

## **Castellino Prenatal and Birth Training Cesarean Section Trauma, Impact and Facilitation**

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### **Acknowledgments**

Preparation for this seminar has been extensive. I am personally grateful to Ginny Partridge for her tireless effort to support the gathering and organization of this material. She conducted several Medline searches, photocopied about 150 articles and directly participated in editing the video demonstration case.

### **Introduction and Overview**

To date no other material in the birthing field has stirred me so strongly. Yes, I can and am exploring how this is so for me.

Surgical intervention in birth has reached pandemic proportions in this century. Never before in history have so many babies been born by surgical extraction. Cesarean section births compound all the traumatic impacts we have studied thus far. Every attempt is being made to pace and titrate this material so that you can see, hear, feel, interact, assimilate and integrate your growth and learning in the most efficient compassionate way possible. The end goal is to be able to employ your understanding, compassion and skills with yourself and others, your clients and patients.

The amount of material available about CS births is staggering. The amount of material that addresses the babies' needs in comparison is nearly nonexistent. Research concerning CS impacts on infants and children is just beginning to appear and most of this research is psychosocially oriented. Those psychological or psychosocial studies which include the infant do so in the context of the mother-child relationship or the child's relationship in the family. With the exception of researchers such as Emerson, English and Grof, few have written from the fundamental premise that our view of the world and the way we interact with our world is profoundly and fundamentally influenced by our prenatal life, from preconception onward. The notion that the birth process has profound and lasting long-range effects on our whole being, mentally, emotionally, physically, somatically is still buried in the psyches of researchers out of their present awareness. Moreover, except for the most cursory attention to the most obvious physiological effects, morbidity and mortality, there is striking little attention given to the long term impacts of high tech and surgical extraction on the realm of human potential itself.

As we will graphically see, the net effect of high technological efficiency with minimal human contact and narrow attention to detail is to separate the individual from him/herself. The separation of the body from the mind is reinforced and often caused by surgical intervention at birth. In the process of attempting to buffer mothers and families from pain, treating birth as an illness and turning birth into a medical emergency, babies

and families are insidiously stimulated into overwhelm, shock and dissociation in order to survive the ordeal. The expressions of human contact, touch, compassion and understanding are sorely overlooked. As we will see, the traumatic impacts are not simply on the individuals subjected to surgical births; the world culture is profoundly impacted as well.

To prepare for this workshop, three obstetric textbooks, DeLee and Greenhill (1943), Oxorn-Foote (1985), and *William's Obstetrics* (1993) were studied. In addition, a Medline search was conducted on CS articles. Close to 600 journal titles and abstracts were reviewed. More than 125 were selected for direct review and a smaller group for the bibliography of this chapter.

### **Statistics**

Existing research shows that there are cases where birth by CS section is necessary and life-saving. There are a small percentage of cases (less than 2%) where CS proved to be the appropriate birthing venue to follow. In fact there is a birth clinic in Vienna, Austria where for over a 20-year period and 50,000 births the CS rate is 1.4%. The baby and mother morbidity and mortality rates for this clinic are also excellent. The CS rate in the US in the early 1990s is 23% to just under 25%. Although some effort is now being directed to reducing these numbers, researchers do not expect the CS rate to drop dramatically in the near future. Most CS births happen because of poor preparation of the birthing parents, early healthcare mismanagement of labor, attitudes and beliefs towards women and birthing practices on the part of health care providers, and institutional economic need. There is a preponderance of evidence which suggests that the greater proportion of cesarean births are iatrogenically caused. Supportive statistics for this assertion will be provided later in this chapter.

More than half of the babies and children I have treated over the past two years and many adults I have treated were born by cesarean section.

### **Scope of this section of the seminar**

This section of the seminar is designed to give you a comprehensive understanding of the cesarean birthing process. This understanding is directly relevant to the Facilitation of cesarean-birthed persons of all ages for prenatal and birth trauma. Knowing the sequence of events that happens for CS-born people allows the practitioner to both

- educate CS-born adults clients and parents of CS-born babies and
- track the client therapy process.

In this chapter we will explore the psychosocial dimensions of cesarean birth, medical procedures, assessment and Facilitation protocols. We will take an in-depth view of one case study of an eight-year-old boy. You will see videos of his birth and portions of Facilitation sessions that specifically relate to his birth. Attention will be given to assessment of the strategies of consciousness the cesarean-born person takes and the

quality and the level of conscious the cesarean-born person orients themselves to in order to manage their unresolved trauma and shock trauma.

**Practitioner skill areas will include:**

1. Visual identification protocol for cesarean cranial molding.
2. Review of assessment of trauma vs. shock and appropriate Facilitation protocols when treating the cesarean-born person.
3. Assessment of patient/ client resources to determine facilitation sequence for CS trauma.
4. Patient/ client oriented facilitation protocol with respect to pacing, titration needs, facilitation sequences.
5. Verbal, empathic and kinesthetic skills with adults and children who were born by cesarean section.

The skill areas for facilitation of people born with trauma from come from the italicized areas below.

**Reading** for this seminar comes from:

Oxorn-Foote, *Human Labor and Birth*,  
Ch. 46, "Cesarean Section."  
Reeder, Martin and Koniak, *Maternity Nursing*,  
Ch. 39. "Operative Obstetrics."  
Bennett and Brown, *Miles Textbook for Midwives*, pp. 456- 459.  
Ch. 28, Obstetric Anesthesia and Operations, read the section titled,  
"Cesarean Section."

