus are restricted, it very often does move when the pregnant woman is resting and so may disturb her sleep.

That the last weeks may be so trying may be nature's way of preparing your client for the birth of the baby. By the time it comes she is probably fed up with the wait.

Labor is the final chapter of pregnancy. Some women may be better prepared for it than others, depending a good deal on the type of delivery they will be having. Those preparing for birth without the use of drugs will probably have been attending classes during the third trimester and will be more familiar with the experience of labor than a woman who chooses to have a drug-assisted delivery. In any case I believe there is a great deal of mystery about labor and childbirth in our culture and it can add to the fear and tension many women feel as they anticipate the experience of birth. In my research
I have read a good deal of material that dispels much of
the mystery, but it does seem the missing element is having
birthing described so that the reader knows what it feels
like. That still remains a mystery.

There are helpful guidelines about the approach
of labor that may make it easier to identify when it comes.
The uterus contracts throughout pregnancy in preparation
for birth and the contractions are discernible in the
latter part of the third trimester. They are known as
Braxton-Hicks contractions. It is the uterus tightening
every now and then that your client will feel. It is
believed to be a natural process of strengthening the uter­
ine muscles in preparation for labor.

Sometime in the last few weeks of the third tri­
mester the baby's head drops into the pelvis. This is
known as "lightening" and your client may literally feel
a lightness; it may be easier for her to breathe and may
diminish heartburn because the stomach and diaphragm will
have more room to move.

Another hint that labor will be approaching is the
"bloody show". This is the release from the vagina of
the mucous plug that helped seal the cervix during preg­
nancy. There may also be a sudden gush of clear liquid
when the water bag breaks. Apparently a number of women
experience several days of diarrhea just before they go
into labor--perhaps a way nature has of preparing the
body for birth.
There does seem to be a mystery about how labor begins. It is believed that when the pituitary gland secretes the oxytocic hormone labor is initiated. Labor is the distention and contraction of the uterus. Labor isn't considered to have begun until contractions become regular.

The early sensations of labor may be dull, intermittent low backache, or intermittent feelings of discomfort low in the abdomen, similar to cramps in the menstrual period. Sometimes these symptoms disappear after a few hours and are called "false labor"; or they may continue and become both more frequent and regular. One way generally used to measure the regularity of the contractions is by timing the interval between the beginning of one contraction and the beginning of the next. Your client can recognize the contractions by the discomfort she feels or by the hardening and visible rising up of the uterus which she and her mate can feel with their hands on her abdomen.

The contractions may begin irregularly at first, say every 10 or 30 minutes and then come more often at regular time intervals, say every 15 minutes, then 10, then 5. Generally when contractions are 5 minutes apart your doctor will advise you to go to the hospital or to the birth center or if you are delivering at home you will know you are in the first stage of labor. The work of the first stage of labor is for the cervix to thin and dilate
fully—about 10 centimeters or the size of a fist—to allow the baby to descend out of the uterus. The time it takes to dilate varies greatly from individual to individual. It generally takes longer for first babies than for subsequent babies and averages 6 to 18 hours for first and 2 to 6 for second. It is important to keep in mind that the length of labor can vary greatly and still be normal and healthy.

The last part of the first stage of labor is known as transition. Transition lasts in the region of 1 to 2 hours with first babies and as short as 5 minutes with subsequent babies. The contractions of this period are often the longest and hardest of the entire labor. As the baby prepares to move down from the now dilated cervix and approach the vaginal opening the pregnant woman may feel an overwhelming urge to push the baby out. During this stage she may find it extremely difficult to hold back this urge to push but must because to do so might injure the cervix and the baby. It seems to be a universally difficult time during birth.

Second stage labor is the actual expulsion of the baby from out of the mother's body.

Third stage labor is considered the time between delivery of the baby and delivery of the placenta. This is generally a short time; sometimes as little as 5 minutes.

During this last trimester the fetus is preparing for birth by thumb sucking, maturing and gaining in size.
and weight. From the 6th month to term the fetus grows from 13 to 20 inches and nearly triples its weight. At the seventh month it will weigh approximately 4 pounds.

By the 8th month the fetus weighs in the region of 3 to 5 pounds. By the 9th month it may be 18" long and weigh over 5 pounds.

By the end of the 9th month, or 40 weeks, the fetus is a full term baby, has smooth skin, long fingernails and toenails and weighs approximately 6 to 9 pounds and is in the range of 20 inches long. These figures of course allow for lots of variation within the range of normal and healthy.

The third trimester, then, may be difficult for the pregnant woman in ways similar to the first trimester and specifically to the last. As in the first trimester she may experience nausea, frequent urination, constipation, anxiety about the baby and herself, varicose veins and hemorrhoids (which may be more troublesome to more women in the third trimester). What may be new to your client at this time are leg cramps, swollen ankles, backache, shortness of breath, insomnia and impatience. Of course these symptoms may come earlier for your client or not at all and their intensity varies within individuals. What is important to keep in mind is that if she does experience some, none or all of these symptoms she is not unique nor is her experience out of the range of normal.

The third trimester culminates in labor and birth.
The onset of labor begins with several signs over a few week period. Among the signs your client may encounter are Braxton-Hicks contractions— the uterus practicing the tension and relaxing motions of labor, lightening— when the baby's head drops, bloody show— when the cervix expels the mucous plug that has sealed it, the breaking of the water bag, irregular contractions, and finally regular consistent contractions of the first stage of labor. When the cervix is dilated and the baby moves down towards the vagina the woman will be in transition to the second stage of labor when the vagina stretches to allow the baby's head and body to pass through. And finally after delivery of the baby, the placenta will be delivered and the third and final stage of labor will have been completed.

The fetus, in these final months, grows to approximately 20 inches in length and some 6 to 9 pounds in weight.
B. PSYCHOLOGICAL

The third trimester carries with it many psychological issues for the pregnant woman. The first trimester presented her with the fact of pregnancy and the confusion and doubt that may have accompanied it. She had to deal with accepting the fetus as being part of her. The second trimester was a time with less anxiety and the reality of a moving living separate life within her. The third trimester is preparation for the living reality of a separate person coming into her life. She readies herself to accept that baby as a new person in her life.

