Castellino Prenatal and Birth Training
Forceps Trauma, Impact and Facilitation
Revised October 2011

by Raymond Castellino, D.C., R.P.P., RCST®

Assessment of Birth Trauma from Surgical Intervention

When I originally organized the training curriculum I needed to look at areas of study and skills. The nine areas listed below comprised the original list that I made to begin writing and creating the curriculum design. This list is organized around my perception of the baby's need and was written before I really began to articulate the work from the perspective of infant-centered family therapy. I include it here because it remains a useful list, though incomplete.

1. *Energetic patterns*
2. *Conjunct Site*
3. *Conjunct Pathway*
4. *Vector Pattern*
5. *Cranial lesion pattern*
6. *Macro movement schema*
7. *Micro movement schema*
   - *Tides / Fluid system/ Ventricular system/ esoteric Pineal - Pituitary relationship*
8. *Static posture or schema / Body tone*
9. *Psychic patterns/psychological corollaries*
   - *Mistaken assumptions*
   - *Primary goal structure*
   - *Emotional patterns*
   - *Survival Strategies*
   - *Boundary Skills/needs*
   - *Strategies of consciousness*

Thanks to Ginny Partridge for going to the UCLA medical library and copying several research articles on forceps and vacuum extraction use.

©Copyright April 9, 1996, revised April 8, 1999 Raymond Castellino, D.C., R.P.P., 1105 N. Ontare, Santa Barbara, CA 93105, (805) 687-2897. This material may not be reproduced for any reason.

Introduction and overview of forceps trauma

In this section of the workshop we will focus on the effect of forceps trauma at birth and its effects on later life.

Skills you will be focusing on are:

1. Visual identification protocol for forceps cranial molding.
2. Assessment of resources to determine facilitation sequence for forceps.
3. Verbal, empathic and kinesthetic skills with adults and children concerning forceps trauma as a boundary violation.
4. Facilitation protocols for working with forceps trauma.

In most cases, forceps trauma includes great overwhelming boundary violation and helplessness to the baby even if the use of forceps saved her life. This means that, in most forceps deliveries, the baby goes into shock. The facilitation protocol for forceps trauma requires that the practitioner be able to assess the patient/client responses in ways that allow the client/patient to access their resources so they can make productive active use of the vital energy locked in forceps trauma sequelae.

Having an overview understanding of how forceps are used and the sequence in which they are applied helps the practitioner track the client's responses and develop appropriate therapeutic repatterning interventions with them.

Readings for the forceps portion of this training come from:

- Bennett and Brown, *Miles, Textbook for Midwives*, pp. 451-455
  Chapter 28, read the sections under "Obstetric Operations."
- Oxorn and Foote, *Human Labor and Birth*, Ch 24 through 28.
  Ch. 24, "Obstetric Forceps"
  Ch. 25, "Anterior Position of the Occiput: Delivery by Forceps."
  Ch. 26, "Arrested Transverse Positions of the Occiput."
  Ch. 27, "Arrested Posterior Positions of the Occiput."
  Ch. 28, "Arrested Face Presentation."
- *Maternity Nursing*, Ch. 39, "Operative Obstetrics."

History of forceps use

- Forceps are referred to in Sanskrit (1500 BC), Egyptian, Greek, Roman and Arabic writings. Modern OBs assume that they were used to extract fetuses that died.
- Modern forceps were invented in 1580 (DeLee and Greenhill) by Peter Chamberlen in England. There are now over 700 different variations of obstetrical forceps.
- In the 1930s and 40s, many OBs reported outlet forceps with episiotomy was superior to spontaneous delivery. During these years, many institutions report that forceps were being used as often as 50% of the time. By 1950, forceps were in use for 70% of all births. 10% of the previous number were midforceps (Yeomans and Hankins, 1992).
- With the increased use of cesarean section, vacuum extraction, blood transfusion, antibiotics, oxytocin and improvements in anesthesia technology, forceps use has decreased.

©Copyright April 9, 1996, revised April 8, 1999 Raymond Castellino, D.C., R.P.P., 1105 N. Ontare, Santa Barbara, CA 93105, (805) 687-2897. This material may not be reproduced for any reason.

- Decreased use of forceps meant that fewer OBs were being trained in forceps operative techniques.
- Midforceps debate has been ongoing since the 30s and 40s. Better controlled studies on midforceps use began to appear in the early 1980s. By 1988 the American College of Obstetricians and Gynecologists (ACOG) changed the classification of forceps operations, advocating outlet forceps delivery over midforceps.

