Some Considerations Concerning a Birth Process

On 26 January, 2021, a 40 year old woman pregnant with her first child (after trying for 15 years and then adopting 3 children) came to me for a treatment at the recommendation of her Midwife.

She was 3 weeks away from her due date for delivery. Her history was unremarkable except for a sledding accident at age 20 where she had a traumatic event/hard blow to her coccyx/sacral area after which she could not get out of bed for a week. Since that time of the sledding accident she has had some pain in sitting.

The Midwife had specifically sent the client to me to see if I could do something which would facilitate the baby to "drop down" in positioning. In addition the Midwife noted that her cervix was not dilated (no pressure as baby did not descend into the birth canal) in spite of the fact that the baby could have been safely delivered at any time due to its full development and full size as noted on ultrasound and other diagnostic testing instruments.

The mother had been placed on "standby" for a "C-Section" delivery due to the nature of the position of the baby at this time.

When the client, prospective mother, came to me at 3 weeks prior to her due date, she presented with shortness of breath with a very large baby pressing very high up under her respiratory diaphragm positioned with the baby parallel to the respiratory diaphragm lying on it and pressing on it both with the client in verticality and also horizontally lying on the mattress table.

In this session, I worked to give length having to work through the back of the spine and the surrounding fascia in a way to also lengthen the front of the spine and surrounding fascia with her lying supine on the table while also taking into consideration the pelvic tilt. I also worked with her lying on each side with the idea to give space for the respiratory excursion. I then worked on bringing the pelvis around with her sitting on my hands right under her sitting bones easing them out while putting the top of my head softly into the thoracic spinal area asking her to let her belly go thus encouraging ACMOT.

I stood her up – the breathing was better and it appeared that the baby had "dropped". I then did some work with her on Normal Function starting with hanging on the wall. As I did a bit more with Normal Function with the client, I could give some time to assess if the work I had done on the table had allowed for the baby to go into a vertical position in relation to the respiratory diaphragm and then to subsequently "drop down".

Much to my amazement, the baby did drop down 50% by visual estimate. Breathing continued to be easy with full excursion. The Midwife saw her that next day happily confirming the aforementioned results.

Two (2) weeks later, the Midwife called me to say that the baby had migrated back upwards to a once again horizontal positioning pressing into the respiratory diaphragm. She wanted to know if I could do another session in 5 days which would be the day before the actual due date for delivery of the baby. I agreed to do so.

I then contacted Dr. Hans Flury, Medical Doctor, to review the situation, the work that I had already done and also to think of what would be the best strategy for helping this woman deliver with ease naturally without surgical intervention.

Here is the essence of what Hans stated:

Hans reflected: The body of a 40 year old pregnant woman is not as resilient as one who is 20 so this can be tricky and a disadvantage for the client. Hans expressed his sympathy of the woman having to suffer nature putting this woman through such an ordeal at this age with less resilience of the tissue to accommodate the baby. Hans further reflected that the cervix is low and very short and not the problem. Hans stated that it was probably more the entrance from the abdominal cavity into the pelvic cavity being not wide enough. Hans proposed that it is the promontorium, that is L5/S1, which is too deep, i.e. too much ventral into the body.

At this point Hans recalled a story where Dr. Ida Rolf asked John Lodge to draw a "perfect spine" in her book, and he drew the sacrum as steep as it never exists! Hans then stated that he remembered from x-rays long ago that the sacrum is very often much closer to horizontal, with S1 reaching far forward!! Hans further noted that with a marked posterior pelvic tilt which this client did have that the

sacrum is often closer to horizontal. Thus it was well noted that the inside is not what the outside appearance suggests.

So it was here that I reflected back to the history of the client, i.e. her sledding accident with subsequent trauma and sequelae to the sacrum/coccyx.

Hans covered important general aspects prior to making specific suggestions for this 2nd session the day prior to delivery date of the pregnant client's baby.

When the client is lying supine on the table, it makes a great difference whether the arms are lying down or up. The upper arm straight out, the lower arm up. With the arms down, the "blocks" are lying beside each other with practically no connection. With one arm up, it is different on this side. There is Passive Tension in the Elastic Sack in front via tendons and fascia of pectoralis major and minor. The upper 5 ribs are pulled up in front and detach slightly from each other. This tension continues a little into the ribcage and the abdominal wall. Hans suggested to test the two sides for the difference with one arm up, the other down. For determining this difference Hans stated that he takes the outside of the hand, probing the left and the right side of the abdominal wall.