The pregnant woman is also preparing, in this third trimester, to regard herself as a mother, in her own personal understanding of what the role means to her. To many women it can carry a frightening sense of responsibility with it and a woman who has been very independent may fear the demands of a dependent baby. For many women being a mother carries with it the expectation of being an adult, of being competent, powerful and effective. Expectations such as these may cause a lot of anxieties in your client or perhaps positive feelings and optimism—confidence in her own abilities. Your client may work on these issues in dreams, fantasizing, daydreaming and thinking very planfully about the child and how it will be to live with a child.
You may also find that your client's mother plays an important role in her understanding of herself as a mother during these 3 months. There may be a reconciling of conflicts between your client and her mother, an appreciation of the mothering your client received, an acceptance on her part of her own neediness and dependency.

Your client and her husband have hopefully been able to communicate their needs and fears and hopes during this time and particularly in this last trimester. Pregnancy is a turning point in both their lives; it causes them both to take stock of themselves and their relationship and their dependency on each other.

There is also the immediate task of preparing for the birth itself. Many women experience fear and anxiety about it, especially for a first birth. Childbirth classes are probably the best way to gain information to allay the fears ignorance of the labor and birth process have caused. It may take a lot of courage for your client to go to class; it's not easy to be vulnerable with a group of strangers. However, the consensus of the literature is that birthing is easier when relaxed than tense, and information and practice brings the capacity to relax.

The waiting is one of the most trying aspects of the end of pregnancy. It may be a time of stress for your client and she may show impatience, irritability, forgetfulness, and may find it difficult to concentrate and make decisions.
The third trimester, then, involves the culmination of the pregnancy: the pregnant woman coming to grips with a sense of herself as a mother, hopefully a healing or an understanding of her relationship with her own mother, continuing communication with her man about their changes individually and together, working through the fear and anxiety of motherhood and the birth experience and the trying nature of waiting, waiting, waiting.
CHAPTER FIVE:  DECISIONS

At the same time that your pregnant client will be made vulnerable, emotionally raw and introspective by the surges of hormones and physiological changes in her body she will also find herself facing some very important decision making. I am thinking particularly of the very early weeks of pregnancy when she may be nauseous, exhausted and off-center and yet will be dealing in one way or another with the tasks of choosing the kind of birth she wants for herself, her baby and her mate; selecting a doctor she feels confidence in and comfortable in working with and deciding whether or not she will want to breast feed. As she sorts through these issues, others may present themselves to her, such as whether or not to seek out genetic counseling or an amniocentesis test; whether or not to join a birth class or locate a support group.

It is a reflection of the intense nature of pregnancy that these very adult decisions, requiring research, thoughtfulness, assertiveness, sound judgment and self-confidence come at a time when the woman's defenses and sense of herself may be very shaky. This is a crucial time for her to have the additional support of a trusted counselor.

In all these decisions the most important questions for your client are very personal ones: Am I comfortable with this? Can I talk easily with this person? Is this
appropriate for me? What do I want? Does this suit me and my mate? Is this what I want for my baby?

Many of these decisions involve working with the medical community. Your client may feel intimidated by the authoritarianism of some doctors, nurses and hospital staffs and the dogmatic attitudes she may find in them. It certainly wouldn't be unusual if she did feel that way, I know I do.

After working through many of these decisions for myself, I have come to see that one of the side benefits of having done so at a time in my life when I felt particularly unsure of myself, I gained a great deal of the self respect that is now helping me to regard myself as a mother, as an adult capable of making responsible choices.

I regard the issue of birth style the preliminary decision for a pregnant woman to make because generally all other decisions rest upon the choice she makes about the birth she wants. Let me give you some basic information so that you will know the alternatives that are available for your client.

While there may be many variations in birth styles, philosophically there are two fundamental choices.

There is the birth style that places first the needs of the hospital, the staff and the doctor and maybe even the mother before the needs of the baby. The father is pretty much left out of this process. What I mean by
this is that birth is handled as a medical procedure and the aim is for it to be as quick and painless as possible, to meet the scheduling needs of the doctor, staff and hospital and probably, too, because the medical personnel want to spare the mother from enduring a long, painful birthing. What goes hand-in-hand with this type of birth is hospital delivery, and separation of mother and father, with the mother spending her labor mostly alone and then being shifted to a surgical room for delivery under the glare of bright lights. This will be a medicated birth involving either analgesics—pain relievers which give relief from pain without loss of consciousness; anesthetics—which produce either complete or partial loss of feeling, the more familiar being caudals, spinals and epidurals; and amnesics—which leave the mother conscious but with little or no memory of what she experienced from the point the drug is administered until it wears off. The mother is prepped, meaning she is given an enema to clear her lower bowel and has her pubic hair shaved, presumably for hygiene. After the birth the baby is separated from the mother and is housed in a central nursery. The baby feels the effects of the drugs that are administered to the mother and is often dopey, lethargic, may have difficulty clearing his/her own mucous passages and may be weak at sucking for a few days.

There is another style of birthing that is philosophically considerably different and more humane than the
preceding one. This may generally be called "prepared" childbirth and names that are associated with it are Lamaze, Leboyer, Dick-Read and Bradley. It is a birth in which the focus of the medical efforts and the intention of the parents is to bring an undrugged alert infant into the world that will greet it in the gentlest, most humane and understanding way possible. It is a birth in which the mother does not receive medication. The father works with the mother as her coach during the months of preparation before the birth and remains with her throughout labor and delivery. The infant remains with the mother immediately after the birth, resting on her abdomen until the cord stops pulsating and is then cut; and then breast feeding is begun shortly thereafter to enhance the emotional attachment between baby and mother, to give the baby colostrum from the mother's breast which provides antibodies against infection and also to expel the afterbirth and assist the uterus in contracting to a non-pregnancy state.