These notes include an updated version of a paper presented by Carol Sakala to the 1989 annual meeting of the American Public Health in Chicago, IL, and printed in *Social Science Medicine* in 1993, as well as several charts, graphs and images from other texts and research sources.

**Hypothesis: If the parents have awareness of their prenatal issues and choices concerning their previously unconscious pre- and perinatal patterns, they will have freer, healthier births and babies. Preconception preparation with pre- and perinatal education and trauma resolution therapy will reduce the need for invasive birthing practices.**

## The origin of the term 'Cesarean Section':

There is no evidence that the term originated with the birth of Julius Caesar, though Webster's Dictionary mentions this as the source of the spelling, since it has been a commonly accepted myth. In fact, his mother was said to have lived to her 90s (Jane English). 'Caesar' is Latin for Emperor. As early as 715, CSs in the Roman Empire by law were performed on the death of the mother. This was later called "lex Caesarea" (law of the emperor). The term is also said to possibly originate with the Latin verb to cut "caedere." In Latin, an abdominal birth is termed 'partus caesareus.' (Melmed, p. 267). In translation to English, 'ae' is normally spelled 'e.'

I have used the modern spelling of the word, **cesarean**, as used in current medical literature. Jane English prefers the spelling 'caesarean.'

## Cesarean Section Statistics

It has been clearly statistically established that women who birth with supportive companions (primary partner and friends) and healthcare givers (doulas and midwives) who believe in the innate ability of women to birth their babies are healthier, require significantly less technological interventions, spend less money and have healthier babies. In contrast, there is a mounting body of evidence that women and babies who are subjected to CSs have more complications and end up in poorer health than women and babies who experience natural deliveries.

Sakala reports 3 basic solutions to this pandemic problem:

1. To simply stop performing CSs.
2. Managed care. Continue high tech births and lower the CS rate.
3. The widespread use of doulas and midwives.

The National Childbirth Congress created a mother/maternity friendly initiative, a consensus statement from the major birthing organizations throughout the US. I participated in writing that document. I strongly suggest the adoption of the policies that document advocates for all birthing practices. I also suggest an update of the WHO Baby Friendly document.

Sakala states, "We have seen that research evidence indicates that large numbers of cesareans are performed without benefit in the United States. Many risks of surgical birth to mothers, infants, and families are well-documented, and many possible risks have not been systematically investigated." Shearer states underscores the "hypothesis that the impact of surgical birth may endure for months or even years, may have a far reaching influence on how the mother feels about herself and others, may influence the long term psychological stability of the family, and may, at least initially, impede optimum psychosocial development of the infant."

From the work of pre- and perinatal researchers like, Emerson, Grof, Jane English and myself, there is no question that the mode of birth has lifelong effects on humans. People born by CS often have similar physical health problems, signature cranial molding traits, and distinctive personality characteristics that, unless resolved, impact the person's entire life.

There are several ironic factors which become obvious when an examination of the use of CS worldwide and in the US are considered:

1. Women and babies from the lower income brackets, the poorest health insurance coverage, the lower educational backgrounds and the poorest health receive the fewest CSs. In contrast women and babies from higher income brackets, better health insurance like Blue Cross, private obstetrics care, higher educational backgrounds and the best health are the most likely to receive CSs.
2. The diagnoses which are used to justify CSs have risen dramatically. Sakala and others suggest that institutional money needs and economic factors in this country and throughout the world have contributed to the rise in the CS rate. She states that hospital birthing rooms are "co-opting" birthing parents to high tech births with marketing strategies.
3. The widespread belief within the medical community during the 1970s and 80s that performing CSs would deter possible malpractice litigation. Localio, et. al have shown just the opposite. The risk of litigation goes up when CSs are performed.
4. Within the massive amounts of CS research, very little of it focuses on CSs' effects on babies. Most research for babies has to do with short term physical effects, "morbidity and mortality." There has been little attention given to the iatrogenic effects of CSs. Sakala refers to Shearer and Mutryn who use the term "vulnerable child syndrome" to describe traumatic outcomes in children. (See lists of traumatic effects listed in the research as compiled by Shearer).

Comparison studies between hospital births and births which take place in settings other than hospitals, such as free standing birthing centers or homes, show that the relatively low number of families that choose to birth outside of hospital settings enjoy a CS rate in the US of 4.3% (Sakala p 1235) with fewer complications throughout this birthing group. However, Sakala reports, "The hospital group, however, had significantly higher rates of morbid conditions, including fetal distress, elevated blood pressure during labor, meconium staining, shoulder dystocia, postpartum hemorrhage, neonatal resuscitation, birth injury, and low 1- and 5-min. Apgar scores. (See Oxorn-Foote p 149 to understand the Apgar score criteria.) Noting the significantly higher rates of CS births and other obstetrical procedures in the hospital group, the authors (Mehl and Peterson) conclude that "for women of low medical risk, there may be aspects of routine hospital obstetrical care within the aggressive management philosophy for labor that contribute

to risk." Similarly, Baruffi *et al.* found that low-risk women using midwifery care in a maternity center had more favorable physical outcomes than those receiving the usual care, whereas high-risk women in the two groups had similar physical outcomes."

The **most common diagnostic reasons** given for CSs (Myers and Gleicher) are:

- |    |                |                |
|----|----------------|----------------|
| 1. | Previous CS    | 35% of all CSs |
| 2. | Dystocia       | 33%            |
| 3. | Breech         | 10%            |
| 4. | Fetal distress | 10%            |
| 5. | Other          | 17%            |

Each of these reasons seldom in itself makes a cesarean section justifiable. Sakala discusses the fallacies of each rational at length. Sakala and others suggest that these diagnoses more often reflect the beliefs of the birth professionals. Shearer observes that the four most common diagnoses listed above and discussed below are "clinically gray areas." I have personally treated several cases where CSs were performed to solve problems that were iatrogenically caused in the first place.

