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

Revised October 2011

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Acknowledgments
Preparation for this training module 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 this chapter, three obstetric textbooks, DeLee and Greenhill (1943), Oxorn-Foote (1985), and *William's Obstetrics* (1993) where 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 that 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 chapter 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 section, 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 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. There was widespread belief within the medical community during the 1970s and 80s that performing CSs would deter possible malpractice litigation. Localio, et. all 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. 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 or Cytotec. 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 choose 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 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.
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> 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 (supposedly for 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 has 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