Waikato Home Birth Association Inc. Newsm 1996

Maggie Banks
Te Awa Rd
RD 3
HAMILTON

Expiry:7/96

Disclaimer: Opinions expressed in this magazine are not necessarily those of the Waikato Home Birth Association Inc.

WATERBIRTH INFORMATION EVENING
TUESDAY 14 MAY 7.30 PM
LINK HOUSE, TE AROHA ST.

SENDER:
Waikato Home Birth Association Inc.
P.O. Box 12099
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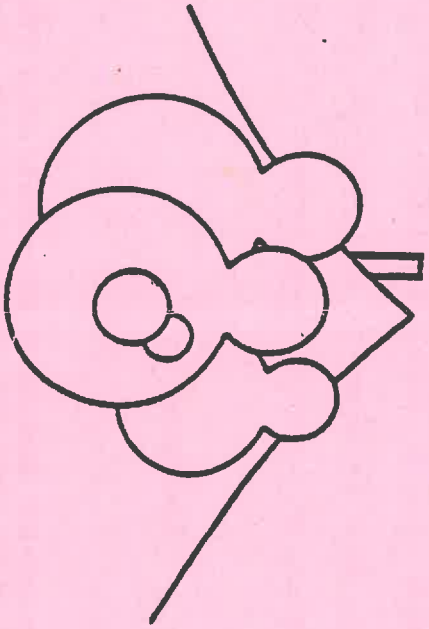
Waikato Home Birth Association Inc.

Newsmagazine 1996



MAY

PHONE NUMBERS:

Glenys Parton	855-1842	Treasurer
Joanne Ridder	847-4987	Mailing List Coordinator
Christine Hussey	849-1750	Newsmagazine Editor

Please post Birth Stories & articles to Christine c/o 131 Woolrich Rd, RD 8, Hamilton

The **W.H.B.A. Library** is now located at 25 Roy St, Hamilton.
Phone Joanne Ridder to arrange a time to borrow or return books & tapes.

Hi everyone,

Well I've just completed my 2nd to last shift and as you can tell the computer is still to be unpacked. My new address is on the front cover so please keep sending in your birth stories and articles.

Thank you to Clare and Belinda for your letters. Your comments are always welcome. Well I'm going to unpack more boxes. Please take care

Christine

Dear Editor,

I wanted to write and thank you for the wonderful article "Pigs Can Fly" in the April issue of the Home Birth Association Magazine. I found it interesting, enlightening and what's more, pleasant reading. What a special person Dorothy must be for sharing such a personal story with us.

I believe that some people have found it a little "extremist" however and I can see that the messages in Dorothy's article may indeed be too much for some peoples belief systems to cope with - and that's fine. We are all entitled to our own views and beliefs.

Spiritual beliefs - like thoughts on immunisation and abortion - are individual and unique to each of us, and can cause impassioned debates! It would be a shame if articles which give a different view are not printed for fear of being outside some peoples comfort zones. We don't have to agree with or like everything printed in the Home Birth magazine.

I think it's great that the Magazine can print articles like Dorothy's - even though they may not be everyones cup of tea - "vive le difference", I say. I personally enjoy articles which aren't "mainstream" as they certainly give us something to think about.

"Always for the underdog",

Clare Shallcross

The WHBA endorses the following sample of quotes taken from "Qualities we expect in a midwife" in the booklet "Have you considered a home birth?"

A midwife should see her role as a facilitator who can help a woman explore and research options for her birthing experience and help her articulate her own needs in the birthing situation. She can do this by including the woman in her own health care, building her knowledge of and confidence in her own body.

The midwife must at all times respect a woman's right to make informed choices over her birth. It is the woman who is in charge of her birth (or her advocate who she has empowered on her behalf) and it is the woman who delivers her own baby. From this philosophy we see it is important that a written birth plan be viewed as a document of informed consent, a respected contract of care between midwife and woman.

Midwifery is a Women Centered Profession

Information and names of practicing Home Birth Midwives is available, phone Joanne Ridder, 847-4987

SUBSCRIPTION FORM

If there is a **GREEN** spot on this form then it is time to renew your subscription.

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The $20 minimum fee will list me as a member of the Association and entitles me to 11 issues of the Newsmagazine and use of the Library, located at 25 Roy Street, Hamilton, ph 847-4987

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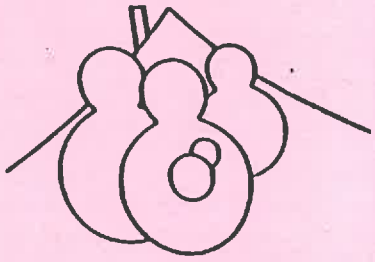

NAME:.....

ADDRESS:.....

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are administering. The historical high respect for learned people has made paternalistic medicine reasonably acceptable in Japan ...

"They are used to functioning in groups and to being treated uniformly ... education is highly disciplinary and group-oriented. Unless there is a very good reason, it is considered unfair to make exceptions for individuals ...

"People, especially women, who have been raised in this way are unlikely to question authority or to expect much individual attention. Even if they are dissatisfied with the care, it is improbable that they will be assertive about changing it or even express their disappointment. Changing hospital, or obtaining a second opinion, is uncommon in Japan, partly because the hospitals rarely transfer records, but also because of the embarrassment and breach of trust involved ...

"Maintaining harmony is also a tradition in Japan. (They) are very reluctant to do anything which will upset the harmony of a situation, and people must be quite desperate before openly complaining, especially in a forceful manner ...

"Taking these cultural aspects into consideration, it is understandable why Japanese hospitals can continue to provide impersonal care."

And *how* do they cope with the pain of childbirth so stoically? The book elaborates: "In a society like Japan, which emphasises orderly behaviour and discipline, psychoprophylaxis seems to work quite well. Most of the [techniques] taught under the name of 'Lamaze' are similar to those taught in the US during the 1970s and 1980s, keeping the woman in control by using conditioned reflex and coaching ...

"Another approach is the 'Red Cross Method' ... that uses abdominal breathing, has women labouring on their backs and does not include a special support person ...