There are variations, as I have said, between these two birth styles but philosophically they do divide the spectrum of birth styles your client will have to choose from.

Prepared childbirth can take place in a hospital setting. Some hospitals have alternative birth rooms, which look much like bedrooms and where the husband and wife spend labor and delivery together. They usually go
home with the baby within twenty-four hours of the birth.

It is also possible to have prepared childbirth in the hospital under more routine conditions, with the mother remaining in the hospital for approximately four days. If the hospital has "rooming-in" she can have the baby in a crib next to her bed throughout the day. This helps the mother establish an attachment to her baby, makes it easy for her to breast feed and provides an opportunity for her to learn about infant care from the staff nurses.

Prepared childbirth can also take place in settings other than the hospital. There are people who regard hospitals as institutions for sickness and not suitable places for the natural and healthy process of birthing. So they choose to have their babies in their own homes or in a small clinic set-up or in a doctor's office. In all these circumstances trained obstetricians and/or nurse-midwives carefully check the progress of the mother and in the event of problems will immediately remove her to a hospital.

I hope this gives you an idea of the possibilities of birthing. I strongly recommend that your client read a few books on the subject so that she can select particular details that she does or does not want as part of her delivery and can discuss them with people she interviews as she begins to select a doctor.

I emphasize deciding on birth style first because
it will help your client to select the doctor she wants to work with. How does she go about selecting a doctor? Here are some suggestions I have gleaned from the literature in the field and from my own experience.

It's important for her to be well informed about what she wants. Then she can begin asking for referrals of hospitals and/or clinics who share her preferences in birthing. She can ask her family doctor. She can visit hospitals and if she sees one or two where the facilities seem comfortable and the staff friendly she can ask for referrals from the labor and delivery nurses who can give very revealing information about the doctors who use their facilities. I found this an invaluable source. She can call birth preparation teachers and get referrals from them. She can also ask for recommendations from people she knows personally who have had babies.

Once your client has these names and numbers her next step is to call and ask questions. Some doctors will talk over the telephone; some will suggest a consultation; others, perhaps with a group practice, will have orientations where prospective clients are invited in for a discussion of what their services offer.

Your client may find some or all of this process of asking people questions very difficult to do. She may feel a lot of anxiety about the birth process itself and she may also find it hard to ask for time, to feel important enough to get the answers she wants to make her
decisions. Here she needs a lot of support, and the opportunity to practice some of those questions with you, her counselor. You can role play with her a cooperative nurse, an uncooperative nurse; a doctor who supports prepared childbirth, a doctor who does not. Let her experience uncooperative people first with you and she'll be better able to handle them in reality. Most of all, listen to her anxiety. It's awkward to be thinking about birth styles when her due date may be seven months away and the thought of the birth frightens her. It will help her to talk about her anxieties with you at the same time she persists in gathering information and researching her choices.

It's also very, very important for your client to trust her own intuition and her own feelings in this process of selection. A doctor may come at the top of many referral lists but if she speaks with him and feels intuitively that this is a person she does not trust and would not feel comfortable talking to, then that's not the doctor for her. I listened to my own feelings in just such a situation and decided against the "well-recommended" doctor. I ended up feeling very much at home in a group practice in an alternative birth center and now every time I call up with a question and am immediately given information, reassurance and help, I am grateful I waited until I found people to work with that offered the emotional support I need to feel comfortable.
Among the issues that may come up once your client has selected a birth style and a doctor who supports her choice in birth styles are genetic counseling and the amniocentesis test. Perhaps there has been a history of an inherited abnormality in your client's or her husband's family. Perhaps your client is worried about a drug she may have taken in the early weeks of her pregnancy when she did not know she was pregnant. Or your client may be over 34-years-of-age and troubled by fears that she may bear a Down syndrome child, the odds of which increase with maternal age. Or, your client may have had a child already that was handicapped or a Down syndrome child. With these kinds of questions she can ask her doctor for a referral to a genetic counselor, who is an advisor with special training in medical genetics, the study of how traits are passed from parents to offspring. Genetic counseling involves taking a complete family tree with information about the genetic and medical history of the patient and family.

Amniocentesis is a specialized test designed to examine the chromosomal structure of the fetus to determine whether any genetic abnormalities due to chromosome irregularities exist. There is a medical geneticist on the staff as well as a radiologist and an obstetrician. Amniocentesis does not give information about all possible abnormalities but it does about those which can be detected
by an ultra-sound picture of the fetus, e.g. spina bifida, and those caused by chromosomal irregularities, e.g. Down syndrome.

Amniocentesis is performed about 16 weeks dated from the last menstrual period. The test consists of a family history (genetic counseling), a sonogram (an ultra sound picture of the fetus), amniotic fluid taken from the uterus which is extracted by a needle inserted into the mother's abdomen and a follow-up of the child for several years.

One of the possible and dreaded outcomes of genetic counseling and amniocentesis testing is that the fetus is abnormal. Your client and her mate will have to deal with the decision of whether or not to abort that fetus. It may be an agonizing decision for them to make and they will need time with you, hopefully together, to work through their grief, their guilt, their fears and their ultimate choice. For some it may be a terrible loss but the decision will be very clear to abort.

During these weeks of choices and decision-making, your client may look for groups to help her in the process in addition to her counseling time with you. I found a great absence of such groups for the first critical months of pregnancy and really hope to see the gap filled. One way is through group counseling sessions, given by you at your own office or through a private doctor or birth center. During the early months it would be in-
valuable for a pregnant woman to have a group she can meet with weekly or every other week to discuss her feelings, discoveries and fears.

