Report to the Mental Health Foundation on the Birth and Being Congress Melbourne, May, 1979. Ros Capper.

The principal speakers at the Congress were:

Dr.Graeme Farrant, Psychiatrist, now with a practice in Primal Therapy in Melbourne, Director, Australian Birth Foundation.
Sheila Kitzinger, Author and childbirth educator in the U.K.
Suzanne Arms, Author and film maker from U.S.A.
Dr.John Kennell, Professor of paediatrics at Case Western University school of medicine, Ohio, and researcher into maternal-infant bonding with Marshall Klaus, author.
Jacqui Showell, Physiotherapist at Adelaide Children's Hospital.
Jean Liedloff, Author from U.K.
Dr.Stan Reid, Medical Director, King Edward Memorial Hospital, Perth.

I tape recorded the lectures by Dr.Farrant, Sheila Kitzinger, Dr.Kennell, Jacquie Showell.
The inked numbers relate to my comments which I attach to these notes.

Sheila Kitzinger:

"One way of thinking about birth is as a medical crisis the pregnancy a sort of disease which has to be terminated by the midwife. The obstetrician actively manages the labour with all the sophisticated technology at his disposal: it can be ultrasound, continuous electronic monitoring, regional anaesthesia, oxytocin intravenous drip. The woman is wired up for all these machines and appliances, a passive patient acted upon by the doctor. The baby is the end product of it all - like any product leaving the factory.

"Rules and regulations about the correct rate of labour, the correct rate of dilatation, severe time restrictions on the time the woman is allowed to be in the second stage of labour together with this technology make intervention in the progress of labour commonplace nowadays so that it is really rather rare to find a woman who has been allowed to labour entirely at her own pace in her own way.

"Amniotomy is done very often on admission to hospital - as soon as a finger can be introduced into the cervix.The foetus is monitored continuously, very often there is a complete ban on food and often on fluids also during labour, just in case the woman may need a caesarean section. The woman is immobilized, very often lying down, unable to walk around or get into an upright position so that she uses

gravity to help the descent of the baby and to encourage more effective uterine contractions.

"These interventionist practices all contribute to what we can call the complete medicalization of childbirth - so that it is something doctors 'do' to women rather than something women do for themselves.

"Labour is accelerated or 'augmented' (and many obstetricians prefer that word but it means the same thing) so that it is completed for example within II hours, some obstetricians say IO hours and some say 8 hours from 2cm dilatation. There are some obstetricians who believe that in multigravidae labour should always be completed within 6 hours from 2cm. If it is not completed within that time it is first of all 'augmented' with a drip and the baby is delivered by forceps, or if dilatation is insufficient, by caesarean section. Episiotomy is another of the interventionist practices. In the United States the episiotomy rate is 98% and the other 2% are the ones delivered before the obststrician comes! Episiotomy is becoming more and more a routine part of childbirth, thus turning every delivery into a surgical operation.[2]

"In the practice of some obstetricians, lift out forceps is also routine and they consider that this is in no way not natural childbirth. They will often insist to patients that this is not intervention at all but this is just lifting the baby out to save the last contractions of the second stage and to reduce the trauma to both mother and baby.

"I think it seems reasonable to ask under these circumstances if many women can expect to be able to use the techniques they have learned at ant-natal classes and to have any sort of natural birth.

"Now the interventionist obstetricians' use of these new surgical and monitoring techniques often produces an iatrogenic effect which makes still more intervention necessary. It's a sort of spiral - you do one thing and because you have done that you have to do something else. For example: when the artificial rupture of the membranes is done in order to put a clip on the foetal skull, this may mean that oxytocin has to be used to 'augment' uterine contractions if dilatation does not seem to be proceeding fast enough. Otherwise we run the risk of lengthening labour and possible infection. Having given the woman the oxytocin drip to make the contractions stronger and more frequent, you then perhaps have to give her I50mls of pethidine to cope with the pain that results. The pethidine may mean that the contractions are not quite so effective, so you put the drip in faster, the pain gets worse so she then needs an epidural.