"Women who are not trained in any techniques for coping with the birth will either seek an anaesthetised birth (very rare) or just 'grin and bear it'."

Despite the lack of supportive human hands or words of encouragement throughout labour, if asked, this woman would say she had plenty of support, says Karen.

"They have the most amazing network of women who are totally supportive of their role as a mother," she says.

"We may find it appalling that in Japan women are expected to give up work, often as soon as they are pregnant, but the strength of their social network is a major compensation.

"When you see groups of Japanese women, they touch each other and often hold hands. Initially they were very polite and formal to us, but once we established a rapport, we were friends for life."

For the Japanese women who do return to work following the birth of a baby, the small midwifery clinics dotted around the big cities often have daycare facilities attached.

These women – and they are increasing in numbers – leave their babies in the clinics during the day and can use the clinic's electric breast pumps to express milk.

Until the early 1950s, the clinics – owned and run by midwives – were very common. Japanese women gave birth at home, or in one of the clinics, usually with family members present.

With the Americanisation of Japan following World War II, high-tech, big hospital birthplaces became the norm. Few women choose smaller, private hospitals which offer active birth, or the option of being upright for the second stage of labour.

The fact that greater numbers of foreign women now live in Japan than have done so in the past is having an impact on the small midwifery clinics and the number of home births attended by a domiciliary midwife, but Japanese clients are still few. Only 0.1% of Japanese women opt for a home birth and around 1.5% deliver in a midwife's clinic.

Childbirth in Japan points out: "Although the percentage of Japanese women giving birth in these places (at home or in midwifery clinics) is steadily declining, the percentage of foreigners choosing this kind of birth continues to rise ...

"An American woman who gave birth at a clinic in Kanagawa described the scene there: 'I loved going to my midwife's clinic because of all the babies and toddlers who would inevitably be waiting with their mothers, either for prenatal checks or for breast massage. The warmth of all the mother/child interactions was always wonderful.'

"The few problems that foreign women have at midwife clinics are

MOTHER KNOWS BEST

Michel Odent pioneered the use of water in labour and has long urged the professionals to listen to what women want in childbirth. Keren Williams found out more about his views

WATER BIRTH, MICHEL ODENT

WATER birth has been given a rough ride from the media recently. For many consumers of maternity services and midwives, it is synonymous with the name of Michel Odent, the French obstetrician who pioneered the therapeutic use of water in childbirth during the 1970s.

Dr Odent's hospital in France was the only one in the world to encourage women to use water as a method of pain control for seven years until 1985, when aquatic birthing was introduced at a hospital in California. His own writings on the subject are arguably the most definitive research on water birth and his guidance on water temperature, and how to ensure full control over the environment for the woman, is followed by many professionals who encourage the use of water therapy.

Michel Odent now divides his time between attending home births and working at the Primal Health Research Centre, a London-based charity he set up to research the link between what happens in the womb and what happens during the rest of life.

Through his work at the centre, Dr Odent is now gathering data on water birth, which he hopes will address important questions over mortality and safety. The recent case of a baby who 'died in the water' in Sweden stirred up opposition from the Royal College of Obstetricians and Gynaecologists to the practice of water births. But, as Dr Odent points out, water birth is a misnomer as few babies are actually born underwater — most women merely use the pool for pain relief. It was only a matter of time before the college declared a state of emergency over the practice, he says.

'We know that the perinatal mortality rate is below eight per 1000, but in any birthing situation we still have babies who do not survive,' he says. 'But that is not seen as a reason to ban babies from being born on dry land. The negative side of the college's position on this is to create fear. Fear is the enemy.'

Research into water birth is thin on the ground, he agrees, but hopes the furore surrounding the Swedish baby will encourage more definitive research, and that hospitals and professional organisations will produce clearer guidance for midwives and doctors. However, he believes there has been a paucity of research in relation to water birth because in a process as natural as childbirth 'controlled' studies are difficult to conduct.

'Some women are so attracted to water, it is difficult to place women in a control group and say "You cannot use water here". In the end, what you may end up measuring is women's disappointment,' he says. 'What we have to do is to evaluate how many women a year use water and come up with rates of perinatal death.'

He is committed to the idea that women need greater choice in childbirth and is concerned that to remove the option to use water detracts from the sentiments contained in the Department of Health report *Changing Childbirth*.[1] Greater choice, he agrees, will only come about when midwifery is allowed to change with the times.

Widely travelled and experienced, and deeply committed, Dr Odent hopes he knows what women want and what makes for good maternity care. In his travels around the world, he has seen the best and worst of maternity services. His conclusion is the same as that of many midwives — that we should return to the roots of midwifery and rediscover the skills lost to medicalised childbirth.

'We're moving into the post-electronic age,' says Dr Odent, 'where procedures such as routine continuous monitoring are no longer sustainable. Research clearly shows that monitoring creates more problems than it prevents. When doctors introduced it they were not educated to think of the woman's needs. Technology has been the main threat to the midwife. She has become a technician, not a midwife.' In the post-electronic age roles will reverse, he claims. 'Midwives will be totally autonomous — the key professionals in maternity care.'

Dr Odent believes midwifery should be totally separate from medicine, with the midwife being the first point of contact for a pregnant woman. Only when problems arise should the midwife refer the woman to a doctor. The doctor he says, should take a back-up role, ready to take over if things go wrong. 'Extending the role of the midwife to include things like forceps deliveries is not the point,' says Dr Odent. 'Midwives should be rediscovering their original role so that medicine and midwifery are kept separate. Only then can midwives become autonomous.'

Dr Odent turns to his experiences in the Netherlands and Japan, where home births and small midwifery-led centres are commonplace. The Netherlands boasts impressive statistics: the Caesarean section rate is between 6–8%, compared with about 13% in the UK for 1992, and its perinatal and maternal mortality rates are low. One in three babies is born at home and one in three in a hospital is attended by a midwife who works autonomously. Only a third are cared for by obstetricians, says Dr Odent.