Types of forceps (See Oxorn and Foote, pp. 332-333)

Simpson (1845) and Kjelland (1917) are the most common types

Why forceps?
Forceps are used because the baby has ceased to make forward progress. Medical indications recommended by Yeomans and Hankins include:

- Maternal exhaustion, lack of cooperation and excessive analgesia
- Maternal diseases: cardiac, pulmonary, cerebrovascular, neuromuscular
- Presumed fetal jeopardy
- Prolonged second stage (this is the medical second stage which begins when the cervix is fully dilated and end with the birth of the baby. The prolonged time may be caused by deflexion attitudes (face, brow or median vertex or military presentations), asynclitism, malposition)

Prerequisites for use of forceps
Yeoman and Hankins also list recommended prerequisites for the use of forceps (which they also recommend for vacuum extraction):

- Complete cervical dilation
- Ruptured membranes
- Vertex presentation
- Head engaged
- Position known
- No fetopelvic disproportion
- Adequate analgesia
- Cesarean section capability
- Empty bladder and rectum
- Experienced operator
- Patient consent

If forceps are used with great skill, attentive tracking with the mother and baby and informed consent for both (yes, even the baby), the use of forceps can be a mutually cooperative process. If forceps are used when they are contraindicated (cephalopelvic disproportion [the baby's head is too large], the cervix is not fully dilated, malposition, the baby's head is not engaged, lack of operator experience, etc.), the results can be catastrophic. Elective use of forceps (because the OB chooses for his/her convenience) not indicated for the medical needs of the mother and baby and are always contraindicated.

Forceps classification (ACOG) according to Station and Rotation:
(from Yeomans and Hankins, 1992)

©Copyright April 9, 1996, revised April 8, 1999 Raymond Castellino, D.C., R.P.P., 1105 N. Ontare, Santa Barbara, CA 93105, (805) 687-2897. This material may not be reproduced for any reason.

	1965		1988
Outlet	Scalp is or has been visible at the introitus without separating labia. Skull has reached pelvic floor. Sagittal suture in anteroposterior diameter.	Outlet	Scalp is or has been visible at the introitus without separating labia. Skull has reached pelvic floor. Sagittal suture in anteroposterior diameter. With rotation ≤ 45°
Mid	Head engaged, conditions for outlet not met. Any rotation. Term "low midforceps" disapproved.	Low	Station ≥ +2 cm Rotation ≤ 45° Rotation > 45°
		Mid	Station < +2 cm Head engaged
High	Unengaged		

OB Application Procedures
Understanding and being able to recognize the medical protocol will enable you to recognize the medical trauma sequelae in your patient/client's somatic schema. Correlation of the patient/client's trauma patterns with the medical procedure can help the patient change their relationship to their trauma and help free their vital energy to enrich others and their own lives. It is essential to allow the patient/client to show you their process within the safety of their witness perspective. Do not overlay your knowledge of the medical sequelae onto them. Discover how they correlate. The videotape of Gabrielle's work is an excellent example of how to discover with the child the correlation between the medical sequelae and his somatic pattern.

The following is a **summary overview** from Oxorn and Foote (see pp. 355 to 364):

1. Preparation: OB reviews indicators/contraindicators makes sure this is the proper operation. Patient is placed in position. Surgical area is cleaned. Anesthesia is administered (spinal, local, general).
2. OB orientation: check baby's presenting position with vaginal exam.
3. Before application of the forceps and with each step in the process, visualize the baby's position and the procedure prior to application of each forcep. (This step is left out of Oxorn and Foote and strongly encouraged by Dennen, *Forceps Deliveries.* It is a step that I believe can make the process much more gentle for the baby.)
4. Apply forceps in LOA, first the left blade then the right.
5. Lock forceps: (see p. 362 of Oxorn and Foote).
6. Extraction of the head:
    a. Pre-extraction examination. The OB must make sure that:
        1. the heart rate is normal
        2. that there is nothing between the blades and the fetal head,
        3. the instrument is properly placed. This is accomplished by doing a vaginal exam. If the blades are off center, they must be unlocked, then moved to proper position.
    b. Trial traction with a gentle pull, then reassess
    c. Birth of head and forceps removal can be done in two ways:
        1. Traction continues as the head is born, then forceps are removed.
        2. As the head crowns, forceps are removed. Then birth the head.