Then you observe that the foetal head is tending to rotate because the tone of the pelvic floor which encourages the baby to turn round into the correct position for delivery has gone completely with an epidural and it is just sagging there. Then, ofcourse, you may have a prolonged second stage, late deceleration of the foetal heart and forceps delivery.

"Obstetricians are often very unwilling to acknowledge the relationship between the different techniques they are doing. There are very careful studies of the effect of one technique on another but often it is because they can't see the wood for the trees and stand back far enough from the labour to see the interaction of all these different kinds of interventionist techniques. At the same time, the environment in which birth takes place can actually be threatening for the woman, and because it is threatening it may inhibit psycho/physical coordination and even uterine action.

".....it was clear that the way a woman was treated in labour, whether she felt she was a person or just a body on the table, affected the way she reacted to her baby and also that some mothers, the most vulnerable ones, seemed exposed to special risks from this kind of childbirth - special emotional risks - and they didn't feel that their babies belonged to them. They often felt that the babies were simply hospital property."[3]

Following on from that part of her lecture I recorded are these notes:

Sheila stated that how society patterns coming into life and leaving it tells us a lot about institutionalizing and depersonalizing, and less about relationships than techniques.

There is no 'natural' childbirth - birth has always been patterned by culture.

with regard to home birth, Sheila thought that midwifery consultants from overseas who are experienced in home births would need to come and train those interested in learning home birth midwifery. This is because the midwifery training is based only in hospitals or polytechnics and hospital in New Zealand. She added that good ante natal care is the cornerstone of home births.

Sheila uses a tape recording of a crying baby in her ante natal classes. She plays it for 2 minutes then asks the women in the class what they would do. She then plays it again and asks what they would do now. Thus child care is introduced in a realistic manner.

With regard to labour, Sheila had this to say:
Most women experience pain from 5cm to full dilatation. Then comes the transition stage when she would stop bearing down. Many hospital staff members act as a gang of cheer leaders and THEY are doing the bearing down! 'Push' is the wrong word as is the oft heard sentence ' hold on to your breath, don't let it go....' as there is then not enough oxygen for the baby causing hypoxis and acidosis, reducing the arterial pressure and placental oxygen. It is superimposing rhythms on the woman that would come naturally. The work of Dr.Roberto Caldeyro-Barcia President of the International Federation of Gynaecologists and Obstetricians and Director of the Latin American Centre for Perinatology was quoted by Sheila with regard to the lack of oxygen due to these pushing instructions. She also mentioned Dr.Barcia's research in the area of induced labour where he states that if the membranes are ruptured too early, the protective amniotic fluid can no longer cushion the infant's head from powerful contractions which press the wall of the uterine canal against the foetal skull. Tracings from foetal heart monitors have shown that as each contraction increases this pressure a marked decrease in blood (and therefore oxygen) to the baby occurs in early membrane ruptures. This is rarely seen in babies where the mother's membranes are still intact.

In his report, Dr.Barcia added that in X-Rays from his recent studies he noted that there was a disalignment of the parietal bones of the infant's skull occurring with twice the frequency in infant of induced labour than with those not induced. Where oxytocin is used as well, contractions are so intensified that this may also cause a disalignment of the parietal bones. Dr.Barcia has found that despite correct dosage of oxytocin and proper monitoring of mothers, almost 75% of uterine contractions were shown to result in a reduction of oxygen to the foetus' brain . This disalignment is quite different from the natural 'moulding' that occurs in normal birth, and it may cause brain damage and possible brain haemorrhage.

Sheila Kitzinger thought that 'open' is a more appropriate word than 'push', and that waves of satisfaction and release would result. She demonstrated by asking whole Congress to join her in 'bearing down' that pushing results in a clamped mouth and jaw - whereas an open mouth will give the desired result of an open vagina. Ideally, the mother would feel the 'otherness' of the baby's head as it crowns, life it out and place it over her thigh. She may hold the cord to see that the baby will be a separate being. She would wait for the baby to

look for the breast before it suckles and the cord would be cut when the mother feels ready for it to be cut.