*Previous CS* has been proven by proponents of VBAC (*vaginal birth after cesarean*) to be an inappropriate reason for CS. In recent years, many women with previous CS histories have had vaginal deliveries. However, 80% of the women who had previous CSs and gave birth in 1990 had repeat CSs. 20% had VBAC. By 1996 the rate of VBAC in the US was 29.4% (*Birth*, Sept, 1996, reported in *Midwifery Today*, Winter, 1996).

The most common reason given by physicians for doing repeat CS is the possibility of uterine rupture at the scar from the previous CS. The risk of this happening seems to be elevated by the use of Pitocin. A study published in 1993 in the *Journal of Obstetrics and Gynecology* of over 8500 women over 3 years found the incidence of uterine rupture for VBAC to be .82%. The ruptures happened with women who had been given Pitocin (reported in *Midwifery Today*, Winter, 1996).

The rate of successful VBAC is much higher for women working with midwives. Midwives responding to a survey reported 88% of their clients attempted VBAC and 78% did so successfully. This gives an overall rate of 69% (*Birth*, Sept., 1996).

Women's choice of a repeat CS over a vaginal birth is highly influenced by the attitude of their physicians and partners. In a study reported in *Birth* (Sept, 1996), no women whose physician discouraged VBAC tried it. If the physician encouraged VBAC, the women were 4 times as likely to chose it. The women cited fear of labor and probability of not being able to deliver vaginally as reasons for electing repeat CS.

Given encouragement to try labor, women will often deliver vaginally more often. A study of Nova Scotia women over a 6 year period compared trial of labor and elective CS. 60% of those women who tried labor were able to deliver vaginally. Women under 35 who had had a previous vaginal delivery were most successful. The uterine rupture

rate was .3% for the laboring group, .03% for the elective CS group. None of the mothers died (NEJM, 9/5/96 reported in *Special Delivery*, Winter 97, p 25).

Shearer reports that VBAC is less dangerous than repeat CS to both mother and baby except for the approximately 1% of women with a previous 'Classical' incision or a new medical condition necessitating a CS. (Shearer, 1224).

*Dystocia* is often associated with the term "failure to progress." Dystocia indicates that the labor is too slow or has stopped progressing. Sakala states:

Dystocia is a catchall category encompassing a variety of clinical circumstances. Broadly speaking, obstetrics identifies and classifies problems relating to limitations of the mother's anatomy--either her pelvis or the soft tissue of her vaginal area (the *passage*), to dysfunctional uterine contractions (the *powers*), or to problematic placement or abnormal form of the baby (the *passenger*) (Sakala, "Midwifery Care" p 1239).

The italicized terms, *passage*, *powers* and *passenger* are old obstetric terms. They are frequently used by DeLee and Greenhill, *Principles and Practice of Obstetrics*, 1943. These designations show ignorance of the baby's ability to participate in his/her own birth.

Sakala comments:

Reflecting the interests of professionals and bureaucratic institutions, birth is treated in an assembly-line fashion, with most women subjected to standards of efficiency that bear little relation to the physiology and individuality of birth. In many institutions, one is now said to have dystocia after laboring for 12 hours or less, regardless of medical status of mother and child or of prospects for vaginal birth. The oppressive 'climate of doubt' that pervades medical childbearing inevitably affects the will, confidence and capabilities of childbearing women (Sakala, "Medically Unnecessary CS" 1179).

Shearer reports the work of Sokol who found upon examining CS records that up to 30% of women given CS had "no identifiable risk factor in pregnancy or labor." Sokol concluded that many of the CSs were done as a result of misdiagnosis, especially of dystocia.

In reference to the baby being too large, Shearer reports a 1980 study that showed 1/3 to 1/2 of the women who previously gave birth by CS (for a supposedly too large a baby for their pelvis) were later able to give birth by VBAC. This was to babies whose weight exceeded that which had supposedly necessitated the CS. (Shearer, 1224).

*Breech* or the births with the "after coming head" have decreased because of lack of obstetrical training in favor of CSs. Practices such as external version or turning the baby to the head first position prior to birth have been excluded from obstetric curricula.

Ina May Gaskin at the Farm has an excellent record for successful breech deliveries. Also, in Europe, the proponents of water birth are doing water breech deliveries. These people and others feel that breech deliveries with skilled birthing attendants do not cause undue risk to the unborn.

*Fetal distress* diagnosis has increased from 1.4% in 1980 to 8.8% in 1989. The use of fetal monitors and reliance on electronic monitoring is reported to falsely indicate fetal distress with regularity. Many physicians mistakenly act as if CS is risk free. Because of concern about forceps use, many OBs are resorting to CS instead (Sakala, "Medically Unnecessary CS," 1180).



## Psychological correlates for cesarean-born persons

Throughout human history, except in very rare instances when the mother died and the baby was surgically extracted and lived, babies have birthed vaginally. William Emerson makes the point that strong ancestral imprinting in favor of vaginal birthing exists within all of us. It has not been until this century that surgical births have come into vogue especially in the last 15 years when CS rates have become approximately 25%. The psychic confusion this causes in the CS-born individual is substantial:

- boundary shock (Emerson)
- fascination for detail
- body/mind splits
- directional confusion
- infant hypersensitivity
- vulnerable child syndrome
- tactile defensiveness
- pacing difficulties
- breastfeeding agitation
- fear reaction to sudden noises
- respiratory weakness
- tendency to respiratory illnesses
- cesarean interruption syndrome
- disturbances in bonding and attachment
- idiosyncratic behavior.

