

Caesarean birth & how to support women pre- and post surgery

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Caesarean birth & how to support women pre- and post-surgery

1. Introduction:

After episiotomy, caesarean section is the most common operation performed on women – over 20% of babies are born in this way in the UK, and in some countries over 40% (e.g. Brazil – up to 80% in private hospitals, a large part of Latin America, a great part of the Asian continent, Southern Italy – (Odent; 5)) (Gordon; 419). If the need becomes apparent during pregnancy (e.g. placenta praevia), a caesarean may be **'planned'**; if it occurs in labour, it is known as an **'emergency caesarean'** (e.g. foetal distress, abnormal bleeding, high blood pressure, prolapsed umbilical cord and lack of oxygen to the baby), usually performed as it is considered essential to the baby's safety; and if it is through personal choice it is termed **'elective.'** Choosing to have a caesarean (elective) with no medical necessity is a topic of heated debate – some women may choose this option due to fear of the pain of vaginal birth (perhaps after a previous traumatic experience), fear of harming their baby or due to doubts over their physical ability, others due to scars from physical abuse. In most cases, the preference is to avoid the operation unless it is necessary to deliver a baby safely – this is due to higher maternal risks, higher costs and a longer recovery period. (Gordon; 420)

Most midwives and antenatal classes encourage active engagement in maintaining good antenatal health through balanced diet and a modified exercise programme (walking, swimming, yoga) to increase the mother's chances of a vaginal birth, which is what most desire as it is what they feel is natural and right. However, many caesareans are necessary and should not always be avoided – they can be life-saving to mother and baby in some cases. "Caesareans, and more rarely chemical inductions of labour are sometimes necessary to the safety of mother or baby. At the same time we need to recognise that caesarean surgery significantly increases the risk of death of a woman." (Gaskin; 290)

My interest in how to support women pre- and post- caesarean birth began during the course of my case studies when one of my clients, Mrs H, presented with placenta praevia – it was her first pregnancy, and another, Mrs T, with a breech presentation and a complicated history of labour - her third pregnancy.

i. Placenta Praevia:

If a placenta is found to be low-lying in the uterus at the 18-20-week scan, it is not appropriate to talk of a planned caesarean at that stage since as the uterus enlarges with the growth of the baby, it is often the case that the placenta moves with it into the upper part of the uterus away from the cervix. "Only six percent of low-lying placentas which were detected at by ultrasound in early pregnancy turn out to be lying over the cervix." (Kitzinger; p139) When I met Mrs H for the first session, I used this information as positive encouragement that she may well not have to have a caesarean. She really wanted to have a natural birth more than anything and said she would feel cheated if she had to go down the caesarean route. However, if Placenta Praevia is present in the last weeks of pregnancy, as it was in the case of Mrs H, the risks of depriving the baby of nourishment and oxygen during a vaginal birth due to the placenta likely being torn away from its roots as the uterus thinned are so great that it almost certainly means delivery by Caesarean. This occurs in about 1 in every 200 births and Antepartum Haemorrhage (APH) or bright red bleeding from week 27 onwards is a typical symptom of this condition (Kitzinger; p139), although my client did not present with this. "A real placenta praevia is a diagnosis of late pregnancy. It is an absolute indication for caesarean." (Odent; p74)

ii. Breech presentation:

This was Mrs T's 3rd pregnancy – her first two were characterised by early onset of labour at 32-33 weeks, with two traumatic birth experiences, not involving caesarean. Her first baby – a boy – was healthy in utero but was diagnosed with cerebral palsy after the birth and her second child – a girl – also experienced incompetent care which caused her to need several operations to her scalp after she was born. Mrs T's consultant would only have her in his care if she agreed to a planned caesarean at week 38 due to her being high risk; as it was she went into spontaneous labour at week 37, early as she expected. Since the baby was also breech it was clear that she would only be offered a caesarean, which is what happened. Mrs T was more than happy to go along with this advice as she did not want to repeat painful birth experiences, although she would, in an ideal world, have loved to have had a spontaneous natural birth with no need for intervention of any kind – to see if her body really could do it.