Following birth the mother may need to piece the birth together - especially if she received drugs during labour. It is necessary for someone to be there to help her come to terms with what happened and if necessary to receive the validity of her feelings that she failed,4 rather than glossing over her feelings. With regard to maternal/infant bonding Sheila talked of the hospitals who now say 'we permit bonding' or 'we allow time for bonding' thus demonstrating their lack of knowledge about bonding altogether.

Suzanne Arms:

Suzanne wrote the book 'The Immaculate Deception' published in 1975 in which she documents the myths and realities of childbirth in the United States. She showed us her film 'Five Women, Five Births' which shows the different birth choices made by 5 families and includes their discussions about the choice chosen. It includes a caesarean birth which demonstrates how that baby could receive immediate skin contact by being given straight to the father in the operating theatre - the mother had received a general anaesthetic.5

Some of the points Suzanne made in her lecture were: The trend is for people to go to the services instead of services for the people with regard to birth.6

She talked of the whole political scene around foetal monitoring in the United States ; of how these machines have been donated to hospitals to be tested, Professorial Chairs being financed by the manufacturer concerned, then a Seminar is set up to publicize how effective the machines are. No effort is made to compare their effectiveness with other ways of foetal monitoring e.g. auscultation.7 She is very concerned at the exporting of these machines to other countries similarly bedazzled by technology. She talked of the 'A Bomb approach' to birth - the high technology approach - in a similar way to Sheila Kitzinger's comments on the 'spiral'.

Suzanne also mentioned the non manipulative ways of getting labour started and keeping it going. Many participants said they had tried these ways and they work. These way include nipple stimulation by the partner, and a photo of a baby about to breast feed.

Dr.Sten Read:

Sten showed slides of the hospital where he is Medical Director in Perth. He has planned for an in-hospital Birth Centre there to be in use later this year. He has used a lot of ideas from the Mount Zion Centre in the United States. There will be 2 motel-type units with a double bed, stereo, lounge, kitchenette, toilet, shower. Visitors and staff must be invited in by the family. Oxygen and other emergency equipment is all hidden away in the birth room and there is a fully equipped obstetric room 50 feet away. The service will be for low risk mothers as defined by the criteria set down by the medical staff. There is a domiciliary service for follow up care as each family only stays for 24 hours. 8

Dr.John Kennell:

Dr.Kennell and Dr.Marshall Klaus wrote the book 'Maternal-Infant Bonding' and his lecture was based on further research on this important subject. He made the point that women who have lived for I60 hours approximately behave in a certain way with their baby for a few hours and this can affect months or years of the mother/child relationship. His studies show that WHATEVER is done in the immediate period following birth makes an important difference to mothering.

Dr. Kennell described a recent study which was set up by S.O'Connor a paediatrician in Nashville in order to see if there was a discernible connection between the amount of contact a mother had with her baby and subsequent mothering. The normal routine in the hospital used for the study was to show the baby to the mother and then it would be placed in the newborn nursery for I2 hours. Dr.O'Connor arranged that I58 mothers would continue to have normal hospital routine but that I43 mothers who were chosen for a control group would have I2 hours of extra contact with their baby from birth. Subsequently 9 mothers in the first group displayed either obvious abuse of their child or the child failed to thrive, whereas this was the case with only one mother/baby in the second group. Dr.Kennell cited other similar studies in other countries where the result was similar.

Dr. Kennell described the fat/protein ratios in the milk of different animals to demonstrate that this ratio in human breast milk is significantly lower than all of them. It therefore follows that a baby should be almost a continual feeder for the early weeks of life. Dr. Kennell thinks that babies need almost constant carrying also.

Jacqui Showell:

Talked of her work with babies with neurodevelopmental problems. She thinks that hospitals need someone with a 'license to touch' as both mothers and babies may need gentle massage to relieve tension which has its basis in the birth they have just experienced. Jacquie will often massage the mother to relieve her tension enough for the mother to then handle her baby in a relaxed manner. Tension may be transferred otherwise. She talked of a baby's environmental needs following birth. They are:
Movement - in a front sling or cradle.
skin stimulation - massage, cuddling, breast feeding.
familiar sounds - next to the mother's heart and hearing her speak.
feeding - on a more or less continuous basis.
Dim light.
Flexed position - never a straight spine after 9 months flexed in the uterus.
Jacquie talked of babies with the common problem of 'colic' in the first months, and she hypothesized that their pain threshold is lower causing wind or urinating to be interpreted as pain. She prefers to call them 'sensitive' babies rather than the more common terms of 'naughty', 'wilful' or 'demanding'.