Jane English notes that, because CS-born babies live in a vaginal birth world, their sense that they are strangers in a strange land is amplified. They thus overcompensate by becoming intellectual and detail oriented people, often cut off from feeling effective in the emotional milieu. At the bottom of the table titled, "A Rough Map of how the Perinatal Realms May Look to a Non-Labor Caesarean Born Person" Jane English include a list of overall comments about trauma and shock impacts on the cesarean-born person.

'Boundary shock' is the term Emerson uses to describe the cumulative impact of the birth sequence from when the obstetrician reaches in, dislodges, rotates the baby, lifts the baby's head and then pulls him/her out through the incision. Emerson uses the terms: 'section dislodge, section rotation and section lift.' For Jeramiah (the boy who's birth tape and therapy we will watch) this whole sequence including getting his cord cut and being suctioned simultaneously, then being transferred to the pediatrician and whisked away to another table took no more than 1 minute 25 seconds. The pace at which all that happened was quite a bit faster than he could integrate. All those experiences got locked into his body as he went into deeper levels of shock/terror/rage/abandonment and dissociation. All this plus more suctioning, tests, antibiotics in his eyes, nose, towels into his mouth, shots and trimming the cord under bright lights! Too much!! Too much!! The issues this brings up for the therapeutic setting are substantial.

Both the pacing and the fact that all the individual issues from each of those birth segments stack on top of each other, as is were, contribute to what I consider the most fundamental impacts from cesarean shock trauma: the *body /mind split*. This impact causes the individual to stay in their head, compensating by becoming intellectually adept and spending a significant amount of energy as an avoidance recapitulation avoiding deep feelings. The cesarean-born person can manifest this trait by controlling the emotional tone in their relationships, by staying task oriented, attending to detail, problem solving and using their intellect. Having a strong intellect is not problematical. However, if the person uses their intellect to avoid deep feelings, they will miss out on the richness of deep bonded intimate contact in their relationships. People close to them may feel unheard often. I have worked with several cesarean-born people who have had to effort to learn the skill of being able to perceive when they are safe enough to allow this kind of intimacy into their lives.

The mind/body split is similar to that noted in the Emerson/Sills stage four birth dynamics only in the CS-born person the split is amplified compared to a vaginally-born person who is separated from his/her mother at birth.

Emerson provides a long list of symptoms. I added several items to the list (marked 'rc') which he as found consistent in many clients born by CS.

- Boundary issues--no boundaries against intrusion, may be over or under boundaried. Doesn't recognize other people's boundaries.
- Body/mind split (rc)
- Invasion fantasies (wartime, sorority/fraternity)
- Boundary confusion—where does my space end and yours start?
- Whose feeling is whose?
- Whose fault is it? It's not my fault, defensiveness
- Guilt—never feel like they've earned what they earned
- Lack of self empowerment—hard to see they have struggled and earned
- Lack of self worth—I've not done anything to deserve what I have
- Often have things which in fact they didn't earn
- Can't say no and mean it.
- Can't say yes and mean it w/o boundaries
- Fear of engulfment
- Have more spiritual trust—that the universe will take care of them
- Separation anxiety--more than normal because they were taken away, often for long periods, after birth
- Require others to protect them, angry when they are not protected
- Anticipate emergencies in life, and need to be saved
- Strong attention to catastrophic changes (rc)
- Initiate sudden changes as a way of dealing with conflict
- When upset, cry helplessly or withdraw helplessly for hours
- Guilt that they hurt others—CSs cause mama pain

- Guilt that they exist—their section disempowered mama
- Feel overpowered by women
- The "I can't" syndrome
- The "I'm stuck" syndrome (if CS was done because baby was stuck)
- Fear and or fascination with knives (we/rc)
- Feel like they can't do things right
- Incompletion syndrome—hard time completing tasks
- Headstrong (avoidance recapitulation)
- Attract unforeseen interruptions and/or are unaware that they interrupt others (we/rc)
- Desire to struggle (have the birth they never had)
- Know things, won't accept input from anyone else
- Have difficulty seeing issues from others point of view (rc)
- Confusion syndrome—If something is too rapid, confusion willful—impose will
- If someone else changes the rules--confusion—difficult to adapt
- Change heart and minds (especially if birth was like that)
- Oppositional personalities (ask for help, yes but)
- Help is seen as manipulation, intrusion, a put down, disempowerment
- Oppositional personalities—see help as opposing them
- Rescue fantasies fluctuate with 'I'll do it myself'
- Oppositional—will do the opposite of what you say
- Crave hugging cause never had physical contact and pressure they needed during birth
- Long for pressure (contractions) that they never had, but will resist any pressure at all
- Tend to construe things in terms of pressure
- Intellectual avoidance compensation (rc)
- Attention to detail (make great proofreaders), can miss the big picture (rc)
- Visually oriented (rc)
- Organizers—organizes others (rc) Great at marshalling a team of helpers to complete a project; they assume a willing team is available. (Jane English)
- Logical problem solvers (rc)
- Content oriented, not process oriented (rc)
- Director type people (rc)
- May have difficulty hearing emotional tone (rc)
- Tend to think ahead of others (rc)
- Fast with their minds, not necessarily coordinated with their bodies (rc)
- Lose their keys. Difficulty keeping track of thing they use every day (rc)

Key words: boundary violations/ shadow betrayal/ interruption issues/ power issues/ authority issues/ self esteem issues/ confusions/ survival defenses/ strategies of consciousness/polarization issues.