Types of breech presentations:

1. **Frank Breech** – buttocks first with hips flexed and knees extended so the legs are like splints along the baby's trunk.
2. **Complete Breech** – hips and knees are flexed but not below the buttocks
3. **Footling presentations** – one or both feet are below the buttocks

Odent lists breech presentation under '**debatable indications for caesarean.**' (see the rest of these below) (2004; 76). Having attended 300 breech births by the vaginal route, he suggests that the optimal conditions for this are a place with no one else present except an experienced, motherly and low-profile midwife who is not scared by a breech birth. If it is clear that the first stage of labour is long and difficult, then a caesarean should be the course of action. If not, he recommends total privacy to allow the birth to progress as easily and as fast as possible. However, it is not easy to find an obstetrician today who would accept responsibility of a breech birth by the vaginal route. (Odent; 78). Most routinely schedule caesarean births; there are, on the other hand, independent midwives who advertise this as their forte or at least offer women and their partners the choice. The main reason breech babies are delivered surgically is, according to Connolly and Sullivan (2004; 15), that the baby's head might become stuck during the birth if the legs or buttocks descend first, thus perhaps compressing the umbilical cord stuck in the birth canal, depriving the baby of oxygen and thus possibly causing brain damage. A recent study has shown that "babies born vaginally from the frank breech position were three times more likely to suffer serious injury or death than frank breech babies delivered by planned caesarean. For that reason alone, many physicians won't attempt a vaginal birth if the baby is breech when labour begins."(2004; 15)

If a baby is presenting buttocks first (breech) after 36 weeks, it is possible to turn it by a procedure called *external version*. If done before this time, the baby may move back again. It is successful in 70% of cases done between weeks 37 and 39. (Kitzinger; 243). In China, the use of *moxibustion*, (a herbal stick of Motherwort which is heated) to turn breech babies is centuries old. The moxa is lit and held over a point on the edge of the nail of the little toe, the theory behind which is that the heat travels up the bladder meridian, which is linked to the uterus. (West; 88). Other suggested complementary practices include inverted yoga poses (head level or lower than the rest of the body), positive visualisation of the baby being in the cephalic presentation (head down), walking for 20 minutes a day, as well as adopting forward-leaning positions from week 34. Homeopaths may prescribe *Pulsatilla*. (West; 89). Kitzinger, in the same way as Odent, reassures women that their bodies are designed to expand during labour, particularly the bones and tissues of the pelvis, therefore making delivery of a breech baby a distinct possibility, as long as the first stage of labour is not inefficient, painful and protracted and as long as the mother is in a supported squatting position and not dorsal or semi-seated. (Kitzinger; 275).

As the following information demonstrates, both my clients fell into categories where caesarean was really unavoidable in that it was to make birth safe for them and their babies. Although breech presentation is a debatable indication, according to Odent, in the case of Mrs T, planned

caesarean was her only option due also to her two previous traumatic and early onset labours, in the opinion of her consultant and medical team.

2. Reasons to be offered a Caesarean:

Caesarean rates have risen almost everywhere in the world; one of the main reasons why is that the operation has become safer and more acceptable. Before the Second World War, the Classical Section (vertical incision through skin, fascia and uterine muscle an inch above the navel to an inch above the pubic bone) was performed as a last resort as the risks of bleeding from the thick uterine wall and of infection were too high, as were those of bowel adhesions to the uterine scarring causing abdominal obstruction. However, the development of the Transverse incision (side to side) in a thin zone called the low segment reduced all kinds of complications and was cosmetically acceptable in the time of the bikini revolution. This happened at the same time as the introduction of safer methods of anaesthesia, the first antibiotics, blood transfusions and intravenous drips. (Odent, pp9-10); and the technique continues to evolve.

i. Absolute Indications for caesarean birth:

- **Cord prolapse** – if the bag of waters ruptures and the cord slips through the cervix to the vagina, becoming vulnerable to compression and therefore could cut off the baby's blood supply.
- **Placenta Praevia** (see above)
- **Placenta Abruptio** – the placenta separates from the uterine wall before or during labour; typically experienced as a sudden, terrible and continuous abdominal pain. This is one of the main causes of intrauterine death.
- **Brow Presentation** – the head of the baby is midway between full flexion and complete extension.
- **Transverse lie or Shoulder presentation** – baby lying horizontally. It also involves a modification to the incision in this type of caesarean.
- **Cardiac Arrest** – occurring once in every 30,000 late pregnancies. Speed and timing of caesarean are critical.

ii. Debatable indications for a caesarean birth:

- Previous caesarean (uterine scarring) – see information below on VBACs (iii)
- Failure to progress in labour – perhaps related to fear (see below)
- Foetal distress – related to failure to progress

- Cephalopelvic disproportion (CPD) – baby’s head is too large to fit through the mother’s pelvis – this can only really be known once labour has begun and often women give birth vaginally to bigger babies in subsequent pregnancies.
- Fibroids & ovarian cysts – if large and low they can block the baby’s passage
- Previous anal sphincter rupture
- Breech presentation – see above for information on vaginal breech birth
- Twin births – as one baby is usually breech or in 8% of cases, both are. Kitzinger (348) cites a study where birth outcomes in two areas of Denmark were compared – one where caesarean rates were twice as high as the other, but there was no difference in rates of mortality or morbidity perinatally.
- Triplets
- HIV-infected women – to reduce transmission of the virus from mother to baby
- Herpes virus – if a woman has developed it for the first time in pregnancy and hasn’t built up antibodies so could transfer it to baby in a vaginal delivery.

iii. Vaginal Birth After Caesarean (VBAC):

There is a lot of confusing and often contradictory information surrounding VBACs. Ina May Gaskin and her team at the Farm Midwifery Centre in Tennessee, USA have attended out of hospital VBACs for over twenty years with a 98% success rate – two women they referred to hospital during labour due to suspected dehiscence (thinning or separation of the previous scar). She puts their success down to the fact that **none** of the women in their care had induced labours with use of prostaglandins or oxytocin (Gaskin; 302). She suggests that VBAC is safe when other risk factors such as Cytotec or other prostaglandin induction aren’t added (Gaskin; 295). They would also always send women to hospital for care by a highly skilled obstetrician in cases where there is a case of placenta accreta (placenta overlying previous scar), if a woman in their care has had more than three previous caesareans and no vaginal births or those with previous classical incisions if they have also never given birth vaginally. (Gaskin; 302). She suggests that the confusion arises due to media-driven obstetric policy – the fear of malpractice lawsuits is a huge factor. (p300) “The risk of rupture of a uterine scar in a woman with a previous transverse lower uterine incision (the safest location on the uterus for incision) has always been and remains 0.5%.” (p295)

3. 'Risks' associated with caesarean births:

“Caesarean surgery is just as risky as any other major abdominal surgery for the mother – a considerably higher risk for her than vaginal birth. With repeat caesarean she has three times the chance of dying and roughly five to ten times the risk of complications such as infection, dangerous blood loss, transfusions, complications from anaesthesia, injuries to the bladder, intestines or urethra; future bowel obstructions, hysterectomy, ectopic pregnancies, infertility and dangerous placental complications. ...most of the above complications involve weeks of recovery, inconvenience, emotional trauma and expense, at the least. (Gaskin; 295)

The rate of C-section in the USA is 24% or up to 50% in certain hospitals. “But there has not been a corresponding rise in foetal survival rate.” (Kitzinger; 348) In fact, it has been shown that caesarean birth can pose risks to the baby’s postnatal health too. Montagu (61) posits that it is the cutaneous stimulation of the foetus during labour “which activates the autonomic nervous system, with (this) in turn acting upon the respiratory centres and viscera.” So, these short, intermittent stimulations of the skin produced over a prolonged period of time by contractions upon the body of the foetus “appear to be perfectly designed to prepare it for postnatal functioning.” However, when there is inadequate cutaneous stimulation, as in the case of Caesarean-born babies, “we should expect to find disturbances in the gastrointestinal, genitourinary and respiratory functions” (1986; 61). Gordon (421) also points out that babies born by c-section are more likely to have breathing difficulties as they have not been exposed to the same hormones as a baby delivered vaginally.