In Japan, 42% of women deliver in small units where high-technology births are rare, and some units are run by independent midwives. The country also has the lowest perinatal mortality rates in the world.

'Small centres are special in Japan. Women know their midwife in advance and it's a very female environment, so

they have a special feeling of privacy, which is crucial when a woman is in labour,' says Dr Odent.

Changing Childbirth proposes that women should know one midwife who ensures continuity of care, that 30% of women should have the midwife as the lead professional and 75% should know the person who cares for them during their delivery. Dr Odent welcomes these proposals and says that smaller units, like those in Japan, are the key. Smaller units provide a more intimate and less hierarchical service.

If midwives are to play a central role in maternity care, they will need to find those skills that were lost in the 1970s when medical intervention became the norm. Health professionals' whole perception of childbirth needs to change before midwives can reclaim lost ground.

The midwife's main role is one of watching and waiting, says Dr Odent. 'We are culturally conditioned to believe women need support during labour, that women cannot give birth by themselves. But this is not so. A good midwife is one who sits quietly in the background, so the woman does not feel observed and is free to follow her own instincts. A midwife is not a coach.

'Traditionally midwives took the place of a labouring woman's mother — she offered security, so the woman felt protected and safe. When a dolphin gives birth, other dolphins circle around her, protecting her from harm, so she feels secure enough to focus on the birth.'

Now that midwifery-led services are set to become a real possibility, Dr Odent hopes midwives will be free to abandon old models of care, where examinations are determined by the clock.

'In hospitals, regular vaginal examinations are carried out and a woman is not free to express how she feels about what is happening to her. When women feel secure and private, midwives will not need to perform routine examinations. They will be able to use their experience to assess progress by observing the woman's body language: her position, the noises she makes, and her movements.'

Developing midwifery as a profession and employing more midwives is how Dr Odent sees the way forward. Only then will women be offered real choice in childbirth. Home births and small midwifery-led birthing centres should be a real option for women, he believes. At the moment, only about 1% of births take place in the home because doctors and midwives are led to believe home birth is dangerous.

Home births and small midwifery-led centres should be offered to women as an option, believes Michel Odent (above), pictured (left) assisting at a water birth

'The current medical attitude is deeply entrenched. Most medical students never imagine the environment could influence the outcome of the birth. If such topics were included in the curriculum, the belief that home birth is dangerous would be challenged,' he explains.

A recent survey carried out by the National Childbirth Trust found many women were unaware they had a choice about where they could deliver.[2] Over half said they were offered no choice, and a staggering 94% said they received no written information about alternative places of birth and who could provide care. This reluctance to offer choice stems from the misconception that obstetric-led care is always best. If childbirth is going to change, a change in attitude will be needed first, says Dr Odent. MT

REFERENCES

[1]DoH Expert Maternity Group. *Changing Childbirth*. London: HMSO, 1993.

[2]Newburn, M. Choice, continuity and care. *New Generation* 1993; 12: 2.

More about Michel Odent's views on midwifery and childbirth can be found in his latest book, *The Nature of Birth and Breastfeeding*, published by Bergin and Garvey, £14.95

The Primal Health Research Centre can be contacted at 59 Roderick Road, London NW3 2NP

Karen Williams is a freelance journalist

THE Japanese Way of Birth

In Japan, you don't cry out. You don't ask for pain relief. No-one rubs your back. No-one tells you when to push. You simply have your baby. Quietly. Stoically. Efficiently. And no-one would dream of complaining.

Picture this: A brightly-lit delivery room in a large, well-equipped maternity hospital. In the middle, flat on her back on a bed, hooked to a fetal heart monitor, feet up in stirrups and vital bits covered with a sheet, a woman is having a baby.

Labouring silently, she seems in a trance-like state, although she's had no pain relief. Before being wheeled into the centre of this delivery theatre, she has laboured for many hours in a long ward lined with other women in various stages of silent labour.

Occasionally, a midwife takes a fleeting peek under the sheet to assess the situation, but few words are spoken. At no stage does anyone urge her to push. At last, the baby crowns for the final time, and slips into this stark, white world. The midwife snips and ties the umbilical cord and the woman has her child.

During this remarkable process, some foreign visitors are ushered into the room. Despite the protestations of some women in the group, the midwife assures them that the labouring woman is happy to have an audience. Sure enough, she breaks her trance to nod and smile her consent as they spread about the room. In any case, the delivery theatre has windows all around it to permit viewing by hospital staff or perhaps husbands, if they feel so inclined. This is birth in the 1990s, Japanese style.

A group of New Zealand midwives witnessed this birth during a visit to Kobe last year for an international midwifery congress. To Christchurch midwives Karen Guilliland, Jacqui Anderson and Julie Hasson the incongruity was glaring.

Here was a woman, apparently well prepared for giving birth, having attended ante-natal classes, coping with her labour purely through a meditative process (sometimes called psychoprophylaxis), without the support of her partner or any friend.

Japanese mothers have given birth in this stoic, silent way for generations. But in modern, high-tech Japan, this birthing process seems strangely out of place.

And in spite of our horror at the lack of privacy, the absence of any pain relief or partner support, and the compulsory horizontal-plus-stirrups delivery position, the woman appears to give birth effortlessly. Her perineum – the area between the anus and vagina which is stretched to capacity as the baby's head crowns – is untorn by this birth process.

In New Zealand and other Western countries, episiotomy – cutting the perineum to deliver the head – is a more common practice than in Japan. Midwife Julie Hasson says that, there, the perineum is a sacred part of the body, so episiotomies are avoided wherever possible.

Another plus for birth Japanese style is the low rate of caesarean sections – around 8%, compared with up to 23% in New Zealand.

Of New Zealand's base hospitals (fully equipped for caesarean deliveries), caesarean rates vary from 23% of Christchurch Women's to 18% at National Women's in Auckland and the lowest figure of 6.3% at Middlemore Hospital in Auckland..

Why do these women give birth on a hospital conveyer belt, receive no explanation for any medical intervention the midwife or doctor may provide – and go home happy?