Forceps trauma impacts: Forceps can impact the person in several ways. It can:

©Copyright April 9, 1996, revised April 8, 1999 Raymond Castellino, D.C., R.P.P., 1105 N. Ontare, Santa Barbara, CA 93105, (805) 687-2897. This material may not be reproduced for any reason.

- cause the person to feel helpless to assert appropriate boundaries or cause her/him to be insensitive to other's boundaries.
- overwhelm the will.
- cause the person to seek resistance in his or her life without knowing why. Anger and rage are often present. Depending on what birth stage the forceps were placed, the person will blame herself (high), be confused (mid), blame others (outlet).
- interrupt proprioceptive awareness and movement continuity through the stages of any movement (intention, preparation, assertion, follow through and integration stages).
- medially compress the cranial structures, especially causing intraosseous medial compression of the sphenoid great wings and temporal bones. Often noticeable marks are apparent on the person's head where forceps were placed.
- cause compression somatic pain syndromes in the vicinity where the forceps were placed. This can include pressure headaches in the area of the sphenoid great wings, and the zygoma as well as TMJ problems.
- increase the possibility of epileptic seizures. A study following children from four to seven years showed 22:10 compared to normal delivery in 381 forceps children, 372 normal. There were more partial than generalized seizures. "There was no neurological deficit in any child who had seizures." (Maheshwari, 1992)
- In rare cases, causes cranial fracture and/or nerve palsies (Yeomans and Hankins, 1992).

Forceps are often, though not necessarily, preceded by amniotomy (artificial rupture of membranes), and medications such as synthetic oxytocin (in the US, Pitocin; in Europe, 'Syntocinon' or 'Synoxytocin'), analgesic and anesthetic agents. I have included with these notes an article on the active management of labor by Marsden Wagner, MD, MSPH. Active management of labor may include these practices but it is characterized by the 12-hour time limit on labor given to moms and babies before interventions are begun. Wagner aply points out that this artificial time period is not supported by research.

Since the 1920s and 30s, obstetric skill in the use of forceps has declined. In the 20s through the 60s, high, mid and outlet forceps were employed. During this period, high and midforceps declined for two reasons:

- The decline in obstetric skill. Obstetric schools were not effectively training young OBs how to use them.
- More babies were noticeably injured. Public awareness increased, and more malpractice suits occurred, especially involving the use of high and midforceps. Finally in 1988 the American Board of Obstetricians advocated that the use of late outlet forceps as an acceptable practice and discouraged the other kinds. (Yeomans and Hankins, 1992)

Visual assessment:
Look at photos on video and supplemental notes from DeLee and Greenhill. The key cranial visual cues.

- AP view
- Lateral view

Movement and autonomic patterns:
Look at adults and babies born with forceps during somatic birth work in relationship to pelvic type macromovement schema

- gynecoid

©Copyright April 9, 1996, revised April 8, 1999 Raymond Castellino, D.C., R.P.P., 1105 N. Ontare, Santa Barbara, CA 93105, (805) 687-2897. This material may not be reproduced for any reason.

- android
- anthropoid
- platypelloid

If the baby's head is large enough, a mother's android pelvis can have imprinting effects on a baby psychologically similar to that of forceps.

©Copyright April 9, 1996, revised April 8, 1999 Raymond Castellino, D.C., R.P.P., 1105 N. Ontare, Santa Barbara, CA 93105, (805) 687-2897. This material may not be reproduced for any reason.

Forceps Facilitation Protocols

The facilitation protocols that are presented in this workshop are synthesized by Dr. Castellino primarily from his own work, Dr. William Emerson's work, the cranial work as taught by Franklyn Sills, Dr. Mark Pick's work and Polarity Therapy as presented by Dr. Randolph Stone. The video case review of Gabriel's work was done prior to any knowledge of Dr. Peter Levine's work. This work is pleasingly similar to Dr. Levine's work and follows the same principles.

The facilitation of persons who have experienced forceps trauma must initially include resourcing activities that build the will, establish strong boundary structures in the client's felt sense and give the client a clear sense of control over the facilitation process. Emerson created a facilitation strategy to accomplish this by have the client push away the therapist's hands as they move toward the client's head where the forceps were placed. I refined the process by defining several forceps facilitation protocols.

Facilitation Protocols

1. Take the history. Assess trauma level. Make sure the client has resources for follow-up care.
2. Cranial baseline: sutural system; fluid system; anesthesia? fluid tide pattern.
3. Macromovement patterns: Focus on the body. Track the birth pattern. Notice when changes occur in the client. Discover how the macromovement pattern and the sensation changes in the client correlate. Follow the movement pattern. Discover with the patient/client where she got stuck and how the forceps changed her birth.