Breastfeeding problems
The flow of hormones during the birthing process are the same as those of lactation. “It is debatable whether women who have had no labour can release oxytocin as effectively as those who gave birth in physiological conditions.” (Odent; 66-7). Before 1980 most women who had a caesarean did not breastfeed, quite different from today’s picture; however, “the initiation of lactation cannot be the same as after a birth in physiological conditions. After a caesarean, for obvious reasons, mother and baby need help.” (Odent, 70) Odent also points out that non-labour caesareans seem to be associated with more breastfeeding problems as there has been no opportunity for the release of hormones involved in childbirth and lactation. He, therefore highly recommends that these mothers seek support groups to share their experiences and receive reassurance and assistance.

4. The Massage Therapist’s role in supporting women before and after a caesarean birth:

My client, Mrs H had been monitored for low-lying placenta from her week 20 scan. The first time that I saw her (at week 36) she was still uncertain as to the outcome. After this session, we talked at length about positive visualisation and imagining the placenta moving up away from the cervix as the uterus was growing. I also lent her a CD with visualisations and a book, which she took away excitedly! She left with a very positive spring in her step. As it was only the second time that I had met Mrs H when she informed me she was, after all, going to have to have a caesarean birth due to placenta praevia, I really felt such sympathy for her as she seemed so utterly disappointed, as though something had been taken from her. **“Both yesterday and today she has felt quite flat and detached from everything; anxious and not feeling excited – just knows to expect the unexpected – this she knows is due to the fact that she has been told she must have a caesarean due to the still low-lying placenta.** However, she is starting to feel a bit more positive and prepped for the birth in this way, having chosen some music to be played while she is having the baby – Mrs H and her husband compiled it yesterday evening – so they are doing what they can to be positive about the birth.” (Mrs H case history notes). The third massage session with Mrs H was the last before her scheduled caesarean (3 days’ later) so I focused on encouraging relaxation and the desire to ‘go within’ for inner strength and confidence for the birth; this included a great deal of energy work – “to the spine – with a hold to the occiput and coccyx and palming up the spine where I finally gave an energy hold on GV20 and the third eye.” (case notes, Mrs H) “After the (final) session, I also put together a list of ideas for holistic aftercare for after the operation and birth and dropped it in to her and her husband over the weekend so that they felt supported – she was grateful for that.” (case notes, Mrs H).

“I feel that it would have been of greater benefit had I been able to see her perhaps earlier on in her pregnancy and continue with her care over a longer period, likewise, after the birth of her daughter, **it would have been ideal to have worked earlier after the caesarean to support her both physically and emotionally, as it is clear she had a difficult time with her general health and healing postoperatively. I would like to have been able to introduce lymphatic drainage massage soon after the operation, which could have helped with the scar healing and also general decongestion of tissues and therefore improved immune function sooner.**” (case history evaluation, Mrs H)

This led me to become very interested in how I could better support and treat women who were about to have caesarean births, either through choice or planned, due to medical say-so. I felt there must be so much more that can be offered on a physical, mental and emotional level pre-

and postnatally. These are some of the ideas and advice that I have since tried to incorporate into my practice – either in the massage practice itself or passing on information.

5. Caesarean Birth (Pre-/ Aftercare) Advice:

a. Physical:

i) Before the planned caesarean:

- Lymphatic drainage techniques carried out pre-surgery can facilitate postoperative recovery – preparing the abdominal area for the operation/ decongesting tissues

ii) During the caesarean operation: (teach birth partner)

- Help the mother to breathe as deeply as possible
- Make eye contact and gentle, yet firm hand-holding and stroking to communicate soothing, caring attention

iii) Post Caesarean:

Physically, the major concerns for a mother post-caesarean are: pain from incision, involution (uterus shrinking), abdominal and intestinal gas; extreme fatigue and low energy; need for movement, gentle exercise and other comfort measures; increased risk of thrombophlebitis (2-3 times higher risk than those who birthed vaginally) & pneumonia (Osborne-Sheets; 130).