A book which was presented to Karen Guilliland at the congress – *Childbirth In Japan – Past, Present, Future* – explains:

"Japanese people have not expected the hospital care, especially large hospital care, to be personal. They also generally have not expected professionals to relate to them personally or take much time to explain the care they

By Frances [illegible]lank

Elected Position that is currently vacant and <u>will</u> need to be filled at the AGM on 17 June 1996.

Chairperson (co-ordinator)
Ensures functioning of the Association within the framework of its Constitution and Aims and beliefs; facilitates the monthly Core Group meetings; represents or ensures representation of the Association to all third parties; organises Funding applications are completed on time.

Other positions
Secretary
Ensures minutes of meetings are recorded , and filed; handles correspondence and any follow-up; prepares correspondence summary for monthly meeting; maintains and updates correspondence file/minute book; collects mail; assists and liases with co-ordinators as necessary; ensures agenda is prepared and distributed for monthly meetings.
Julia (who is currently secretary) will be away for two months later this year, and this position is available but is also suitable for job sharing for anyone interested.
Core Group members
Keen, energetic, enthusiastic people are needed to join the WHBA Core group (committee). The Core group is responsible for the "business" of the Association. The more people we have the lighter the load on everybody. If you are interested in making new friends, supporting the home birth option, join the Core group.
SEE YOU AT THE AGM, 7.30PM, LINK HOUSE, TE AROHA ST.

Dear Editor,

I would like to congratulate you and Joanne Ridder on a very professional and enjoyable magazine. I have been a W.H.B.A. member now for about four years. In this time I have had two homebirths and I have three children altogether.

In the past I have enjoyed Dorothy Dando's articles (she is a personal friend). However the April issue of "Pigs can Fly" caused me some personal and professional discomfort. The topics covered including past lives/evil spirits and long distance exorcisms of a three year old boy are far from the topic of Home Birth, and I do not believe have a place in this magazine.

I would also like to point out that the majority of normal healthy three - four year olds have tantrums, throw things around and have periods of insecurity (without being "possessed"). In fact sometimes they even frighten themselves with the anger and frustration they feel.

I wish Dorothy well in the future and look forward to other articles from her on topics relating to Childbirth and parenting.

Thankyou,
Yours sincerely,

Belinda Beetham.

Waikato Home Birth Association Inc. AGM 1996

Monday 17 June, 7-30 pm at Link House, Te Aroha St.

AGENDA:

- Welcome
- Apologies
- Minutes of last AGM
- Treasurer's Report
- Other Reports
- Election of Officers
  - Chairperson
  - Secretary
  - Treasurer
- General Business

NOTE: Any additions to the agenda need to be forwarded to the Secretary (Julia, Ph 855-8266) as soon as possible.

ALL MEMBERS WELCOME

COMING EVENTS - May - June.

Note these dates on your calendar

WHBA Core Group Meeting
Monday 20 May, 7.30pm at 39 Northolt Rd, ph 854-7502.
Contact Julia Drury ph 855-8266 for the agenda.
Note: Meetings now held 3rd Monday of the month.
ALL MEMBERS INVITED TO ATTEND.

WHBA Annual General Meeting
Monday 17 June, 7.30pm at Link House, Te Aroha St.
ALL MEMBERS INVITED TO ATTEND.

Pregnancy and Birth Information Evening
Tuesday 14 May, 7.30pm, at Link House Te Aroha St.
Discussion Topic - Waterbirth. Contact Stephanie Law ph 855-3019

Home Birthers' Coffee Morning.
Monday 20 May, 10am, bring a plate and share morning tea at 40 Vardon Rd.
Bring your baby and toddlers. Welcome to all members.
Contact Brigid Devcich ph 849-9478 or Janet Young ph 854-7502.

Immunisation Awareness Support Group
Wednesday 12 June, 7.30pm at St Andrews Church Hall Lounge.
Guest speaker - Paul Hume, "Building your childrens' Immunity.
Gold coin donation. Contact Clare Shallcross ph 855-6997.
"For an Informed Choice" tapes -two copies are available to borrow from the WHBA Library.

Preparation for Birth Classes
Series begins **Tuesday 28 May,** 7.30 - 9.30pm for 5 weeks.
Contact Stephanie Law ph 855-3019.

Raglan Preparation for Birth Classes
Contact Adele Buckton ph 825 8942 for details.

Pregnancy Yoga and Relaxation Classes
Thursday evenings 5.15pm at Plunket Rooms, Richmond St.
Contact Paulette Whitford ph 856 0130

Cambridge Home Birth Support Group
Contact Angela Welton ph 827-3549 or Sandy Upton ph 827-8361

Te Awamutu Home Birth Support Group
Contact Helleni Quirke ph 07-870-2622, small library available.

recurring chest, arm, or leg pains.[4]

Of these assorted aches, only a small number have medical significance; far fewer are of a serious nature. Even so, these pains are as real and agonizing as those caused by tangible illness. *Discomforts that may be traced to the emotions and treated without medicine are no less genuinely distressing than the discomforts of physical disease.*

What Do These Pains Mean?

Bodily pains can reflect inner turmoil. Just as some people vent their frustrations through alcohol, violence, or angry outbursts, others take their feelings *into* their bodies. Stress resulting from the experience of overly high demands or expectations may come to expression in a tender and irritable belly. Analogously, intense anger and frustration, if held inside, can lead to torrid headaches.

The stress, anger, and frustration that upset children are often rooted in family conflict. Studies indicate that pains are more prevalent in children whose parents are depressed (the depression preceding the pains). Such pains are also common among children who are reluctant to separate from their parents—who are equally apprehensive about their offspring growing up and away from *them*. "Sickness" to these children becomes a way of staying home from school, reflecting their unconscious need to keep watch over parents who they worry might otherwise die, divorce, or perhaps harm each other. Relief from one girl's excruciating migraines came with her realization that the splitting headaches were related to her parents' vicious and endless bickering.