Here the best suggestion I can offer is for your client to ask wherever she can if support groups are available. She can ask her doctor; nursing staff at the hospital; ask in maternity shops, check out bulletin boards in health food stores, church associations, other pregnant women she meets, her local Planned Parenthood Association, the local YWCA, the Red Cross, and so on. If nothing is suitable before, she can look forward to joining a birth preparation class in her sixth or seventh month of pregnancy. She can get referrals to a class through her doctor or any of the other sources I have mentioned in this Chapter. In this case, a referral from the doctor with whom she agrees on birth style is very valuable because that doctor will know from experience which teacher prepares women for the kinds of deliveries he performs. Then with a few names from him or her, your client can find the teacher with whom she feels most at ease. Around this time, too, your client can begin attending meetings of La Leche League International, which is a group that promotes breast feeding, if breast feeding is her choice. La Leche League is a very helpful organization, and I have found them very patient and helpful with all sorts of questions to do with child-birthing.

Birth classes, in general, are weekly meetings
of the pregnant woman and her partner. (The partner may be a friend if her husband chooses not to participate). There should not be more than 8 to 10 couples in a group. The lessons themselves consist of information about nutrition, the physiology of childbirth, exercises to practice for childbirth, breathing techniques to use during the different stages of labor and overall they do a great deal to allay the fear that comes with ignorance of the whole process of childbirth. They are available to anyone who wants them, whatever type of birth has been selected. They are excellent preparation for any kind of birth. There are even classes for women who know they will have caesarian sections and husbands who attend these classes are permitted to be with their wives in the operating room.

Breast feeding is the last area of decision making I will discuss in this chapter. Many others may come up in your particular sessions and as with all these, need to be thought about, talked about, experienced emotionally, explored and tested as your client makes up her mind about what to do.

Nutritionally, breast milk contains the most complete dietary package; it is raw, fresh and sterile and easily digestible. Breast fed babies don't get constipated and are less likely to get digestive disorders than bottle fed babies. It allows the baby to regulate the amount of food he/she wants and because no special
equipment or devices are required it is more economical than bottle feeding. Most of all it brings the baby and mother into very intimate physical contact which may be very satisfying to each of them.

Bottle feeding has its own advantages. It releases the mother from sole responsibility for the child's nourishment by making it possible for other people to feed the baby. In so doing it allows her more freedom to work and come and go, than does breast feeding. It allows the mother time to rest in that her husband can give the baby a feeding. It reduces the anxiety of not knowing how much her baby is consuming.

This is a personal issue, of course, and one which every mother needs to make for herself. I will mention, however, that with some birth styles, doctors will require that mothers do breast feed. This is particularly true of prepared births at non-hospital settings, both for the well being of the baby and because breast feeding insti- tutes hormonal changes in the mother's body which contract the uterus and deter the possibility of hemorrhage. So this is a decision that needs to be made early in your client's pregnancy, along with her choice of birth style and hospital.

Let me add that while I am emphasizing the value of early decision making on these fundamental issues of birthing, not everyone is able to make these decisions early and not everyone feels the same about their choices
a few months down the road. It is almost always possible to make changes later—they may involve more money and possibly some problems of timing (e.g. getting into a birth class; having enough time to prepare properly), but changes can be made.

In conclusion, let me recapitulate briefly the kinds of decisions your pregnant client will have to deal with during the course of her pregnancy. It is my recommendation that they be made as early as possible. Number one is to select a birth style she feels best reflects her philosophy of childbirth. This may be a drug-assisted delivery or it may be prepared childbirth (sometimes referred to as natural childbirth). In selecting a doctor your client may want to examine hospital settings, alternative childbirth centers and the possibility of home delivery. Based on this information she will begin asking for referrals and calling doctors to see who shares her feelings about childbirth and to whom she is comfortable talking. If she has particular fears or a history of family abnormality she may want to consult a genetic counselor or have an amniocentesis test.

As the early decisions are dealt with she may find the need for a support group of other pregnant women to meet with regularly and she may want to find a birth class to sign up with to begin in her sixth or seventh month. If she chooses to have prepared childbirth she will be required to attend classes. She will also need to make a
decision about breast feeding. If she elects to have prepared childbirth in a non-hospital setting she will be expected to breast feed and if she elects to have a drug-assisted hospital delivery she will have a longer time in which to make that decision.

These may be difficult decisions for your client. She may be anxious about the whole arena of childbirth and it will be a struggle for her to gather information, and ask the necessary questions to make her choices. You can help by being supportive, listening actively, helping her to focus on the issues that frighten her and to help her to trust her own intuition in her exploration.
In this Chapter I will discuss with you some basic concepts and guidelines concerning nutrition and exercise for the pregnant woman. I want you to have this information because you are working with a client who is undergoing physical as well as psychological changes and it is important that you are aware of the physical care she requires at this time.

Thus I want to give you some idea of what to expect in the diet and exercise program of your client. I also believe there are many clues to be found in how your client is caring for herself. For example, should your client answer your inquiries about what she is eating daily with such food items as soft drinks, candy bars, fast food chain hamburgers and french fries, then you know that she is either very ignorant about nutrition, not communicating very well with her obstetrician or feeling a good deal of ambivalence about having her baby. Work with her on both fronts at the same time; improving her nutritional intake and the underlying causes for it.

You and your client may be unfamiliar with the pregnant woman's needs for and limitations in exercising. Here, too, there are opportunities for you to explore with your client her anxiety and ambivalence about pregnancy and her fears about childbirth, harming the fetus or hurting herself.
The fundamental concepts of good nutrition have not varied much over time—the basics seem to remain the basics. Attitudes about weight gain do change, however, and guidelines about the recommended quantities of food do vary as well. The current trend is for higher weight gain than twenty years ago. This is a topic for your client to discuss with her doctor, but for your information the literature today advises maternal weight gain of from twenty to forty pounds, with the emphasis of twenty-four to thirty pounds.

What is becoming more and more clear is that the mother's nutrition plays an important role in the healthy development of her unborn child. Poor nutrition may lead to complications in pregnancy, premature babies, low birth weight babies, still born babies, retarded and deformed babies and ill health in the mothers.