Michelle Bush, M.F.C.C. and childbirth educator reports from observing moms and babies in her moms' groups that moms and babies after CSs get easily confused. She reports that Postpartum Depression within the first 6 months after birth is common. She reports that decision-making can be difficult. They can easily relinquish power to outside authority. From my experience with cesarean-born people, these patterns can imprint strong oppositional forces within, causing them to be hyper aware of boundary issues. CS-born people will be OK in authority positions or angry. It will be more difficult for them to accept others in authority to be in authority or angry. They go to overwhelm easily and can be easily affronted. They must maintain control or be confused. They will flood others as a defense mechanism before they get emotionally flooded themselves or rather than accepting their own confusion.

Several years ago I was talking to Jane English. I ineptly referred to her as a CS person. She sharply retorted, "No I am a person who was born by CS." She observes that cesarean-born people as a group are unique and often feel that they don't belong. Hence the title of her book is *Different Doorway: Adventures of Ceasarean Born*.

The long-term effects on children: children are very compliant, good kids and intellectually brilliant, except they override themselves and are unable to verbally communicate their own vulnerability. They are very able to communicate directly or competitively. They're highly visual and verbal, and often tend to avoid the auditory mode. If they were auditory, they would be flooded by their own emotions. They will often cry or lash out. They can often feel like it's their fault and feel the need to defend themselves. This will internalize as shame and externalize as defense. "I didn't do it! It's not my fault!"

CS-born people can often have strong control issues. They are often very directive in their approach to life and relationships. CS-born person can feel compelled to do things quickly, and right the first time. CS-born people are often very competent in the visual, mental realm. They will often lack sensitivity and skill in the auditory, emotional realm. They can be hypersensitive to themselves and easily affronted. They can often be critical of others. Often in the physical, kinesthetic realm they can be cautious in physically challenging situations and can easily feel interrupted in their process.

With boys there is more lashing out, with girls more compliance. If you add forceps or suction extraction to this dynamic, especially for a boy, it can lead to sociopathic behavior.

There is a social dissociation between the visually oriented medical world and the auditorally oriented psychological world. In the literature reviewed, there is little overlap between the references cited in the medical literature and in the psychological literature. The psychological world appears more aware of the obstetrics world than the obstetrics world of the psychological world.

Many of the CS corollaries also apply to high tech effects.

## The Process of doing a Cesarean Section

### Cesarean Section Categories:

- non labored/labored
- elective/non elective, often an emergency CS
- engaged/non engaged

**Fetal position with relationship to incision:** It is important to develop some awareness of the position of the baby's body. For example, if a baby intends to be born headfirst and is extracted feet-first, then the psychological overlay is confusion. This is different than rotational confusion from stage II trauma or forceps rotation.

**Types of incisions.** Each has advantages and disadvantages. Where are the head and the feet in relationship to the incision? This will affect how the baby exits.

- Lower segment of the uterus, transverse incision or bikini cut (use began in the 60s)
  - vertex presentation = head first
  - breech presentation = feet first
- Classical incision: vertical cut into the fundus (rarely used today)
  - vertex presentation = feet first
  - breech presentation = head first

### Reasons given for CS

The common reasons given for doing CS deliveries do not hold up statistically. Following are the common reasons given for doing CSs.

- Prior CS. The CS is chosen ahead. It is 'elective'. Vaginal Birth After Cesarean (VBAC) has become more prevalent during the late 1980's and 90s.
- Dystocia means the baby is stuck, in difficult or prolonged labor. Cephalopelvic disproportion (CPD) or the baby's head being too large for the mother's pelvis is often given as a reason for this.)
- Breech babies are usually delivered by CS due to deficient obstetrics training in vaginal breech birth.
- Fetal distress which can itself be caused by dissociation due to technological intervention, by reaction to the anesthesia, forceps or VE.

### Cephalopelvic disproportion (CPD)

It is impossible to predict ahead of time if the baby's head is too large for the mom's pelvis. Because of the danger of shoulder dystocia, obstetricians look for ways to tell ahead of time and have relied on ultrasounds and estimates of the baby's weight in deciding whether to do a CS. A study published by Rouse et al in JAMA (reported in *Birth Gazette*, Spring 1997: 44) looked at shoulder dystocia and permanent brachial

plexus injury in relationship to CS and what it would take measured in amount of CS to avoid permanent injury. The findings were that ultrasound and the decision to operate if the baby was either 4000 g or 4500 g increased the amount of CSs dramatically while decreasing injuries minimally. To prevent a permanent injury of a fetus over 4500 g, 3695 CSs were performed. To prevent a permanent injury of a fetus over 4000 g, 2345 CSs were performed. They concluded that elective CS for large babies is unsound policy both medically and economically. For diabetic women, the ratios were much lower. 443 CS for 4500 g to prevent injury and 489 CSs for 4000 g babies.

### **Length of labor**

The diagnosis of dystocia includes prolonged labor and failure to progress. The norms for safe laboring time followed by many hospitals are different than that found by others, especially midwives. A review of CNM's deliveries of low-risk women in New Mexico found that the women spent significantly more time in stage one and about the same time in stage two as the Friedman norms followed by many hospitals with no more morbidity (Albers).