Some children embrace their pain for the rewards or privileges it brings. They use the pain to gain special treatment and attention, or to escape situations and responsibilities they dislike or find threatening. Although such youngsters may appear to be exploiting their distress for sneaky purposes, they may actually be motivated by wholehearted longings and anxieties. A child may find, for example, that when he is sick to his stomach, his parents care for him with affection that does not come his way in healthier moments.

What Can Be Done?

Until proven innocent, pains—especially those that are ongoing or severe—are worthy of medical attention and should be evaluated by a trusted physician. Avoid emergency rooms when possible. Instead, have your child seen by your regular physician, preferably during a pain attack.

If your child's good health is officially declared, hold on to that truth. Later, should your child begin writhing in pain, remind yourself of how robust and healthy she is most of the time—perhaps even minutes ago. Remember, too, how resilient she is, and how quickly she recovers from these episodes.

If reasonable medical inquiry has turned up no likely physical cause for the pain, focus your efforts elsewhere. Consider your child's emotional life: what is going on at school, in the family, in your child, in yourself? Many parents prefer medical explanations to anything even suggestive of emotional ones. Such parents may unknowingly encourage the pains rather than their child's direct expression of anger.

How to walk the parental tightrope of heeding the pains without making too much of them? Resist the temptation to take action. Instead of running to yet another doctor or doling out more aspirin, stop and listen to your child. Let him know you hear his pain, and his fear. Rather than offering quick assurances, let him know you understand his dread. Tell him, "I can see just *how* frightened you are."

The causes of growing pains are sometimes complex and well entrenched, and may require the help of a trained therapist. A play-and-talk therapist can help your child see the meanings these growing pains carry, and the attentions and protections they offer. A family therapist focuses more on the functions that these symptoms serve in the family system. A behavioral psychologist can offer techniques to help your child feel more in control of the pains and the situations that give rise to them. The most effective plan may be to integrate elements from each of these approaches.

Loving parents are naturally concerned about their children's health. When that concern flies in the face of medical findings, however, it may be time to look for other answers. Pain is a call for help. And children with growing pains are yowling for help in the challenging process called growing up.

Notes

1. Neil L. Schechter, "Recurrent Pains in Children," *Pediatric Clinics of North America* 31 (5 Oct 1984): 949–968.
2. Melvin D. Levine and Leonard A. Rappaport, "Recurrent Abdominal Pain in School Children," *Pediatric Clinics of North America* 31 (5 Oct 1984): 969–991.
3. Barry Zuckerman et al., "Stomachaches and Headaches in a Community Sample of Preschool Children," *Pediatrics* 79 (5 May 1987): 677–682.
4. Suzanne L. Bowyer and J. Roger Hollister, "Limb Pain in Childhood," *Pediatric Clinics of North America* 31 (5 Oct 1984): 1053–1082.

Richard Bromfield, PhD, a traditional play-and-talk therapist, is a psychologist on the faculty of Harvard Medical School. An earlier version of the opening of this article appeared in his book Playing for Real: A Child Therapist Explores the World of Play Therapy and the Inner Worlds of Children *(Plume/Penguin, 1993).*

Growing Pains

Of these assorted aches, only a small number have medical significance; far fewer are of a serious nature. Even so, these pains are as real and agonizing as those caused by tangible illness.

Richard Bromfield

Many children feel pains—in their stomachs, heads, and virtually all other body parts—without being sick. Sometimes these aches make physiological sense and mimic those of real disease; other times, they appear bizarre and anatomically illogical. Like the fickle shimmying and pings that bedevil our cars yet disappear when we pull into the service station, these symptoms often vanish the moment the child lies on the examining table.

The Diagnostic Plight

Children experiencing "pain attacks" frequently visit doctors, especially after hours. Yet, these frightening, expensive, and time-consuming emergency-room evaluations are seldom helpful. The physician, under great pressure to treat acutely ill patients, may not sense the emotional meaning of a child's pain. Even those who do are unlikely to intervene adequately; neither the rushed environment of the emergency room nor the brief relationship with the family invites such action. Moreover, families who prefer that all be left status quo until the next late-night visit may adjudge this to be just as well.

Physicians pressured by worried parents, fearful of malpractice suits, or skeptical of psychological explanations may refer the child to specialists or may conduct more tests, even when quite sure that nothing is wrong. This approach is apt to subject the child to inconvenient, uncomfortable, costly, and risky diagnostic procedures. What's more, these extensive workups often fail to set a child's mind at ease; in fact, they may endow the symptom with greater legitimacy and heighten the child's fears. "If it's really nothing, why do I have to keep seeing more doctors for more tests?" asked a boy plagued by migraines.

Despite clean bills of health, pains notoriously persist. Some children undergoing prolonged physical assessments become convinced that something malignant is going on inside them, something that even the high-tech machines cannot detect. And some parents begin to adopt their children's symptoms as *causes célèbres* to distract them from their own unsatisfying lives. The search for illness can immobilize families, causing them to put off important decisions and delay the search for nonmedical help until some physical source of the symptom is uncovered. Often it never is.

According to pediatricians, these growing pains are among the most frequently reported complaints.[1] Surveys conducted in the United States and other industrialized nations reveal that 10 to 15 percent of school-age children have stomachaches.[2] A whopping 37 to 75 percent have occasional headaches, and about 10 percent have chronic headaches, including migraines.[3] About 7 percent have

Morrinsville/Te Aroha Area Home Birth Support Group
Friday 31 May, 10am, bring a plate and share morning tea. Contact Dianne Simmons ph 07-884-9792 for details of address.
Meeting regularly on the last Friday of the month.

Te Ahuru Mowai o Waikato - Whakawhanau ki te kainga. The Sheltered Haven Homebirth for Maori Women. Contact Rangimarie Hohaia 07-871-5858.

WAIKATO HOME BIRTH ASSOCIATION LIBRARY

At present the library is being stored at Joanne Ridder's - **25 Roy Street, Nawton** please phone **847-4987.**

Selection of Titles available: Number.