Let me share with you a list of the basic nutritional components that are necessary for a balanced diet at any time, but especially during the term of your client's pregnancy.

Protein: Found in meat, fish, eggs, milk, beans and cheese. Contributes to the building of tissue, a solid placenta, and a strong uterus. It also keeps the blood sugar high. Recommended is at least 80 grams a day, preferably over 100.

Vitamin A: Found in vegetables, whole milk, fortified milk. Offers resistance to infection,
strengthens mucous membranes, important in function of eyesight. Vegetables also provide roughage, excellent in preventing constipation.

**Vitamin B**: Found in bread, wholegrains, liver, brewer's yeast, wheat germ. Helps to prevent nervousness and irritability, skin problems, lethargy, constipation and reduces changes in pigmentation of skin.

**Vitamin C**: Found in citrus fruits, potatoes, broccoli, green leafy vegetables, canteloupe. Keeps capillary and cell walls strong and builds a strong placenta, fights viruses and infections, helps absorb iron and calcium.

**Vitamin D**: Sunshine, milk, fish-liver oil. Works with calcium to strengthen bones and tissues.

**Vitamin E**: Whole grains, corn, peanuts, eggs, green leafy vegetables. Helps the body utilize oxygen, promotes healing and helps the body metabolize Vitamin A.

**Vitamin K**: Synthesized by the body from a balanced diet. It is necessary to the clotting mechanism of the blood.

**Folic Acid**: Found in leafy green vegetables, liver, kidneys, brewer's yeast. Folic acid is necessary to prevent anemia and fatigue. Essential for protein synthesis in early pregnancy and for blood formation and formation of new cells.

**Iron**: Found in liver, raisins, beets, fish, egg yolks, meat, molasses. Iron is a main component of
hemoglobin and the blood hemoglobin carries oxygen to the fetus and mother's cells. The fetus draws on mother's iron reserve to store iron in its liver to last for approximately six months after birth. During labor mother will need lots of oxygen (supplied by the hemoglobin) for her uterus and for the baby's brain cells.

**Calcium:** Found in milk, milk products, stone ground grain. Helps counteract sleeplessness, irritability, muscle cramps, nerve pains and uterine ligament pains. These may be signs of a deficiency in calcium. Can be taken in supplement form along with yogurt or Vitamin C on an empty stomach to increase absorption.

There are many minerals found in trace amounts in the foods mentioned above that are necessary for the body to utilize all nutrients it receives. A well balanced diet will provide them.

**Fluids:** 6 to 8 glasses of water or fruit juice daily. Fluids aid the circulation of blood and body fluids help the distribution of mineral salts and stimulate the digestion and assimilation of foods. Lots of water helps prevent urinary infections. (Boston Women's Health Book Collective: 1976)

Generally speaking, a well balanced diet will provide daily needs of the above nutrients. However, many women do take supplemental daily vitamins to ensure themselves and the fetus of adequate nutrients and in particular to provide vital iron, folic acid and calcium.
Your client's obstetrician will probably make such a recommendation to her.

Here's an example of daily eating for your client:

1. Every day, 2-4 glasses of milk or equivalent in cheese or yogurt.
2. Two eggs.
3. Two or more servings of fish, liver, chicken, lean beef, lamb, pork or cheese (or dried beans peas or nuts);
4. One or two servings of fresh green leafy vegetables;
5. Two or three slices of whole grain bread.
6. A piece of citrus fruit or glass of fruit juice
7. One pat of butter;
8. Four times a week a whole-grain cereal;
9. Five times a week a yellow or orange colored vegetable;
10. Liver once a week;
11. A baked potato three times a week.

This food plan is a universal guideline I have found in much literature in the field. I suggest that if your client has not done so before, have her keep a diary of the food she eats every day for a week. Have her record the quantities and the grams of protein she eats and take an honest look at how well she is meeting her nutritional needs. I keep such a diary every day and it has made me very aware of the food I am putting into my
Jokes are made about special food cravings pregnant women sometimes have. Or a ravenous appetite that causes huge weight gains. It is very possible that these are signals that your client's body is deficient in iron or protein and it is important that she discuss this with her doctor and examine her diet carefully. Her body is giving her information that may appear misleading.

On the other hand, many sources suggest pregnant women would do well to eliminate certain substances from their daily intake. Included in these are caffeine (found in coffee, tea, cola drinks, chocolate products), alcohol (except perhaps in small amounts occasionally but this is under considerable controversy), cigarette smoking, sugar (at least beyond a moderate amount), artificial additives and preservatives and pharmaceutical and recreational drugs. These substances have been found to cause deformities, low birth weight, mental retardation and other problems in babies.

Talk with your client about the way she feels about changes she may be making or feels she ought to be making in her diet. She may not feel self-sacrificing or devoted to the fetus; she may want to eat what she wants to eat. She may not really believe she's pregnant and so deny it by eating poorly. Explore the area with her.

The focus of exercise in pregnancy is on the well-being of your pregnant client and to prepare her for labor
and delivery. It is important for her to know that the fetus is well protected from bumps and shocks in the water insulated uterus. Any caution in the area is primarily aimed at the pregnant woman because she may increase her chances of injury because she tires easily and her body feels awkward. It's important for her to exercise common sense in whatever exercise she undertakes with the following guidelines: During pregnancy it's safest not to take up a new and strenuous sport; weight-bearing sports may be dangerous and; competitive sports may be too exhausting.

Generally speaking, it seems safe and healthy for your client to continue in the activities she is accustomed to. If she's already jogging it's fine for her to continue. Swimming is excellent exercise, as is walking. A daily exercise routine is vital. Listening to her body is her best guideline for what's healthy for her; if she feels strain, especially in the lower abdomen, that's a signal for her to stop, or ease off. I, myself, have continued with my daily yoga routine and as one or two of the postures have become a strain on my abdomen, I have eliminated them from my routine and found others to replace them. I have learned to trust my body as a guide; so, too, can your client.