### **Fetal distress**

The AMOG recommends that in cases of suspected fetal distress, that the timing from decision to operate to incision be no more than 30 minutes. However, a study published in 1997 (Chauhan, et. al.) showed that:

- About half of the CSs started after more than 30 minutes from decision to incision.
- Pathological acidosis was found in only 7.9% of these babies.
- The babies' health was not correlated with the timing of the CS. Longer decision-incision time was not connected to worse outcome.
- The CS rate for babies judged to be in fetal distress was about the same as for those without fetal distress.

They excluded CPD, multiple births, abnormal presentations, premature labor and stalled labor. Most of the diagnoses were done by fetal heart monitor tracings.

### **Mom's safety and comfort**

In reality, a mom's safety and comfort issues can in fact be a contributing factor to failure to start labor or to progress, which could cause her to end up with a CS. If the mother does not feel safe, she will be less capable of relaxing and opening up which is necessary for birth.

For example: In the early 1990s a mid-thirties couple was referred to me because she was two weeks past her due date. They came to see me on a Thursday or Friday. Her OB was concerned that if she did not birth soon, her baby might go into fetal distress. He told her that if did not go into labor by Monday, she would have to deliver by CS. She knew she was going to have a daughter because of the routine ultrasounds that were performed during her pregnancy. During the session, she said that she was really afraid that when her daughter was born that she was going to be sexually abused like

she was when she was a child. The baby's father was perplexed and really beautiful. He was a very traditional businessman. He loved his family very much. I asked him to talk about his feeling about his wife being abused by her father. He was angry that she was hurt and abused. While he spoke I asked him to tell her and his baby what he would do to protect both of them. He promised that he would do every thing in his power to make sure that his baby would never be sexually abused. She went into labor on Saturday and birthed Sunday morning vaginally.

### **Other CS components**

- Anesthesia
- Extraction dynamics
- Post-operative handling

### **Key trauma points in a CS birth sequence (Emerson and Castellino terminology):**

Surgical preparation: Mother is often isolation, pain is often amplified because of isolation / feeling of failure / defeat / helplessness.

Anesthesia general: Facilitation for a cesarean section requires the anesthesia protocols described in the anesthesia seminar. If there was spinal anesthesia (typical from the late 70s, 80s and 90s) the abdomen goes numb from diaphragm down which causes inability to access strength in the legs, getting the power to the legs and difficulty grounding.

Section engagement or the section lodge: Stage one usually. Find out how far the client got engaged. You can often see a telltale brim impression around the cranium, often from the forehead to the zygoma or cheekbones. The client's movement patterns will often indicate how far they lodged. Often the Section lodge is quite traumatic because if there is active strong labor, or labor under the influence of Pitocin, significant cranial molding can occur confluent with trauma or shock.

Section dislodge--Can be very strong. Happens quickly after first touch from OB. This action interrupts and reverses the ancestral orientation in the vaginal direction.

Section rotation--If bikini or transverse cut, obstetrician must rotate the baby's head to be able to lift the baby out. The baby, child or adult will show you these movements in their somatic work or their play.

Section lift--Babies can be lifted out with hands, forceps or vacuum suction.

Physical separation from mom. Suction of airways and cord are often cut simultaneously.

Transfer from OB to pediatrician, being whisked away to the pediatric table.  
Stage four medical procedures.

Pacing: The sequence from the section dislodge to the pediatric table usually happens at a very fast rate (could be within 1 to 2 minutes). Baby has no time to adjust. Baby's space is so rapidly invaded that the baby goes into shock.  
Boundary shock and separation shock.

Possible RDS (respiratory distress syndrome) and/or admission to NICU. The most common reason for admission to the NICU is "iatrogenic prematurity and lung disease" The CS may have been done before the baby was full term due to miscalculation. Whether the baby is premature or full-term, the incidence of RDS is much higher in babies born by elective DC without labor than in babies born by CS after labor began. Shearer postulates that the marked difference in RDS is due to the low level of catecholamines in the non-laboring baby. The catecholamines facilitate lung function and redirect blood to the heart and brain. The lack of it creates lower metabolic rate and lower blood sugar levels and make it more difficult for the baby to tolerate periods of hypoxia (Shearer, p 1225-26).

Possible physical injury, such as lacerations (.4%-1.9% recorded in the birth chart). A study published in 1997 of 896 CSs found the incidence of recorded lacerations is higher with nonvertex (6%) than with vertex (1.4%). It also found that only 1 of the 17 lacerations were recorded on the mom's birth record as well as the child's and concluded that laceration is not rare and is either not recognized or not reported by obstetricians (*Obs & Gyn*, Sept. 97 reported in *Midwifery Today*, Autumn, 98).

A 1981 and 1988 studies showed Apgar scores of CS babies are likely to be lower than for vaginal births, even when not including babies born by CS due to fetal distress.

One study notes "fewer quiet alert periods after birth" compared to vaginally birthed babies (Shearer, 1225-26).



## CS effects on the Mom, Dad and future pregnancies

Mom's have just been through major surgery and are less available for bonding.

### Mortality risk for the mom

Mom who have had a CS are 2-11 times as likely to die as moms who birth vaginally.

The major complications are:

- Infection
- Hemorrhage
- Anesthesia complications/accidents
- Pulmonary embolism, a possibility from any surgery.

Repeat CS is the only category of birth in the US for which the mortality rate did not decrease in the 70s.

### Morbidity for the mom

Complications for mom are 5-10 times as likely as in vaginal birth. The most common is infection. The mother who has an infection will have less energy to be with her baby and will be in the hospital longer, interfering with the bonding process.