Baby Massage	3	The Active Partner's book	8
Sensitive Midwifery	20	Home Birth	24
The Tenth Month	32	Birth Matters	37
Childbirth without Fear	46	Save the Midwife	48
Reclaiming Birth	54	Immunization	61
Pregnancy and Childbirth	67	Birth without violence	77
Baby and Child	82	Womanly Art of Breastfeeding	
Birth	86	Book of Massage	89
Making Birth Easier	106	Crying for Help	128
Breast is Best	132	The Billings Method	148
Coping with Morning Sickness		Guide to healthy Pregnancy etc	
Ultrahealth	204	Birth over 35	211
Vaccination	215	What can I eat	220
The Continuum Concept	227	Sleep book for tired parents	232

Dear Christine

I have really enjoyed reading the birth stories in your newsletter. Each one is different but they are all so positive. Here is the story of Rebecca's birth.

With our baby two weeks overdue it was a great relief when labour finally started. Our first baby had been born in a small maternity unit. It had been a normal straight forward delivery. This time I was keen to deliver at home and my husband Kevin was in agreement too. The more we had found out about homebirth the more it seemed right. I was impressed by how much the Home Birth Association promoted trusting a woman's body and not rushing in to interfere and start the "cascade of intervention".

Matthew, our son, was enjoying an overnight stay at his Nanna and Poppa's. Contractions started about 4pm on October 19. Kevin and I put on a video (a comedy "Dave") to help distract us from the contractions which were coming every few minutes and reasonably strong. Like my first labour the contractions were close together right from the start but built in intensity and length over time. We heated up a couple of wheat packs in the microwave and put one on my lower abdomen and one on my back. These were great. After an hour or so I decided that the baby was really going to come tonight and let the midwife, Annette know. Another half an hour went by with me puffing my way through contractions. The video was getting paused more and more often as I found I had to get up and pace about or lean over the kitchen bench. We decided to ask Annette to come. I had a heavy show about then too. Annette arrived. The contractions continued to get stronger. I found leaning forward over the back of a chair quite comfortable. It also helped to focus my vision on a distant object.

Before too long we decided to abandon the video, which wasn't quite finished and I got into a lovely deep bath. Kevin was holding my hand and rubbing my shoulders through the contractions which really helped. Also the verbal encouragement from him and Annette made a huge difference. The time seemed to pass quickly. We chatted between contractions, speculating on the sex and size of the baby.

It was now about 8pm and I could feel the baby moving lower and lower. The baby had been lying with her back towards my hip but by now had turned so her back was towards my tummy.

Janine, the second midwife, arrived and helped Kevin set up the lounge ready with the birthmat and cushions and so on. Once I got out of the bath I tried several positions before I got comfortable lying on my side on the floor with Kevin sitting above me on the sofa supporting my upper leg. I was grunting and groaning a lot. I appreciated the pauses between contractions. I let the contractions push the baby down slowly and allow everything time to stretch. Slowly the dark hair of our baby appeared. Then came the eyes, nose and mouth. Thank God, the head was out. Phew the shoulders were guided out next

milk the remedy is usually very simple. By watching the baby and not the clock it is possible to get baby and milk supply synchronised. Ban all supplements, dummies and anything that may be interfering with normal breastfeeding. Ensure correct positioning (check with La Leche League if you are unsure about this), and spend a few days feeding at least two hourly during the day and three to four hourly at night. This may seem next to impossible for a mother with other young children at home. However, it is important enough to arrange for the partner to be home to take over other duties, or to enlist the help of friends or family. This is often where the value of a support group such as La Leche League comes in. La Leche League not only provides correct information and telephone assistance, but also the companionship of mothers who have experienced the same, or similar problems. The supportive friendships are invaluable in times of need. Casual visitors should be discouraged or given chores during these first few days, just as in the days or weeks immediately after birth. Any reduction in housework for the mother is beneficial. The reluctant father may need to be reminded of how much money (and stress) breastfeeding saves, not just on the cost of formula but also because a healthier baby means fewer visits to the doctor.

Improvement should be seen within a few days of semi-constant breastfeeding; in a few cases it may be necessary to check for an underlying problem in the baby; e.g. an insufficient sucking mechanism may have a variety of causes. If a supplement is required this need not be given in a bottle. A lactation aid will ensure the baby also still gets the benefits of breastmilk (and will not create nipple confusion where a baby starts to prefer the easier bottle) and keeps lactation going so the baby may be able to return to sole breastfeeding when the problem stage is over.

A mother who has seen her way clear through any variety of breastfeeding difficulties - with the support of people who believe in her - will continue with her mothering with greater confidence and self-esteem, knowing she has persevered to do what is best for her baby. The effect of this on her entire attitude and success as a mother is immeasurable.

MADDY MAXWELL

REFERENCES:

The Problem of Not Enough Milk - Jack Newman, form LLL NZ

Publication Breastfeeding Communique Number 2 1990

Breastfeeding Matters - Maureen Minchin

The Womanly Art of Breastfeeding - LLL International

Tauranga La Leche League - Phone Chris Ryan 544-1814

HINTS FOR BREASTFEEDING

Rub on CALENDULA CREAM regularly to the breast before birth to allow the tissue and nipple to be firm, but stimulated for breastfeeding.

If the breastmilk does not 'drop' easily then an intake of iron is needed for the mother ... include NETTLE tea. daily, 1/4 tsp of Blackstrap Molasses daily in a warm drink until the milk is flowing well, then decrease the amount taken. A small glass of rich stout was given in the past which worked wonders (but mind the yeast and alcohol content).

When the breasts are sore a very warm Olive Oil pack applied will bring relief ... but if the breast is hot the Homoeopathic remedy is BELLADONNA, if engorged but not hot try PULSATILLA. This is easy to identify as the mother is usually a little weepy.

If the baby does not suckle well; then they have low levels of iron, which means that the mother must increase her levels for the baby to obtain more through the breastmilk.

When the milk supply appears to be drying up, or there is not enough to sustain the supply then take some more iron, especially in foods, such as fresh green vegetables, molasses and nettle tea and include the nursing herb, BLESSED THISTLE ... just x2 capsules daily after food.