iv) Mother – 6-12 hours after surgery:

- Gentle, frequent movement to produce pain relief and improve circulation – wiggling feet / sliding legs (bending and straightening) / bracing legs in bed. Then, brief walks, within 6-12 hours of surgery help with peristalsis and therefore ease of elimination, hasten incision healing, improve bladder tone and reduce the risk of postsurgical complications such as thrombophlebitis and pneumonia (Osborne-Sheets; 130);
- Other recommended exercises post-surgery are (Noble; 199-201):
 - Diaphragmatic deep breathing (upper, mid chest & abdomen – with wall tightening as exhale) – this helps to dissipate trapped air under diaphragm from surgery which may be causing pain under shoulder blade.

- Huffing (forced exhalation by pulling in the abdominal wall rather than pushing it out – therefore less painful than coughing) - important to rid the lungs of excess mucous after shallow breathing during the (epidural /general) anaesthetic.
- Bridge and twist – good for prevention of gas pain done twice a day for first three days
- Pelvic rocking (lie on back and gently rock pelvis front to back, using abdominal and buttock muscles – can support incision with hands) – to help sluggish intestines
- Relief from gas can be obtained by lying on left side with knees curled up while gently kneading abdomen in clockwise direction
- Check midline (recti muscles) on third day – then progress to abdominal toning exercises as for any postpartum mother
- Take as many naps as possible and ask for extensive assistance with daily tasks; Expect nurturing and attentive care!
- Work on pressure/ reflex points on the feet can address pain from gas, the incision and constipation initially while the abdomen is still out of bounds
- Breastfeeding – perhaps side-lying initially will be more comfortable until pain from gas has dissipated. If the baby is reluctant to suck (common after medical analgesia) milk production may be low, so working on shiatsu points ST18 and L1 can help with lactation. If engorgement occurs, try working points GB21, ST36 and SP6 to help milk flow.(Yates; 137).

v) Weeks 1+ Post-surgery:

Postpartum goals are: to nurture and provide emotional support; facilitate restoration of pre-pregnancy physiology; promote pelvic floor healing and comfort (after increased weight of enlarging uterus during pregnancy); rebalance spinal and pelvic realignment; restore and normalise abdominal structures; restore normal walking patterns; prevent and reduce back and neck pain from newborn care (Osborne-Sheets;148)

- It is normal after a caesarean to experience pain from incision, involution (uterus shrinking) and abdominal and intestinal gas. Start to introduce gentle abdominal kneading to reestablish peristalsis, ease gas pain and foster lymphatic flow. Start to focus on the ileocaecal valve for elimination / constipation
- Delay abdominal techniques until medical clearance is given and the incision has healed – 2-3 weeks before doing any massage work which mobilises the scar tissue.

Appropriate, sequential therapy to the incision site may gradually be introduced over subsequent sessions to speed healing and reduce fibrous build-up in and around the scar. Start with light, stationary touch and subtle vibration of the skin. Gentle lymphatic stroking techniques to the inguinal nodes can facilitate drainage and healing of oedematous scar tissue. As time progresses, deeper massage to progressive layers (skin, superficial fascia, deep fascia then the muscle layer) can be introduced - Many sessions may be necessary before friction is possible on the scar tissue.

- Avoid all leg massage until clearance is given from the medical team due to risk of clots
- General Lymphatic drainage assists the body in its healing – promoting immune function, circulation and parasympathetic response
- Further structural stresses occur during the many hours of nursing, bending, lifting, carrying and playing required by childcare (Osborne-Sheets; 25) so addressing these through appropriate massage techniques and postural advice is an important goal. (Ordinary activities are difficult after a caesarean so try to have a high bed, cot and changing table to reduce abdominal strain. Even with this furniture, it may still be necessary to ask others to help care for the newborn)
- Encourage the mother to regularly do a series of post-caesarean/ postpartum exercises to tone abdominal muscles- (Noble; 231) – these include:
 - Posture check
 - Pelvic floor contractions
 - Deep abdominal breathing & wall tightening
 - Pelvic tilting
 - bridging
 - heel sliding
 - straight and diagonal curl-ups – keep chin tucked in, roll smoothly forward on outbreath coming up only as far as upper back naturally bends and keeping waist in floor. With diagonal curl-ups bring left / right shoulder to opposite knee
 - progressive abdominal exercises over successive weeks– curl-ups with arms folded across chest / hands behind head / leg lowering with bent knees / double leg lowering with bent knees
 - ideally, join a class where you will be given the correct advice and can share experiences / ask questions in a supportive environment

vi) Natural Medications to consider with professional advice: (Mother)

