

Understanding the Consequences of Caesarean Birth

by

Graham Kennedy RCST

The purpose of this article is to inform both parents and professionals of the effects that caesarean sections (C-sections) have upon babies, and how these effects can last into adulthood unless some form of therapeutic intervention is made.

C-section rates have risen dramatically over the last 30 years. In the 1970's, the rate was 4.3% in the UK and 5.5% in the US. Today, the rate in the UK has risen from 15-25% depending of location. In the US, the rate varies anywhere from 20-50%. In some parts of Central and South America and south-east Asia, C-section rates can be as high as 90%, largely because these areas have imported our western medical model of birth.

Whilst it is true that there are a number of conditions for which C-sections are absolutely necessary, it is estimated that over half the sections performed in this country are completely unnecessary. The current trend towards this type of birth reflects a number of different attitudes within society:

- There is now a considerable fear of litigation within the medical community as a whole. Obstetricians feel that C-sections are the safer option for both mother and baby, thus reducing any potential legal challenge.
- Poor preparation of the parents towards the birth experience – many parents, particularly those who are pregnant for the first-time, are relatively uninformed of the birth process and its different facets. They may have heard from friends about particular experiences that were difficult or distressing. They may also have heard how C-section babies tend to be quieter and “better babies” than many of those born vaginally. There may also be some strong anxiety and fear about the whole process. In this environment, opting for a C-section may seem to be the best option for all concerned.
- Attitudes and beliefs about women and birth – in our society, the birth process is largely medicalised and labouring women are often perceived to be patients that need to be managed. There is little awareness, or trust, of a woman's instinctual processes or the naturalness of birth. In this context, the C-section becomes the pinnacle of the managed labour.

The increased use of C-sections today also comes about as the end result of a cascade effect of a number of different interventions. There are two types of caesarean section – **elective** and **emergency**. An elective

section is one in which the decision to deliver the baby surgically has been made during the pregnancy and before the onset of labour. An emergency section is performed due to specific conditions developing during the labour.

Elective Caesareans - there are two types of elective C-section. Those in which labour has started and those in which labour has not started. Today, many elective sections are performed up to 2 weeks before the due date if there are any complications with the pregnancy. It is now also recognised that there is a better outcome for the baby if it is allowed to experience some labour contractions prior to the caesarean than if it has experienced no contractions. The process of labour adds the final touch to the maturation of the baby's lungs and also creates the compression/expansion cycle, which is a necessary pre-requisite for the lungs to clear the fluid within them and to help stimulate the first breath of the baby. Consequently, babies born from non-labour elective C-sections often have greater respiratory problems than those born from other types of C-section.

In my experience, babies born from elective sections have a significant amount of shock imprinted as a result of this process. The following analogy may help to explain this. Imagine sitting in your front room, feeling safe and secure, knowing that you have to go out later in the day but for now you can just rest. Suddenly someone breaks down the wall of your house and drags you out through it. Do you think this might be a stressful event for you? Do you think that you might also have some strong emotions about what happened to you? The same is true for babies.

Many elective section babies are not yet ready or prepared to leave the womb. As a result, most freeze and withdraw into themselves. This freeze/withdrawal overlies all the strong emotions and stress responses imprinted at the birth. It is for this reason that these babies tend to be quite calm, placid and generally very easy. Most parents and professionals are unable to differentiate this placidity from a normal healthy state. During therapy when we start to remove this outer layer of freezing the deeper stress responses and emotions tend to come to the surface. This can be of major concern to parents who suddenly find their calm, quiet baby has started screaming with rage and may be inconsolable for periods of time. It is important to reassure them that this is only a temporary process as the deeper traumatic forces and stress responses work their way out.

Emergency Caesareans - with an emergency C-section, labour starts normally but some problem arises during labour that cannot be resolved by any other means. The result of this is that emergency sections tend to be more stressful with a greater degree of anxiety than in elective sections. This results in more stress hormones flooding both mother and baby, setting up a cascade effect of potential physiological problems. Babies born by emergency sections generally have a higher amount of imprinted stress and trauma to both mother and baby than elective sections.

The procedure

A caesarean section is a major abdominal surgical procedure in which the mother usually remains conscious. She usually receives anaesthesia by means of a spinal block, although in emergencies a general anaesthetic can

be used. A transverse, or bikini-line, incision is the most common type used. Today, the incision made is quite small so that there is a degree of compression of the baby as it is removed from the baby. This type of delivery provides for better outcomes for both mother and baby.

Following the birth, the baby is shown to the mother and then quickly removed for an obstetrical check-up. The baby also needs to be separated from its mother for up to 1 ½ hours while she is undergoing post-operative care. For much of this time, the baby may be with its father or placed in an incubator. This reduces the ability for the baby to bond with its mother. However, it is often the case, where the father has been caretaking the baby during this time that he develops a very strong bond with the child.

Women who have had C-sections are often surprised at how long it takes for full recuperation to take place. This can be in the order of 2-3 months. In this time, the woman needs to be very careful with her level of activity, in particular lifting. This means that she may not be able to do as much for her new baby in its first few months of life that she would like. This can be a source of guilt and frustration and can lead to some women over-compensating afterwards.