To increase baby's immunity levels, increase the quality of the breastmilk and help to balance the hormones for the breastfeeding period in both mother and child, then take the Herb BLESSED THISTLE x2 capsules daily after food.

Dry nipples need an application of CALENDULA CREAM which will not upset the baby. Be aware of what goes on the nipple as this is absorbed by baby.

If milk release is painful and mum is still sore after birth then take the Homoeopathic remedy ARNICA 30c daily until better. This also helps with bruising.

Mothers who are breastfeeding must stay off acid foods such as oranges, grapes, citrus, red meats, preserved meats, anything with food colouring and sugar as this upsets the baby's digestive system and will give them wind. Alcohol makes the baby sleepy and unable to feed, too much lettuce and cabbage will cause wind too. Wholegrain rice, fresh vegetables, soups are a sound base for every meal to allow mum to feed the best quality milk for her child.

Healthy Options
Dec/Jan 1992

PARENTING SECTION

'Support for Breastfeeding Mothers'

Marianne Simmons

La Leche League International Inc.

Breastmilk - we all know it is the best start parents can give their children for a healthy life, but for some women the difficulties they experience, coupled with possible lack of support from family and friends or health professionals, makes the continuation of breastfeeding next to impossible.

The most distressing situation must be when a mother has great intentions to breastfeed but low (or no) weight gain of the baby makes changing to a formula seem the only solution. With adequate support and encouragement it is almost always impossible to build up the mothers milk supply.

By looking at the physiology of lactation we can see why many common practices interfere with the correct establishment of breastfeeding. When a baby suckles at the breast this stimulates prolactin to be released, which causes the production of milk. The more the baby suckles and empties the breast, the more prolactin will be produced and the more milk the baby will receive - simple supply and demand.

The let down reflex is stimulated by the baby's sucking and, once established, when the mother thinks of the baby or hears the baby cry. This produces oxytocin which causes the ejection of milk to where the baby can get it. This reflex can easily be inhibited by embarrassment, lack of confidence, pain or anxiety. Complete demand feeding is often essential to properly establish the milk supply and the notion of two to three hourly "demand" feeding may not be enough for many new babies. As babies are all individuals the amount of time spent at the breast during each feeding may also vary dramatically and if the baby is correctly positioned, nipple soreness should not be a problem. The use of any kind of supplement, or dummies, will always affect the establishment of a good milk supply to some degree just during the early days but also when growth spurts are experien

Conflicting advice from caregiver hospital may not only enhance th problems, but be detrimental to the confidence a mother has in her ov abilities, and inhibit the let down reflex.

Many babies do not conform to normal weight gain patterns and can be very worrying for a new mother. How can she and her hea professionals know if her baby is healthy? A normal healthy baby at least six wet nappies a day, is and active and looks healthy with good muscle tone. A baby that is failing to thrive looks thin, lethargy and often is sleepy. Urine output low, and if a slow gaining baby i sleeping through the night this is good sign.

When a baby is not getting enoug

and the body all in a rush. The feeling of joy and relief was overwhelming. A daughter! I wept as I held Rebecca for the first time. All 10lb 8oz of her.

I thoroughly enjoyed the first days of Rebecca's life. I loved not being separated from my son and husband, when we needed each other most. I felt very nurtured and supported. I felt proud too of delivering such a big beautiful baby the way it was meant to happen.

Jeni Palmer

BIRTH NOTICES

On	these parents:	had a:	named:	where:	Midwife / s
22/3/96	Suzanne & Dave Forsythe	daughter	Stella	Hamilton	Belinda/Jane
30/3/96	Nikki & Gary Pound	daughter	Morgan	Hamilton	Sally
6/4/96	Catherine & Doug Bridge	son	Francis	Hamilton	Adele/Jane
9/4/96	Corinne Beck & Gary Henderson	son	Tobias	Matamata	Jane/Maggie
28/4/96	Frances & David West	daughter	Hannah	Hamilton	Adele/Jane

Sheryl Nelson's Birth Story of Crystal Eleanor Nelson.

In March when I first found out I was expecting I didn't know what to do or who to talk to. Then a week later I got enough courage to tell my Mum, she wasn't happy at all as I was only 16 years old. But as we talked about me being a mother and what I had planned with my future, I decided to keep my baby that is a part of me. Mum and Dad said they would be there for me and support my decision.

As the weeks turned into months I could feel my baby moving, then I realised this wasn't a dream. When I met Adele Buckton I felt a lot better as she gave me all the advice I needed. We talked about home birthing because I don't like hospitals.

With lots of love and encouragement from Dad, my sister Tracey, Mum and also Adele I started to look forward to my baby's birth. Baby was due on November 5th, I was prepared to go over two weeks or more, from the due date.

I woke up on Sunday morning 5th Nov at 5.30am feeling little niggling pains. I woke up Tracey and Mum at 6.30am and then decided to rearrange the lounge to fit in the birthing pool. Mum rang Adele at 7.30am to let her know what was happening. At 10.30am we decided to go to church as I was still feeling O.K. 12.30pm I thought we had better go home as the pains were 5 minutes apart and I had a show. Mum and Tracey started to fill the birthing pool up and Dad and I talked while I walked around and sat and rested between contractions.

At 3.45 I felt the need to have Adele with me as the contractions were stronger, so Mum rang her. Adele arrived and checked me and I hopped into the birthing pool at 5.30pm. After I had got into the pool I felt such a relief from the pressure as I laid back and relaxed in the pool. After all the walking I had done my legs felt like they were going to fall off.

Dad, Tracey and Mum worked in rotation to be with me and support me. Adele was wonderful and really encouraging. At one stage Adele gave Mum a hug as Mum was tearful.

6.45pm I asked Adele for something for the pain, but I put in my birth plan that I wanted a drug free birth, so the family and Adele kept my mind off the pain. At that time Dad was being my leaning post, and I was beginning to rest between contractions, 1 every 2-3 minutes. The warm water helped me to relax and move freely. 7pm I had another show. 7.45pm my waters broke and contractions 1-2 every 11/2 minutes.