Aside from the feeling of well being and good muscle tone that come with regular exercise, there are specific benefits and goals aimed for in pre-natal exercise. They are: to learn to relax completely and voluntarily,
to provide rest during the course of pregnancy and to use
during the first stage of labor; to practice correct
breathing which helps make labor comfortable; to exercise
the Kegel muscle, which is a muscle supporting the vagina
and reproductive organs and to learn to relax it to make
birth of the baby easier; the pelvic rock which is good
for body mechanics, excellent to relieve backache and
which strengthens the muscles which support the uterus
and; squatting, which spreads the perineum and accustoms
the legs to being spread wide for delivery.

These areas are covered by every birth preparation
exercise program I have researched and seem universally
to cover the special physical needs and techniques your
client will be required to perform to facilitate a comfor-
table birth experience. Knowing about them will give your
client a guideline in what to look for in any exercise or
birth class she wants to join. She can ask the teacher if
she covers each of these areas.

Classes can be found through your client's doctor,
referrals from other women, through the YWCA, local Depart-
ments of Recreation and Parks, local private gyms and dance
studios for women, birth classes, books, and so forth. No
matter what kind of birth your client has selected, it
will help her prepare physically and emotionally to make
exercise a part of her daily program. The better prepared
she is for childbirth, the less fear she will feel, the
more comfortably she will be able to move through the
psychological process of her pregnancy experience.

Nutrition and exercise, then, are vital ingredients in the well being of your pregnant client. Nutrition has a direct bearing on the health of the fetus and exercise, though more indirectly, has a bearing as well.

Both areas offer you as a counselor both direct and indirect information about the psychological state of your client. Explore with her what she eats daily; is it in any way inconsistent with her expressed feelings about her pregnancy? Discuss any inconsistencies with her and the fears and anxieties they may reveal. Share with her your knowledge of nutrition and help her form some guidelines for herself. Find out what kind of physical activity she engages in and on how regular a basis. Discuss with her the physical needs of pregnancy and childbirth. She may be ignorant or fearful of hurting the fetus and may need permission to engage in safe physical activity.

As a counselor to a pregnant woman, you are taking part vividly in a process that involves a whole human being with physical, psychological and emotional needs. I hope this information helps you to see the whole of the health of your client.
CHAPTER SEVEN: THE COUPLE TOGETHER

I have thus far focused primarily on the experience of pregnancy for your female client, the pregnant woman. I'm sure, too, that most of the world of people in which she lives also focus on her during this time. However, she is most likely to be married or in a close relationship with a mate and although it may not be commonly recognized, he, too, is thrust into profound changes by the fact of pregnancy.

Fathers-to-be have been a largely unexplored group in our culture. In this chapter I will discuss with you some of the experiences the mate of your client may encounter. They may include his own confrontation with himself as a father, with the demands his pregnant wife may place upon him, the physical symptoms he may experience himself during pregnancy, the anxieties he may have about the approaching birth, and his needs during this nine month period.

I will also include material on sexuality and the need for communication between the couple during their shared pregnancy.

Not all men will experience the pregnancy in the same way, but I hope the information I have gathered will give you some idea of what may be taking place for your client's mate.

Pregnancy may be a time of personal upheaval for
the mate of your pregnant client as well as for her. The man may confront himself, doubting his own ability to be a responsible parent, an adult. It is a task for him to incorporate the coming child into his planning for the future, to make room for another person in his life. The process for the man also involves a great deal of ambivalence and vulnerability, just as it does for his wife. What may make the process more difficult for him is that our culture does not expect him to be undergoing the same process; there is not a place for him, not quite as yet. With your help, your client can come to appreciate how much a period of transition the pregnancy is for her husband as well as herself, and she can help meet his needs for nurturing and support as well as her own.

It is very common for women to feel the greatest anxiety and ambivalence over the pregnancy during the first trimester, and a diminishing of these feelings as they enter the second. The response may be quite different for the mate. He may feel very comfortable with the idea of early pregnancy but when he actually feels the kicking and sees the changes in his wife's body, the fact of pregnancy is thrust home in a way he had not accepted before and his anxiety may rise considerably. It may help your client to know that this is a very normal experience, and this may be a time when she needs to be sensitive to her husband's emotional needs. Ambivalence is a great part of the process of pregnancy, both for the man and the
woman. It may take a full nine months to adjust to the idea of a baby coming.

Some men experience physical problems during their women's pregnancies that are akin to the women's symptoms. These may include loss of appetite, heartburn, toothache, nausea, fatigue, vomiting, and gastrointestinal problems. Some men put on 10 to 20 pounds which they lose shortly after the birth of the child. Towards the end of pregnancy some men have difficulty in sleeping, general restlessness and anxiety. Many men may begin to work frantically during the last few months of pregnancy. It may reflect their way of coping with the anxiety of approaching fatherhood, of providing for their wife and child; it may be much more a reflection of the husband's need to prepare himself for fatherhood than it is a sign of his neglecting his wife. The sense of increased financial responsibility troubles many men.

It is also not unusual for a man to feel jealous of his wife's capacity to carry a child and to feel jealous of the fuss other people make over her during the pregnancy. I have been startled to see how much attention has been directed towards me when my husband has also been present. Questions that could easily have been addressed to him were addressed to me.

A husband may show his anxiety in indirect ways, by being hostile to his wife's pregnancy, by being sullen, irritable, unsupportive of his wife, and unenthusiastic
in his reaction to the pregnancy. He needs support from his wife and encouragement to talk frankly and openly about his feelings. It is possible that such a man will not change his attitude until the birth of the baby or even longer. His wife, then, will need support from her network of friends, family and from her counselor.

At the same time the man is undergoing a turning point in his life, his wife may need a great deal of nurturing and support from him. It may be difficult for her husband to respond to her when his own dependency needs may be so great at this time. It also may be confusing to him to be the source of nurturing and maternal qualities at the same time he is struggling to see himself as a father and a masculine figure. This combined with changes in his wife's body and in their sexual life can be a source of turmoil for the man. He needs to be able to turn to his wife, too, for his needs, for close communication and for reassurance.