### Long-term effects on future pregnancies

A study reported in the American Journal of Obstetrics and Gynecology in 1996 compared almost 16,938 Finnish women who had had CS with a matched control group of women who birthed vaginally. The CS mom's had

- Decreased fertility, possibly due to scarring of the fallopian tubes or psychological response to CS.
- Increased spontaneous abortion
- Seriously increased numbers of abruptio placenta
- Seriously increased numbers of placenta previa (placenta covering the cervix)
- Small increase in ectopic pregnancies (Hemminki, reported in *Midwifery Today*, Autumn, 1998 and Shearer, p 1226-27)

The risk of ectopic pregnancy was 3.2% (28% higher than following vaginal births) and for placental problems was around 10%. (*American Journal of Obstetrics and Gynecology*, May 1996 reported in *Special Delivery*, Winter 97)

Other studies published the next year found a strong association between having previous CS or spontaneous or induced abortion with the development of placenta previa in a subsequent pregnancy. The risk increased with the number of prior CSs (Ananth, reported in *Midwifery Today*, Autumn, 1998)

Placenta previa can be complicated by placenta accreta (abnormal adhesion of the placenta to the wall of the uterus). This usually results in a hysterectomy due to the

danger to the mother. The risk for placenta accreta and for placenta previa increases with the number of prior CSs (Shearer, p. 1127).

### **Psychosocial impact of CS on the Mom**

CS can result in a cascade of feelings, often not immediately articulated. Most of them are negative (other than relief at the birth of the baby). They result from the surgery itself, often unplanned, from not being able to birth vaginally, from prolonged separation from her baby, from physical pain and discomfort and the effect of anesthesia and both the mother's and baby's ability to bond. Terms listed in a literature review (Mutryn, 1276) include:

- Loss of control
- Loss of self esteem overwhelm, fear, guilt,
- Feeling violated, traumatized, grief-stricken
- Confused, helpless, frustrated,
- Betrayed, hostile, dependent, vulnerable
- Anxious, inadequate, angry, resentful
- Shocked, repressed, in denial
- Shameful, disappointed

Mutryn lists factors which make the mother's psychological healing more problematic. These include:

- Lack of support from medical personnel, spouse, friends
- Difficulty beginning or sustaining breastfeeding
- Prolonged separation from her baby after birth
- Shortened time with the baby immediately after birth
- Complications for mom or baby in addition to the surgery
- Little or no choice in the decision
- Little or no support from the father
- Long labor with pain, discomfort or interventions other than the surgery
- CS unplanned
- Difficulty accepting the pregnancy to begin with
- Little understanding of CS beforehand
- Bias against CS due to religious or sociocultural values
- Belief in the superiority of a 'natural' birth
- Little or no childbirth education
- Undeveloped coping mechanisms and problem solving abilities
- Stress in life
- Higher socioeconomic level

She lists others which may be problems for healing which include:

- Prior abortion and poor resolution of this
- Relationship with parents is strained

- Little contact with infants, children before the birth
- Unsatisfied with sex of the child
- Health of the child compromised
- Body image problems
- Unmarried or stressful situation with the father
- Higher level of education

Without intervention, problems with mother/child bonding which have been documented in the first hour, the first day, the first month can continue for years. Adverse effects documented include (Mutryn, 1276)

- Less frequent touching, handling the child at first meeting, less caretaking behaviors later.
- Less eye contact with the child initially possibly due to the surgery but this persists and was found at 1 month.
- Less positive reaction to seeing their baby the first time
- More difficulties beginning and sustaining breastfeeding. Stop sooner.
- More problems and difficulties (perceived) with babies, toddlers, children as they grow
- More frequent use of physical punishment
- Tendency to make hostile rather than concerned remarks about the child.
- Describe motherhood in negative terms
- Less talking to the child
- Higher incidence of depression for both mom and baby
- Takes longer to respond to child's cry
- More so-called psychosomatic symptoms such as tiredness, headaches, sleep problems

### **Psychosocial effect of CS on the dad**

The effects on the father are more mixed than for the mother. He may have many of the same negative responses to the CS. However, he often takes a more active role in caretaking in the first minutes, hours, days because of the mother's immobility. Having a positive relationship with the surgeon helps as does being part of the decision-making process to have a CS.

On the other hand, there are many negative emotional responses:

- Isolation, being left out
- Inadequacy, feeling of failure to protect
- Grief, loss, fear, fright,
- Anger, helplessness at 'role-failure' as coach especially if the dad is not in the delivery room
- Overwhelm by being present at the surgery

On the positive side, fathers are found to:

- Handle the infant more often immediately after birth
- Be more responsive to their infant's distress symptoms
- Be more satisfied with their child's personality
- Be more satisfied with the couple's approach to parenting
- Spend more time alone with their infants
- Be as attached to their CS children as to their vaginally born children

Mutryn notes that the father's presence and caretaking activities do not guarantee bonding with the baby or his emotional support of the mother. The quality of the parents' bond with each other going into birth is highly important. As for bonding with the baby, researcher found that fathers of CS babies are less likely to interact playfully with them or talk with them and significantly less likely to smile at the children even though they take care of them more often.

### **Effect of CS on the couple's relationship**

Mutryn (p 1277-78) reports several negative results compared to vaginal births:

- Mom were more likely to express anger or negative feelings toward their husbands
- Moms reported sexual problems, partly stemming from feelings about the scar and their self image as women
- Mom's were less likely to want future children and less likely to have them.
- Those who had another child had more complications during pregnancy and birth and less healthy children (more low birth weight babies, more of them died, more malformed children, lower Apgar scores.)