8pm I wanted Adele to see how long to go but in order to do that I'd need to hop out of the pool, so I just leaned on the side and breathed heavily through the contractions. I started getting tired and anxious, so I reached down to find the baby's head was nearly crowned.

8.16pm Adele asked Mum to hop in the pool as Adele didn't think she would be able to reach the baby. 8.18pm I gave birth in the pool. I lifted the little bundle out of the water and hugged my baby for the first time. Then Tracey and I discovered that my beautiful baby was a healthy girl. By this time we all had tears, tears of joy, while we looked upon my beautiful daughter.

My Crystal laid in my arms while her Granddad cut the cord. And then the second midwife, Cathy Knox came. Crystal weighed 7lb 11oz, and had plenty of hair. After Mum dressed her granddaughter I gave Crystal her first feed.

I was relieved and happy that I coped with this birth and all within 141/2 hours I know I have a daughter.

I would like to give a special Thanks to Adele Buckton for all that she has done.

Sheryl Nelson.

usually related to language. Since these midwives speak very little, if any, English, the woman must know Japanese or supply an interpreter."

The big, impersonal hospitals and clinics owned and run by one or two obstetricians (as opposed to those owned and run by midwives), continue to have the greatest pull.

"In Japan, as in America, the more technology you have, the higher your status is deemed," says Jacqui.

In some Japanese cities, the "ob/gyn clinics" – those run by a specialist and catering for up to 22 women at one time – take 50% or more of all women giving birth. However, unlike the hands-off approach of the midwife clinics, in these clinics intervention is often the norm.

Childbirth in Japan observes: "the tendency of the doctors, having a small staff, to induce labour ... Another possible disadvantage of these clinics is that the obstetrician may be extremely busy and overworked ... performing numerous tasks himself because of a lack of ... lab technicians, ultrasound technicians, anaesthetists etc ..."

And further: "With the decline in the birthrate in Japan (around 1.57 children per couple – the lowest birthrate in the world), the smaller maternity hospitals have to be competitive to survive, as do the ob/gyn clinics. If Japanese women continue to navigate to larger institutions, they may lose these other options completely by putting them out of business."

Despite the insecurity this must create for the Japanese midwives who work in clinics or less popular private hospitals, they do earn good salaries by New Zealand standards.

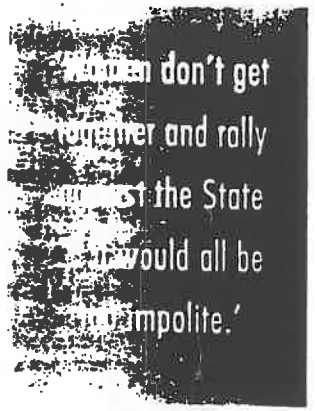
The head of one of the Japanese midwifery schools earns $200,000NZ a year. Other midwives could earn around 14 million yen or $140,000NZ.

However, money does not equate with status in Japan, Karen says.

"Japanese salaries are quite good compared to ours, but midwifery is not a high status position because it is seen as part of the women's sphere.

"Yes, their midwives are well educated – first as nurses, then as midwives – so they receive a good salary, but they have little social standing beyond their immediate work circles."

Karen's address at the Kobe mid-



wifery congress was enthusiastically received, particularly by the older Japanese midwives.

These women – now in their 70s, 80s and 90s – provided almost all the childbirth help at home or in small clinics until the 1950s. They were famed for their ability to "support the perineum" of the labouring woman through controlled breathing and for their constant support during the second stage, in order to avoid a fast delivery and tearing.

"They wanted to know how New Zealand midwives *got back* to where we are now – how we have weakened the blanket dependency on medical experts and technology in childbirth," Karen says. "We said we did it through consumer pressure groups. But in Japan there don't appear to be consumer pressure groups as we know them. Japanese women don't get together and rally against the State ... it would all be too impolite."

Breast massage is considered very important in Japan. Karen tells a story involving a Japanese journalist who interviewed her in Kobe.

The woman, who lived in Tokyo, asked Karen if she could borrow a New Zealand midwife's hotel room "because my room is too small for my breast massager".

After a few questions about this "massager", it turned out the woman had a baby, whom she breastfed when in Tokyo. Because she was away from home, she had to employ a woman whose sole task was to express the journalist's breastmilk every few hours, to maintain her supply. There's a technique called the Oketani Method, which is believed both to improve the quality and quantity of breastmilk and prevent or relieve breastfeeding problems.

"The massage starts during pregnancy and is performed vigorously after the birth by specially-trained midwives," says *Childbirth in Japan*.

"For it to have gained such popularity, there must be some benefits, and the massage is indeed helpful in correcting clogged ducts, relieving severe engorgement, and avoiding surgery for minor breast abscesses. However ... some people claim the massage to be painful ... Others are critical because the mothers are kept dependent on the midwives instead of being taught self-massage. Still others say routine massage is unnecessary altogether."

Breastfeeding on demand, the La Leche League philosophy well known to many New Zealand mothers, has yet to catch on in Japan. Soon after birth, babies are routinely separated from their mothers for 12-24 hours or longer, with little value placed on the early antibody-rich colostrum the mother produces.

Although nearly all babies are breastfed while they're in hospital, usually on a three- or four-hourly regime, many of these feedings are supplemented with glucose water or formula. Babies are routinely weighed before and after breastfeedings and "topped up" if the required amount hasn't been swallowed.

"Mothers interested in demand feeding or 'breastmilk only' often have a difficult time receiving permission to neglect the strict scheduling or refuse supplements," reports *Childbirth in Japan*.

What part do fathers play in all this? Apparently, very little.

Only a tiny proportion of Japanese husbands/fathers are present at the birth of their children – although because the younger generation of Japanese women are expecting more from their marriages than their mothers did, this trend may be changing slowly. N

Frances Adank is a freelance journalist who recently had her second daughter. She lives in Christchurch.