- To prevent bruising and swelling, take **hypericum** 200c every six hours for the first 3 days; For coming to terms with an operative birth take **staphisagria** 30c 3 times a day for

- 5 days; Take lactulose to avoid constipation – to avoid pressure on scar; **Vitamin B12** is a useful supplement for the nervous system – useful for recovery of cut or damaged nerves and good to guard against postnatal depression; **Iron supplements** (e.g. Floradix) are often a good idea as there is usually a greater blood loss during Caesarean.
- Drink Fennel tea to encourage breastmilk production and help reduce chances of colic and wind in baby. To help your milk come in –usually delayed by a few days after a caesarean – take LACTORS (available from www.gentlebirthmethod.com)
 - Refrain from baths for at least 7 days after the caesarean as the area where the skin is sutured should be dry. It takes 7 days for the scar to organise and seal off the subcutaneous tissue.

(Motha; 69-70)

BABY:

- Craniosacral therapy helps to unwind stress patterns on the baby's cranium (good for caesarean and vaginal births)
- Kangaroo care – or skin on skin contact (cuddling, holding and **massaging** baby's skin against yours) has the ultimate healing power; helping babies to gain weight quickly and feel secure therefore helping the bonding process too as the baby can get to know your scent and recognise who his/her parents are.
- Baby Massage - good for caesarean babies who have perhaps not experienced any cutaneous stimulation of labour.

(Motha; 71-73)

b. Mental / emotional:

Whether the birth was vaginal or surgical, all women undergo emotional adjustments in the postpartum period, many reporting the 'baby blues' as hormone levels (progesterone & oestrogen) subside dramatically three to five days after the elation of the birth (Osborne-Sheets; 131).

"The psychological integration of (a woman's) childbearing experience is a critical aspect of postpartum recovery." (Osborne-Sheets; 24). This is especially true if, after a prolonged and difficult labour an emergency caesarean is necessary, leaving the parents often with a deep sense of guilt, failure, sorrow and anger (as well as a sense of loss of control) alongside their profound relief and joy when a healthy baby and mother are the result. (Osborne-Sheets; 120).

- Reassurance is not helpful - it is, in fact, a form of denial – of the woman’s feelings, focusing on the fact she now has a wonderful baby. However, women need to be and feel listened to and encouraged to let their emotions flow rather than repressing them, only to find they resurface at a later stage.
- Books which you could recommend to assist them in this emotional processing are: *A Different Doorway* – Jane English; *Silent Knife* – Nancy Cohen; *Birth After Caesarean* – Bruce Flamm (Noble; 204).
- Providing a warm, holding, nurturing space for the massage, where they can feel listened to, can offer the support mothers need at this emotionally vulnerable time.

i) Terminology:

Language is very emotive - how it is used both pre- and postnatally. Use of the term **caesarean birth** is preferable to that of **Caesarean Section / C- Section**, which generates a host of negative feelings – “of helplessness, loneliness, fear, disappointment, not being part of the birth, being a passive observer, losing control”, whereas if the term Caesarean Birth is used or the phrase ‘**You’re going to give birth by caesarean,**’ “women feel less scared, feel part of what’s happening to them, feel less like a failure, more like a mother – not just a body doctors are working on.” (Birthing From Within; pp199-201).

ii) Bonding:

Many women who deliver by caesarean are afraid that it may impair the bonding process with their newborn baby as they are often unable to be left alone with their partner and baby immediately after the delivery – leaving them with feelings of failure as a parent; this is especially true if the mother underwent general anaesthesia in an emergency caesarean or if the baby suffered some complications and needed medical intervention after birth. However, this does not mean that the mother’s attachment is less strong as a result. “Bonding is a process which takes weeks, months and years. (It) means getting to know and love your baby. If for any reason you can’t hold or be with your baby right after your caesarean, you must not blame yourself. Some situations are beyond your control.” (Connolly & Sullivan; 69) However, if possible it is highly recommended to snuggle with your baby – while the incision is being stitched – letting your baby look at you and learn your scent and voice. Attending a Baby Massage (International Association of Infant Massage (IAIM - www.IAIM.org.uk)) class a few weeks after the birth can offer a fantastic way of providing the ideal environment to enjoy, learn about and bond and connect with one’s baby, whether one has had a caesarean or not.

6. Medical Model vs Midwifery Model:

I feel it is important to note that despite the fact my experiences with my clients showed how caesarean can assist in safe delivery of healthy babies in high risk situations, birth by caesarean section is becoming so commonplace – up to 85% in private hospital births in Latin America to 10% in the Netherlands (WHO recommends that Caesarean rates should never be allowed to go higher than 10-12%) (Kitzinger;349) - that one must question how valid these operations really are in most cases and why they are seen to be so necessary, according to the medical profession.

Many birth educators and obstetricians feel strongly that the medical approach to birth is what, in fact, slows the process of labour and then makes intervention deemed necessary. Many echo the feelings of Odent (2004) “where labour, delivery and birth are concerned, what is specifically human must be eliminated, while mammalian needs must be met” – by this he means the need for privacy and not feeling observed while giving birth, to feel secure, to get rid of all disturbing beliefs surrounding birth, reducing the use of the neocortex (the human rational part of the brain) and using language cautiously (Odent; 19 & 24). Inhibitions originate in the neocortex – the ‘new brain’ or brain of thinking and intellect, highly developed among humans (Odent; 18).

Ina May Gaskin’s Farm Midwifery Centre demonstrates low caesarean and instrumental delivery rates, while mortality rates are also low. She cites two other notable practices/ practitioners which had similar such rates – Dr Stevenson at a home-birth midwifery centre in Victoria, Australia in the 1970s and 80s; Dr Alfred Rockenschaub at Vienna’s Ignaz Semmelweis Frauenklinik between 1965 and 1985. All three practices shared common elements:

- Careful psychological preparation during pregnancy
- Births attended by midwives able to constantly be with the labouring woman
- Obstetrical backup provided by physicians able to recognise the abilities of midwives and women
- A philosophy that women are beautifully and admirably designed to give birth (Gaskin; 270)

Nowadays, people gain their information from TV and mass media, teaching us that giving birth can only be safe with machines. Gaskin hopes that the mass media can one day be used to promote public health in maternity care policy rather than corporate profits (272).

“Electronic Foetal Monitoring was introduced widely in the 1970s on the assumption that it would make labour safer for babies.” (Gaskin; 217). Gaskin refers to research which has shown that

when used routinely it can often lead to the belief that something is not right, leading to emergency caesarean. She suggests that this is less likely to happen with intermittent monitoring of the baby's heartbeat with a Doppler or fetoscope –“ it is also less painful and less likely to lead to ineffective labour and caesarean section.” (Gaskin; 217)

i) Fear/ stress

High levels of adrenaline – the stress / fight or flight hormone which increases heart rate and increases blood flow to muscles, making them tense and powerful - sometimes make labour stop. “The effects of adrenaline should not be underestimated, especially in births that take place in busy hospitals. (They) are the reason that so many women in labour find themselves no longer in labour when they check into a hospital.” (Gaskin; 148). “We need to always remember that mothers who are afraid tend to secrete the hormones that delay or inhibit birth. (Gaskin; 149)