As in any crisis time, the emotions experienced by both man and woman may be painful, raw, confusing and anxiety provoking and yet at the same time offer the possibility of growth in their relationship, of increased closeness and feelings of love for each other, and for a renewal of their marriage. It is very important for them to speak frankly of their feelings and experiences and to listen genuinely and nonjudgmentally to each other. They can learn to be very sensitive to each other's needs
during the course of the pregnancy. It can evolve into a beautiful time for them.

The father's experience of pregnancy may be greatly enhanced if he becomes involved in the pregnancy process with his wife from the beginning. He can be a partner in the decision making of a style of birth to be selected and in the choice of doctor. Here it is particularly important that a willing husband have an opportunity to participate with his wife. He may choose to accompany his wife on visits to the doctor and he can enroll with his wife in birth preparation classes where he has a valued role in the process of labor and delivery itself. This is probably the closest to a rite of passage our culture provides for a man and it is a wonderful forum for husband and wife to discuss their needs and fears and hopes and to work together towards the approach of the baby. It is also very helpful if the husband learns along with his wife as pregnancy progresses, by reading the same books, by talking with the doctor and by keeping in close communication with his wife. With awareness of and sensitivity to each other's needs, husband and wife can work together during their common pregnancy.

Your client's pregnancy will affect her sexual life with her husband in one way or another over the course of the nine months of gestation. The changes in sexual life may be for the better, for the worse, or just be different; in any case what they do provide for is open
and frank communication between the couple and quite possibly an enhancement of their concepts of sexuality.

The wife and/or the husband may find the frequency of their sexual desires different during pregnancy than before pregnancy; their desire may be out of sync; their usual pattern of lovemaking may change; there may be concern over the safety of the fetus and sexuality may change for them with different stages in pregnancy.

Fundamentally it seems most important to me that your client and her husband look upon sexuality with a broad base during pregnancy. Lovemaking includes giving and receiving signs of affection, caring and tenderness, such as caressing, touching, kissing as well as sexual intercourse, oral sex or manual stimulation. What is most important is for the individual couple to communicate freely about their needs, concerns, preferences and anxieties so that they can evolve a sexual life that is pleasurable to them. There is no one standard for acceptable sexuality during pregnancy--in fact it is an area of pregnancy that has been relatively unexplored and that means, fortunately, that the pregnant couple are relatively free from preconceived ideas of how sexuality should be for them. Help them to find their own way and own style through communication with each other.

As a general rule I would suggest your client and her husband question their doctor about sexual guidelines during their pregnancy. I suggest this for two reasons:
first, it is very common for both man and woman to harbor fears that sexual intercourse and/or orgasm may jeopardize the fetus and second, it will allay the anxiety these fears may impose upon the sexual relationship. When there has been a history of miscarriage or signs of sensitivity in this pregnancy a doctor may suggest no intercourse for the first three months or no intercourse around the time a period would have been expected for the first three months. Or, a doctor may say to stop having intercourse later during the pregnancy, for the last 6 weeks perhaps, or before, under certain circumstances. In these instances it is very important that your client get very specific information from the doctor about what is safe and what is not safe to do. Is it all right to have an orgasm but no intercourse? Or intercourse without orgasm? The information should be very clear.

From the literature, it appears that there are differing opinions as to what is safe or harmful to the fetus. Medical opinion is still mixed as to whether or not an orgasm can sometimes initiate premature labor. There are uterine spasms after orgasm that are considered quite normal during pregnancy. The chance of introducing infection to the fetus is very unlikely because the baby is protected behind a closed cervix and its sac is encased protectively in the bony pelvis. Most of the current literature says intercourse is fine for as long as the
couple enjoy engaging in it. I do think for their own peace of mind the couple ought to clarify this with their own doctor. And you can help them keep in mind that sexuality is much more than intercourse and they don't have to stop giving each other sensual pleasure at any time during pregnancy.

There is a great deal of individual variation in how people respond sexually to early pregnancy. In some cases couples feel such great freedom from either having to think about contraception or from trying to have a baby that they can relax and enjoy sex a great deal. Or, it may be that the wife is feeling so lousy with nausea and fatigue that she has no interest in sex. Or the husband may feel so much anxiety himself, about fatherhood and fear of hurting the fetus that he loses interest. Or there may be a couple in which one feels a decrease of sexual interest and the partner feels an increase. It's important for them to talk about their feelings, reduce any sense of rejection one or both might feel, and work out ways to meet their own and the other's needs.

As the pregnancy proceeds your client and her husband may have difficulty adjusting to the woman's enlarging belly and breasts and changes in the nature and smell of her vaginal secretions. The woman may need reassurance and affection to feel she is still desirable. Her man may be turned off by her body, or confused about feeling sexual to a woman so clearly pregnant and in the
process of becoming a mother. The woman may feel uncomfortable and awkward having intercourse.

Again it is important that they talk about their feelings together. With sensitivity and understanding they can work out not only a satisfying sexual relationship to meet their own individual needs throughout their pregnancy, they can also be enriching and expanding their capacity to communicate with each other. Sexuality is a very intimate subject for many people and by discovering they can talk about it and work through changes they may add a whole new dimension to their feelings for each other.

Pregnancy, then, is a time for both your client and her mate to prepare for the birth of their child. Your client's man is undergoing much the same process she is on an emotional and psychological level, though he does not carry the child himself. He may even share some of the physical symptoms of pregnancy.

They are both going through a process of readying themselves for a new person in their lives, of regarding themselves as parents, of many anxieties about the changes that lie ahead of them. Fathers specifically may feel neglected by all the attention their wives are receiving, may feel jealous of her capacity to give birth and, may feel pressured to provide financially for the family.

The husband may feel drained by his wife's dependency needs and by his own at the same time; he may also be confused by the degree to which he is able to be nurturing
and mothering to his wife.