Jacquie showed a film in which she took a baby on her knee, talking softly to it, keeping the spine flexed towards her and stroking its back, stomach, face, chest. She encourages mothers to do this often, and never to hold it out into space as it is picked up but always to hold it next to the body. She will encourage the carrying of the baby in a front sling wherever possible.

Jean Liedloff:

Jean wrote of her experience over a number of years livi with the Yequana Indians in South America in her book 'The Continuum Concept'. She observed the simple ways of child rearing and believes that if a baby is fed and carried on a more or less continuous basis over the first year (not always by the same person), that the infant would be much more independent than is normal in our society thereafter. She advocates young children sleeping with their parents if they wish to and spoke of parents in the U.K. experimenting with these 'continuum' ideas and finding them very satisfactory.

Jean stated that our impulses are accurate in ways that we do not understand but that we can and often are trained out of them. She thought that we should make our intellect a competent servant and not an incompetent master which she thought has happened around birth and child rearing.

Jean believes most strongly that there should be no such job as child rearing per se but that work places should be suitable for children to also be there as their parent works. She considers the more traditional way of rearing children in an isolated suburban house most unsatisfactory for both the mother and the children but does not think the parents and children should be separated as for example with day care centres.

Dr.Graeme Farrant:

The question was posed 'Can babies feel?' Dr. Farrant works with adults in Melbourne , facilitating their re-experiencing of their birth. It is through this work that he has become aware that a baby feels and 'remembers' its birth and handling following birth. He quoted Freud's statement 80 years ago that 'the act of birth is the first experience of fear and is the source and prototype of all future fear reactions'. Dr. Farrant said that a baby does have feelings, it can hurt and it does feel pain; that pain may accumulate, 'short circuit' if excessive and it may reverberate all through life unawarely. Unless a free flowing connection is made between thoughts and feelings it will never be resolved. He added that a neonate needs this free flowing between thoughts and feelings to maximize its adaptation to extra-uterine life and enable it to acquire the knowledge and mastery of its new environment that is necessary in order for it to survive, to develop and to mature.

In 1971 the International Study Group for Pre-Natal . Psychology was founded by Dr.Frederic Kruse, a psychotherapist from West Germany. At an annual meeting in 1978 Dr.Farrant said that 180 delegates from around the world reported on thousands of case histories of people working through their birth memories. Dr.Kruse alone had 2000 such reports from his 30 years of work.

Dr.Farrant thought that in a field of which so little is known even inconclusive studies can establish a degree of probability and can suggest what to allow for when planning future research. In what way an adult re-birth is connected to their actual physical .

birth is almost entirely unknown but connected it does seem to be. Dr.Farrant finished his lecture by stating his belief that preventive psychiatry entails at least a planned conception where the baby is mutually wanted, responsible ante natal care, a spontaneous gentle birth followed by bonding to the parents and breast feeding for as long as the child may want it . Continuous care in infancy and later self regulation will lead to adult integrity and self respect. 'I say to you, your baby has feelings'.

Dr.Michael Epstein:

During Dr.Farrant's lecture time Dr.Epstein, a child psychiatrist working in Melbourne, showed a film he had just made entitled 'Lisa'. This remarkable film followed Dr.Epstein's work with Lisa over a period of 6 months. Lisa's mother had experienced great difficulty in getting help for Lisa who had been labelled autistic because of her behaviour.

Lisa's birth had been induced and was followed by a 30 hour labour. Lisa was kept in the arched position during labour presenting face upwards. After birth she was kept for 'cot treatment' and was not seen by her mother for a considerable length of time.

Lisa arched her back away from her parents from birth, making close cuddling impossible. She had frequent 'tantrums' and did not feed well. She only made occasional sounds by 6 months of age and at 4 years old was still not even 'babbling'. Her mother stated in the film that there was no comparison between Lisa and her siblings.