“ Some phenomena of labour may not have been clearly understood and therefore mistaken for pain, as indeed they are today. The old writings give the impression that natural labour was neither distressing nor difficult; but women who are not distressed and those who present no difficulty are of no special interest and therefore such cases have not been recorded. Difficult cases are recorded and they have tainted and flavoured the science of obstetrics” (Grantly Dick-Read; 155). “Obstetricians have been educated to believe that all labours are horribly painful; they have made a routine of using some analgesic or anaesthetic, whether labour is normal or not. Normal, natural childbirth, free from fear or gross discomfort, is treated in the same way as complicated labour demanding skilled surgical intervention.” (Dick-Read; 156) “ (the ambition of women in labour) is to persevere and be conscious so that they may be aware of the result and reward of their efforts both during pregnancy and labour.” (Dick-Read; 157)

Grantly Dick-Read talks about ‘Cultural Labour’ in which women are “physiologically and mechanically well-equipped but not prepared for childbirth. They have doubts and fears and understand very little of what is going on or the sensations they will be called upon to interpret correctly. Fear inhibits the normal sequence of events during labour. **The Fear-Tension-Pain Syndrome** is present and therefore they have real pain. Their attendants believe in and accept the inevitability of discomfort...their arrival is usually the harbinger of anaesthetics and ‘assistance’ so that the women may be relieved of their turmoil and their infants as quickly as possible. This, with a few minor variations, represents modern obstetric care and attention.” (Dick-Read;157). He suggests they could be prime candidates for a natural birth, but due to their lack of prenatal preparation and education, they accept pain as a fact of childbirth.

This is where **hypnobirthing** and **visualisation** (see Gowri Motha's 'Gentle Birth Method') both have an important role to play in the mental preparation of women for birth; educating and instilling confidence in women as to the incredible natural abilities of their bodies and giving them the tools to manage their own labour in a controlled and as painfree a way as possible, with the power of the confident mind rather than being fearful (thanks to media and cultural 'scare' stories) of the process and therefore becoming tense and thus perhaps slowing labour down, necessitating medical intervention and possibly caesarean.

7. Conclusion:

While the merits of caesarean birth as a life-saving operation must be acknowledged in particular unmitigating circumstances, it is important to keep in mind and encourage, as far as possible, the incredible abilities of women to birth their babies naturally, offering them the optimum conditions.

I feel it is impossible for me to sum up how I feel about childbirth better than Grantly Dick-Read (2004; 254), who points out that prenatal observation and care has gradually unfolded with the progress of medical science and that observations have been almost entirely made upon the abnormalities and diseases of pregnancy. He suggests that the objectives of antenatal care should work towards "(An) increase in the number of normal labours by the removal of anxiety and dread from the mind and thereby avoiding much discomfort during pregnancy and parturition" by educating women so that "the inhibiting influence of fear may be replaced by understanding and confidence." (Dick-Read; 255).

Being pregnant myself throughout the course/ case history period and having therefore read widely on the subject in recent times, I can't help but instinctively feel that if women could have a sense of pride in the wonders and incredible natural abilities of their bodies and confidence in a system which offers privacy and security to enable them to connect with this innate strength without fear and without being bombarded with cultural and media 'myths' and negative birth stories, there would be less need for medical intervention during labour and birth. The whole process of medicalisation of pregnancy and birth and focus on 'what is wrong / could go wrong' starts the moment you begin your antenatal care under a midwifery / GP practice, with numerous scans and tests and little positive language used. It hardly inspires confidence in one's body or the whole process of pregnancy and birth! In an ideal system for labour, the neocortex would not be involved, allowing maximum capacity for expansion of the pelvic tissues and a full hormonal response, not involving the hindering presence of the stress hormone adrenaline, which slows

things down and tightens muscles. Labours might well progress with no foetal distress as a result and positive birth outcomes more akin to the Farm Midwifery Centre may become the norm, rather than the high incidence of interventions, use of drugs and caesareans which are increasingly seen today across the globe. Where this is the case, however, we, as massage therapists can offer emotional support and practical assistance to aid in the healing process with wide-ranging techniques and approaches.

On a positive note for all women who are pregnant now or may one day be – this is now my mantra! -

“Spend your pregnancy loving your uterus and your baby. Positive energy makes a good birth outcome more likely, so go for it.” (Gaskin; 303)

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