The father may make a place for himself in the pregnancy and delivery process by meeting with the doctor and by taking part in childbirth classes and the delivery along with his wife.

Nowhere will the opportunity for frank and open communication between your client and her man be more important than in the area of sexuality. There will be changes in their sexual pattern and it will help them enormously to be able to talk about their changing feelings. They may find differences in desire between nonpregnancy and pregnancy levels and between each other. They may feel great freedom, or considerable anxiety or some of both. They may find their tastes in sexual practices changed during pregnancy. They may find they have doubts about the safety of the baby and about what is considered appropriate sexual behavior during pregnancy.

They both need reassurance and encouragement to talk openly with each other, to explore new or different ways of making love, and to regard love making as a much broader range of expression of affection than strictly as sexual intercourse. They may also need encouragement to talk frankly with their doctor about his/her guidelines for sex in pregnancy.

Most of all this is a time for them to treat each other with understanding, sensitivity and consideration.
CHAPTER EIGHT: THE ISSUES OF PREGNANCY

In this Handbook I have sought to present to you a picture of the possible range of physiological and psychological changes your client might be in the process of experiencing as she progresses over the course of her pregnancy. I believe that with this information you will have the awareness and insight to help your client clarify and focus on important issues that may present themselves during her pregnancy. You may have to listen very carefully, for your client may be very unclear about her concerns in the midst of the turmoil of pregnancy.

Let me discuss with you again some of the major concepts of pregnancy as a time of transition for your client. Pregnancy is a gradual process rather than a discrete event; it is a time when your client is becoming—a pregnant woman, a mother, a changing partner in a marriage. Your client will be confronted by issues from her past which need to be reworked as well as the pressing needs of her pregnancy and future motherhood. The hormonal shifts of pregnancy can be seen as making possible, even facilitating the psychological transitions of pregnancy.

Among the issues that may come up for your client during pregnancy are deeply fundamental ones; such as, facing and resolving emotional dependencies, questioning her capacity to love and to be attached to another human being, working through and reconciling with her own mother,
developing an adult sense of herself, and making a place emotionally for a new person in her life.

Pregnancy involves the stirring up of early, intense and conflicted feelings and sets the stage for the pregnant woman to work them through in a new way. Childbearing involves a step forward in the life cycle. It may be a time of ambivalence, re-evaluation of herself, her skills, and her own parents. Authority problems may be activated during pregnancy particularly in response to the treatment the pregnant woman may receive by people she encounters. She may receive very mixed reactions from friends, she may suddenly find herself the receptacle for advice giving and horror stories about birth defects and deliveries with complications. It's an opportunity for your client to come to terms with society's expectations of her and the expectations she has of herself. Doing so involves a process of living them through by talking them out and testing out new ways of being.

I hope you can help your client see that the turbulence of this period holds great promise for her development and evolution as a person. That pregnancy and childbirth can be thought of as a challenge and that in the process of preparing for childbirth and motherhood she can come to trust herself, her body and her instincts in a way she will keep with her always. A woman may feel pregnancy is a loss of control over herself; I think it is a time of change and reintegration out of which a woman may
emerge with a greater sense of self knowledge and self control than she knew before.

As counselor you can help a great deal by understanding the nature of the pregnancy experience, and by being able to reassure your client that the chaos she may be experiencing is normal and in fact may be designed by nature to happen in just that way.

In the course of your counseling relationship you can also aid your client on her path by providing emotional support, helping her to clarify her feelings and behavior and by presenting issues that will come up during the pregnancy, such as preparing for the next stage of pregnancy and then labor and delivery. It is important for you to ask her how she looks upon childbirth early in the counseling process because there may be a great deal of anxiety here and much material to explore. Women who are able to work through these feelings generally feel much more relaxed in childbirth and are better prepared for it than if they kept their fears hidden.

Pregnancy is an optimal time to bring your client's partner into the counseling sessions. A facilitative and supportive environment may permit them to say aloud the fears and anxieties and the joys they have been hesitant to air. They may want to focus on their changing sexual relationship and you can help provide the environment to allow their exchange of feelings. Just knowing their problems are normal reduces a great deal of anxiety.
for husband and wife.

Both the husband and wife have strong dependency needs during this time and in providing a supportive rela-
tionship you are giving them a great deal.

Both husband and wife may have dreams, some very disturbing dreams, of the child and pregnancy and they can provide a springboard to uncover the fears and anx-
ieties underlying them.

It may help your client and/or her husband to meet regularly with a group of women and/or their husbands who are also going through pregnancy. I have found such groups very rare so you may want to start one yourself, or set one up through a private doctor or hospital. It alleviates much anxiety for parents to hear and say the feelings they're most ashamed in having; it's good for them to know they aren't alone in their experience of pregnancy.

Writing in a journal or a diary may also be very helpful to your client, in providing a forum for her to express and explore her feelings, to experience her process as she undergoes it, and to allow for self expres-
sion between counseling sessions.

You can facilitate your client's movement through the developmental step of pregnancy and childbirth by providing affirmation that it is truly a difficult and turbulent time and by providing a framework in which she can see herself in the process of growth. A supportive
relationship in which you listen, help her focus on critical issues, and help her to anticipate the stages that may come next will be very helpful to your client. Some of the issues you may expect to see will be a reworking of old relationships and conflicts, particularly with her mother, changes in and reworking of the relationship with her husband, a struggle towards a new sense of herself as an adult and as a mother, and finding a place for a new person in her life.

In the course of therapy it may help to bring your client's mate into the sessions, thereby facilitating their ability to communicate with each other.

Whatever specific methods you may choose to use in your counseling experience with your pregnant client, remember that this process may very well be an exciting and rewarding one for you. You are taking part in an intense life change over a relatively short period of time and the transition and movement may be powerful and very moving to be part of and to have contributed towards. There is great possibility here for gratification for you as well as your client.
SELECTED BIBLIOGRAPHY

* Indicates recommended reading.