    - Begin with resourcing and repatterning
    - Resimulation must be done without overwhelm
    - Toggle or alternate back and forth between resourcing and resimulation
    - Progressively titrate to patient tolerance
    - Support her integrative process

4. Micromovement cranial patterns:

    - Monitor the fluid tides, correlating with autonomic responses
    - Sutural review
    - Intraosseous sphenoid release
    - Intraosseous temporal release
    - Bilateral temporal compression
    - Intraosseous occipital lesion patterns
    - SBS compression

5. Be sure to finish the session with integration work. When a patient/client is in an integration sequence, she is able to have cortical cognition, can feel her emotions and is in her physical body. Cortex, midbrain and brain stem are all active and cooperative. The patient/client is able to resource from within and without. Bonding occurs at this time.

Basic forceps facilitation strategy

©Copyright April 9, 1996, revised April 8, 1999 Raymond Castellino, D.C., R.P.P., 1105 N. Ontare, Santa Barbara, CA 93105, (805) 687-2897. This material may not be reproduced for any reason.

1. Assess where the forceps were placed by correlating the client's symptom sensations, visual markings, and changes in skin color and by palpating energetic vector patterns. Clients with forceps trauma will often feel pressure where the forceps were placed, especially in the vicinity of the sphenoid great wings. Visual markings may or may not be present. When the somatic trauma memory is activated, because of the autonomic sympathetic skin response, the skin will often turn red in the area where the forceps were placed.
2. Establish energetic boundaries and contact with the client by placing both of your hands two to three feet away on either side of the client's head around where the forceps were placed. Provide enough space so she does not feel your hands there and is not further activating into the forceps sensations or emotional affect.
3. Find the edge of where the client energetically senses the presence of your hands. Back your hands away from the edge, or take them away completely if the sensations are too physically or emotionally strong for her. Make sure she stays present and in contact with you. Do this two or three times.
4. Instruct the client to think about what she would like to do with the forceps. You are working with her on the intention level. Wait a moment. Keep slowing the pace down. Ask her to describe what they want to do. She will usually say something about getting rid of them. She could also say, "I want them to use the forceps because I am stuck and need help." Continue to keep the pace slow. Move your hands back to both sides of her head beyond her sensation range. Slowly move your hands to the edge where she begins to feel the somatic sensation impression of the forceps. Ask her to think about moving the forceps away without moving her hands or arms. Ask her to describe the sensations in her hands and/or arms. Instruct her to let the energy build. Remember that you are working on the intention level now.
5. Ask the client to move slowly. Tell her she will know exactly when to move her hands and arms. Usually she will move her hands to yours. This is the preparation movement. (I believe that if birthing babies are not overwhelmed, they will attempt to move their hands to the place where they feel the discomfort.)
6. Let her make contact with your hands and gradually let the impulse to push build. Keep the pace slow. When she is ready to push, gradually match her pressure. This is the action step of the 5-tier movement sequence. Let her gradually push to the full force of her strength. Do not overpower her. Let her overpower you.
7. Ask her to feel the sensation of the follow-through at the end of the movement.
8. Ask her how she feels doing this. Usually, she will say something like, "I feel really strong or powerful." Remember that you are working with the natal being and repatterning forceps overwhelm. Make sure, at the end of the sequence, that she is able to feel the sensation of successfully pushing away the forceps. This is the integration phase.
9. Repeat this sequence several times.

Cranial sequence:

If the client is able to hold quiet presence and accept your hands on her head in the vicinity of where the forceps were placed, tune yourself to the fluid tide level. Track the fluid tides through several cycles that she presents, i.e., still points, lateral fluctuations, longitudinal tides. Visualize the newborn cranial structures. Identify and track cranial lesion patterns especially the intraosseous lesion patterns of the structures within the compression zone of the forceps. Usually intraosseous lesion patterns occur within the sphenoid, temporal, occiput and facial bones. Keep your attention in the fluid tide level and continue to visualize the newborn cranial structures. The fluid tides will fill the compressed structures with life force. It is common to visually see her

©Copyright April 9, 1996, revised April 8, 1999 Raymond Castellino, D.C., R.P.P., 1105 N. Ontare, Santa Barbara, CA 93105, (805) 687-2897. This material may not be reproduced for any reason.

cranium expand across its coronal (lateral) axis. Ask her to describe the sensations as you do this. She will often state that she is experiencing less pressure and more space in her head.