At 4 years old Lisa was having frequent 'tantrums', was still back arching, did not feed herself and was not talking. Dr. Epstein was familiar with Dr.Farrant's work and he diagnosed Lisa as suffering from birth trauma. He treated Lisa with a lot of patience and time, giving her the opportunity to experience an unobstructed birth as often as she wanted. In the film I saw Lisa's presenting back arching behaviour, and Dr.Epstein facilitating this by holding out an arm as she arched over going slowly head first onto a mattress. She occasionally screamed in a very high pitched tone as she did this.

Dr.Epstein thought that Lisa had been attempting to do this since her birth, such had been the trauma of her experience. Lisa continued this experience for 6 months and the film showed her allowing herself to be massaged and then she would curl up between Dr. Epstein's legs as he sat on the floor with her.

At the end of 6 months, Lisa's mother reported that Lisa was not back arching now, had only the occasional tantrum, fed herself and was now talking - which I saw in the film.

Dr.Epstein believed that babies suffering from birth traum require frequent massage, frequent warm baths and constant movement, all of which are usually denied traumatized babies above all other babies. He believed that a traumatic birth may be a prelude to a traumatic life.

Books referred to:

Sheila Kitzinger:	" The Experience of Childbirth" Published	I962
	"Giving birth" the parents emotions in childbirth	I97I
	"A Place of Birth"	I977
	"Education and counselling for Childbirth"	I977
	"Women and Mothers"	I978
Jean Liedloff	"The Continuum Concept"	I976
Suzanne Arms	"Immaculate Deception"	I975

Film:

Suzanne Arms "Five Women Five Births"
(Suzanne Arms Productions, I5I Lytton Avenue,Palo Alto, California 9430I)

Ros Capper
2a Raroa Crescent,
Kelburn,
Wellington
August I979

My Comments on the lectures given at the Birth And Being Congress:

I. At St.Helen's Hospital, Wellington, 100% of women are now electronicall monitored either externally or internally via an electrode clipped to the foetal skull.
2. The episiotomy rate at St.Helen's Hospital, Wellington is approximatel 95% of all vaginal deliveries.
3. I believe that the seeds of the more severe type of post natal depress ion are sown in this statement. I think that the amount of control a woman and her partner have over their birth ritual is very important t subsequent post natal feelings and behaviour.
4. In this respect most mothers are encouraged to sleep without their newborn infant near when this may not be a high priority in terms of their need to work out what happened and to be listened to. This may b especially important if there was a late decision to do a caesarean section, an epidural anaesthetic or a forceps delivery.
5. Only one copy of this excellent film has been purchased by the National Film Library.
6. This is becoming a national trend in New Zealand with the centralizing of maternity services on a large scale. As a result, in rural areas the women are put at risk of having their baby in a car. This is hardl more safe than in a small maternity hospital. There is also a greater chance of a woman having a birth which involves the use of high technology.
7. Dr.A.D.Haverkamp and assoc iates compared the effectivenes of foetal heart monitoring by machine vs ascultation of foetal heart tones in changing perinatal morbidity and mortality rates and neonatal outcome in a randomized series of high risk patients. There was no difference in infant outcome in any measured capacity between the electronically monitored group and ascultated group. There was one striking difference - the increase in caesarean sections for the EFM group (16.5% EFM V 6.8% ascultated) performed for foetal distress provides evidence that the EFM is associated with an increased section rate without apparent improvement in infant outcome.The interpretation of foetal heart patter is not an exact science and yet obstetricians are encouraging their use (See Women and Health Journal Sept. 1977, Vol2/No2)
8. This is similar to the out-of-hospital Birth Centre we hope to establis in Wellington next year.
9. I have observed that for a mother to walk out of her room in a matern- ity hospital she must first of all place her baby in its crib. Carrying

one's baby is not allowed outside the room. On the contrary, it would seem to be important to encourage the carrying of infants, and one way of doing this would be to give each new mother a front sling. She would be given full instructions as to its use with the baby curled up inside rather than straight up and down. When the mother leaves, the sling would be autoclaved for the next baby.