## Creating a more supportive environment for CSs

Even in the hospital setting within the confines of a CS, it is possible to create a more welcoming environment for the child and to increase the strength of the parent-child bond through emotional support for the mom and baby.

Marshall Klaus is a strong advocate of having doulas at birth. Doulas are trained to give continuous emotional and physical support to the mom throughout labor. He has presented data that the presence of a doula will cut the CS rate in half. (Family Practice News) Presumably, even when a CS happens, the mother will be able to relax and bond better than if she didn't have that support.

Lani Rosenberger, CPM writes in *Birth Gazette* (Spring, 1996) of a couple who knew that the mother needed a CS due to a medical condition and a prior CS 25 years earlier. They found an OB and a hospital who were willing to go along with their birth plan which included:

- CS happened only after natural labor had started.
- Her husband and/or midwife remained with her throughout the birth experience including the CS.
- Mom was awake and alert, given an epidural.
- The drape screening her from a view of the baby's birth was lowered so she could see her baby emerging.
- Immediately after birth, the baby was shown her to mom before going to the pediatric table, accompanied by the father. The father stayed with the baby, touching the baby, during the postbirth procedures.
- The father then brought the baby to the mom for cuddling (nursing was difficult because of the position).
- The father went to the nursery with the baby and stayed with the baby until they were reunited with the mom in the recovery room. The midwife stayed with the mom.
- The father was given a cot to sleep on in the maternity ward with mom and baby until they left the hospital. (They shared the room with other moms with their babies rooming in).

The hospital was so pleased with the outcome of this birth that all the requests of these parents became hospital policy. Fathers or other friends or relatives are now asked to spend the night so that the baby can 'room in' with the mom. The father or relative/friend is asked to accompany the baby whenever the baby goes to the nursery.

## **Facilitation of the CS-born person**

### **Facilitation protocols**

- Resourcing.
- Cranial molding patterns.
- Look at pacing issues.
- Must work in the other person's flow.
- Must engage with creative opposition in a cooperative manner.
- Must set and keep you own boundaries straight and firm.
- Be gentle, persistent and meet them on the intellectual level.
- Titrate into their trauma.
- Birth resimulation:
  - Macromovement patterns
  - Conjunct pathways patterns
  - Static postural patterns
  - Cranial dynamics

### **Facilitation sequence**

1. Establish rapport, empathy.
2. Follow the birth patterns, at the baby's tempo, slowing him down. Tell him what you doing before you do it. Negotiate the slightest difficulty or resistance with the child.
3. Move between repatterning and resimulating. Know where the child is in relationship to the stress matrix.
  - Titrate up; escalate slower than the patient. Discuss and negotiate changes in emotional tone.
  - Negotiate the changes with the client.
  - Alternate between cranial/body work, polarity energy work and active play. Always pay attention to how your actions may or may not resimulate the child's birth.
4. Know where you are in the child's birth to be able to identify what you are doing in relationship to their birth.
5. Work with child in a level before shock. Stay away from shock until the child is well resourced. This means do a lot of titrating and repatterning first.

### **Jeremiah's facilitation**

Jeremiah demonstrates several of the characteristics which Emerson, English and Castellino have noted.

- Boundary issues, the way he treats his mother and sister.
- Fascination with rescue fantasies, toys etc., story of bringing a bag of rescue toys to last session.
- Headstrong
- Difficulty saying no. Can be talked into things by other kids. Fourteen-year-old boy downs the street talking Jeremiah into sexual exploration.
- Not knowing how to appropriately expressing his anger.
- Enjoys the struggle.
- Intellectually bright (stage four)
- Attentive to detail ( can miss the overview)
- Asks for help and then turns it around finds fault or is angry toward the person who helps him. Help is seen as an intrusion, something to be suspicious of.
- Can be oppositional in nature.

## **Titrating the work**

The practitioner works starting with surface levels, moving to deeper levels of consciousness. This is part of the titration process. In order to understand and appreciate the titration needs of the individual, it is very useful to know and consider the levels of consciousness with respect to the Polarity Therapy energy model.

Gunas:

- Airy principle: causal origin/ mental blue print/ capacity for clear thought/ conception/ visual acuity
- Fire principle: motivation/ ability to manifest into the creation/ umbilical affect/ auditory acuity
- Watery principle: manifestation into the creation/ structural integrity/ physical presence.

Peter Levine states that it is the witness state that links the trauma vortex with the counter-vortex. This is the matrix of consciousness that provides for the coupling and ultimate constructive access to the confined energy of shock trauma.

Elemental levels:

- Earth: survival/ safety/ protection fear
- Water: creation/ nurturement, receptivity, procreation - lust
- Fire: boundaries: digestion assimilation, motivation, opposition - anger/rage-fire in the eyes.
- Air: desire/ wants/ deservability/ expressor of the heart human touch and understanding/ greed
- Ether: longing/ listening/ verbal expression - separation and grief.

Titrate the of layers of the work over time. It is important to build the resources to be able to integrate the deep separation feelings. The timing for when to move into different or deeper therapeutic levels must be negotiated with the patient/client. This is not a decision that rests solely in the hands of the practitioner. Yet the practitioner is obligated to provide the matrix for safety and the knowing of where or what level he/she (the practitioner) is willing to explore with the patient/client. This is true for adults, children and infants.

It is contacting the deeper levels of grief and separation that produces the depth of the light which radiate from the eyes. Ultimately that light is a manifest expression of God's presence in us.

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