The following is a list of conditions in which C-section is deemed necessary:

- Placenta praevia
- True cephalopelvic disproportion
- Transverse lie
- Fulminating pre-eclampsia (eclampsia)
- Cord prolapse
- Multiple pregnancy with three or more foetuses

However, C-sections are performed on a regular basis for such conditions as failure to progress, foetal distress, maternal exhaustion, breech presentation and a history of previous C-sections. Many of these conditions are, on their own, poor indicators for C-section.

Clinical considerations of Caesarean births

It is now recognised in the medical profession that there is a degree of stress involved for the baby during its birth process. A recent study published in the Lancet (January 2000) involved studying three categories of birth – normal vaginal, assisted vaginal (forceps and ventouse) and C-sections. This study showed that babies born by assisted delivery had the highest stress response (as measured by cortisol levels), whilst those born by C-section had the lowest stress response.

The results of this study made some health professionals further extol the merits of C-sections, feeling validated that a stress-free arrival into the world is the best option. However, others point out that the liberation of stress-hormones during the birth helps to facilitate the absorption of fluid from the lungs and aids the baby in

taking its first breath. There are also many medical conditions, including chronic fatigue, which are characterised by low levels of stress hormones.

Even many parents, aware of the potential effects that a vaginal birth can have on the moulding of the baby's cranium, believe that C-sections are preferable because they do not produce any moulding. This is untrue. Cranial moulding does not begin at birth, but shifts and changes with the different experiences the growing baby has in utero. The compressive nature of the birth process may then more deeply entrench these already existing patterns into the baby's soma. A significant number of babies born by C-section get their heads stuck under their mother's ribcage, usually in a breech position. This can produce quite pronounced moulding patterns. Also, many C-sections take place after labour has begun and the baby's head has gone part way through mum's pelvis, so there may already be existing Stage 1a and 1b compression patterns present.

A baby born by caesarean section will encounter many different elements that can interrupt its natural birthing and bonding impulse. These include:

- Anaesthesia use
- Surgical opening of the uterus
- Dislodging the baby from the pelvis
- Speed of delivery
- Early cutting of the cord
- Separation from mother
- Psycho-emotional factors

Anaesthesia use

It is important to recognise that the amount of anaesthesia required to provide effective pain relief for a fully-grown woman can have a powerful effect on her baby. The use of epidural anaesthesia has been shown to have a number of different effects on babies. These can include such problems as difficulties with bonding, sleepiness, low energy states and general lack of motivation.

Surgical opening of the uterus

The surgical opening of the uterus creates a strong pressure differential between the contained fluidic world of the baby and the outside world. This pressure change can be an enormous shock to the baby, who strongly withdraws deep inside in an act of self-survival. This sense of withdrawal is palpable in many of those born by C-section. There is often very little motility present with an over-riding sense of shutdown through the system. If left untreated, this can have major repercussions throughout a person's life.

Dislodging the baby from the pelvis

When babies have their heads engaged, it forms a vacuum in which the head is strongly held in the pelvis. Dislodging the head from the pelvis often requires some considerable force, sometimes even involving the use

of forceps. Many mother's are often aware of their lower body being rocked from side to side at this stage of the process. This can be very shocking to the baby and can create strong compressive forces in the baby's head, neck and shoulders.

Speed of delivery

In a normal vaginal birth, the optimal duration of second stage labour is usually considered to be from one to two hours. This process allows the baby time to complete the transition from womb to outside world at a gradual pace. In C-sections, the time from the first incision to the extraction of the baby and cutting of its cord often takes around five minutes. The effects of this on the baby are significant. The baby is completely unable to integrate this speed of transition, creating issues with general pacing and timing. Many C-section children compensate for this by having strongly resisting anyone trying to get them to do anything, particularly if it involves hurrying up.

Early cutting of the cord

In ideal circumstances, the cord would be left uncut until it has stopped pulsing. This allows any blood that is still in the placenta to be transfused back into the baby and gives the baby further time to adjust to its new life. The cutting of the cord also represents more than a physical separation, it is also a psychological separation from mother. Early cutting can therefore create significant shock in the abdominal area and can be a contributing factor to digestive complaints, such as colic.

Separation from mother

Following birth, the next important stage for the baby is to bond with its mother. In the 1970's, it was found that there is a sensitive period after birth that lasts for 30-60 minutes during which the potential for mother-infant bonding is at its optimum. Any separation from mother (particularly for prolonged periods), creates a potential interruption in bonding, which can have effects on relational/social interactions later in life.

Psychological effects

The impacts of birth trauma are not just physical, but also impact us psychologically as well. The following list shows some of the more common psychological effects that can result from C-sections:

- Mind/body splits
- Bonding deficiencies
- Invasion issues
- Tactile defensiveness
- Difficulties with pacing and tempo
- Bonding disturbances
- Control issues
- Directional confusion
- Difficulty starting and/or completing things

Summary

The use of caesarean sections has increased quite dramatically over recent years. Whilst a C-section can be a life-saving intervention in certain circumstances, their use has become routine and commonplace. There is very little awareness of the long-term effects that C-sections have upon the physical, neurological and emotional development of babies. In order to move to a position where we can begin to fully acknowledge and support the needs not only of the labouring woman, but of her baby as well, we need to understand the impact that birth and its associated interventions have on us. I hope this short article goes a little way to redressing this balance.