As the client integrates the impact of these facilitation sequences, it will often dawn on her that she has lived most her life under the pressure or felt sense of forceps. It is common for her to experience deep grief and loss for what her life could have been had she resolved this trauma earlier in her life. Acknowledging the loss of what might have been is often an important part of the healing process.

Sagittal sutural spread

When the cranial sutural system is fixed, the head feels hard. Common sutural fixations for forceps occur in the sagittal suture. The sagittal spread cranial technique can be very helpful for adults and teens. It can be done in the sitting posture or with the client supine. With the client in the sitting posture, stand at their back. Float your hand over his head. Gently use your fingers to spread the sagittal suture.

Psychological corollaries for forceps trauma

Forceps-traumatized patients can present with a variety of psychological symptoms. The person can be caught in an addictive conflict of will, power and boundary issues, self-esteem difficulties, love-hate relationship with authority, loss of personal initiative, need to be rescued and a crisis of will. These people may be defeated and crushed or they may defeat and attempt to crush others. They can feel jerked around and victimized by others. They can be headstrong and strong-willed. Their personality can be oppositional in nature. They are often disconnected from their bodies.

I would love to see a correlative epidemiological study of violent convicts. I'll bet we will see many murderers that were birthed by outlet forceps. After analyzing photographs of O.J. Simpson and Timothy McVeigh, I believe that it is possible that both men were born via forceps.

Emerson reports that people birthed with forceps are often fascinated with heavy metal, motorcycles and weapons made of metal, especially swords. He has done a significant amount of writing on this subject.

©Copyright April 9, 1996, revised April 8, 1999 Raymond Castellino, D.C., R.P.P., 1105 N. Ontare, Santa Barbara, CA 93105, (805) 687-2897. This material may not be reproduced for any reason.

Bibliography

Bayshore, et all, "A Comparison of the Morbidity of Midforceps and Caesarean Delivery," *American Journal of Obstetrics and Gynecology*, 1990;162:1428-35

Dennen Philip C., *Forceps Deliveries,* Third ed., (1989), F. A. Davis Co.

Oxorn and Foote, *Human Labor and Birth,* Fifth ed., (1985), Appleton and Lange. Chapters 25 through 30.

Dierker, et all, "Midforceps Deliveries: Long-term Outcome of Infants," *American Journal of Obstetrics and Gynecology,* 1986;154:764-8

Dierker, et all, The Midforceps: Maternal and Neonatal Outcomes," *American Journal of Obstetrics and Gynecology,* 1985;152:176-83

Dyack, "Rotational Forceps in Midforceps Delivery," *Obstetrics & Gynecology,* Vol. 56, No. 1, July 1980, pp. 123-6

Ingardia, et all, "Forceps - Use and Abuse," *Clinics in Perinatology,* Vol. 8, No. 1, Feb. 1981, pp. 63-77

Maheshwari, M. C., "Forceps delivery as a risk factor in epilepsy: a comparative prospective cohort survey," *Acta Neurologica Scandinavica,* 1990 Jun, 81 (6): 522-3.

Maheshwari, M. C., "Forceps delivery as a risk factor in epilepsy: some further observations," *Japanese Journal of Psychiatry and Neurology,* 1992, Jun, 46 (2): 413-3.

Robertson, et all, "Neonatal and Maternal Outcome in Low-pelvic and Midpelvic Operative Deliveries," *American Journal of Obstetrics and Gynecology,* 1990;162:1436-44

Varner, "Neuropsychiatric Sequelae of Midforceps Deliveries," *Clinics in Perinatology,* Vol. 10, No. 2, June 1983, pp. 455-461

Yeomans, Edward R., Lt. Colonel, USAF, MC and Hankins, Gary D. V., Lt. Colonel, USAF, MC, "Operative Vaginal Delivery in the 1990s," *Clinical Obstetrics and Gynecology,* Vol. 35, #3, September 1992.

Yeomans ER, Gilstrap LC. "The role of forceps in modern obstetrics," *Clinical Obstetrics and Gynecology,* Vol. 35, #3, September 1992.

©Copyright April 9, 1996, revised April 8, 1999 Raymond Castellino, D.C., R.P.P., 1105 N. Ontare, Santa Barbara, CA 93105, (805) 687-2897. This material may not be reproduced for any reason.