On the backside, the tension comes via trapezius and especially the fascia of latissimus dorsi down to the iliac crests and the sacrum. Usually, with both arms up, one can sense this tension in the body stocking, and one can also get a sense of the legs pulling a little in the other direction, caudally. Hans stated that he often needed that when working on the trunk

Breathing from the point of view of Structural Integration with inhalation, the question is how can the volume of the body increase by perhaps 0.5 to 1 liter and where does the mass of the body go? Here is Hans' answer. For a perfectly normal structure in perfect stance, the answer is: the trunk should widen equally left and right, front and back lengthening a little. (We Rolfers love length!) Front/back is a problem, because the front widens much more easily than the back, which disturbs perfect balance, which must be restored again in exhalation, which requires energy along the way. Hans noted that with the client supine on the table, the front/back problem is aggravated. The reason is, that the body automatically expands (breathes) where it is free. (Look for the breath – where does it go in the body?) When a client is observed and one sees that nothing happens in the back wall; the abdomen and the chest go up and lengthen a little.

Hans suggested having the client imagine the trunk as hollow, an Elastic Sack. The client liked this imagery and told me that she also imagined the baby in her arms with this hollow trunk imagery. Hans further stated that after the exhale to wait 2-3 seconds after which I would sense an increasing urge to inhale. Hans wrote to imagine that you don't do it but to let the air flow in through the nose and mouth and then downwards on the front side of the back wall. There is a short stop at the pelvis, i.e. iliac crests and L5/S1, then it flows over it to the back of the pelvic basin and out through the pelvic floor. Further Hans stated that this works clearly only if there is a correspondence in physical reality which is that all the muscles in the back reduce active tension. It was at this point that I told the client that the mattress upon which she was lying was actively holding the weight of her body and into which she could relax. Indeed, her back wall was then lengthened, widened and flattened a little passively by gravity. The volume of air slightly increased with the lowered pressure in the thorax sucking in the air. What Hans found interesting and I did also is that the diaphragm does not "act" then but serves to keep the content of the abdomen, which is under higher pressure, down, i.e. in this case being the baby keeping it more downward away from the respiratory diaphragm in a caudal direction. The respiratory diaphragm then served to make the whole volume gained then available to the lungs. I was able to see this happening by observing the back contour as it lengthened and flattened a little. It was exciting to have this possibility with easier breathing for the pregnant client who had labored to breathe.

So now I am on the side of the client and take one leg up with the knee bent. I take the knee only so far, so that the ischial tuberosities are not pulled up so as to not cause further posterior pelvic tilting. Then a slight axial pressure pushes the tuberosities caudal and back into the mattress. The knee is then taken somewhat lateral as I go with my hand to the inside of the tuberosity in as eloquent a manner as possible. As Hans has taught in the past to "sneak up" with my hand, tips of the fingers 2-4 leading, I aim for the split between ilium and S5 and perhaps S4 from the ventral side, not from behind. I was able to do this without causing distress to the client thankfully. The dorsal side of my fingers were able to sense the sacral vertebrae. Now I take the knee strongly medially, over the other leg. This pulls the ilium away laterally from the sacrum and tenses the tissue. I go with it and hold the ilium laterally away from the sacrum. Then slowly

I let the leg slide down with the knee very much over the other leg, my hand keeping the split wide and open. I did see that the leg is less rotated externally and that it has detached a little from the trunk and that the lower front and back wall of the trunk are more evenly wide. This was done on both sides.

Hans also suggested that I do a Pelvic Lift that we were all taught many years ago only differently. Legs up, knees together, feet apart (supine). One hand under the pelvis from below with fingers 2 and 3 go radially into the body on both sides of the dorsal process of L5 or L4. I did not push but I did lift a little, getting the tissue to let me go in more and more. I did aim for the posterior side of the transverse processes. I placed my other arm in front across the pelvis just above the ASIS medially, the right more than the left because of the pelvic standard torsion. That pulled the ilia in back away from the sacrum and made room for my fingers in back. This same hand very slowly "combed" through the dense tissue on the bone toward the sacrum. I tried to get a little into the space between L5 and S1 where the disc is, and to pull the sacrum (without pulling into a posterior pelvic tilt) from above just around the edge, distally. After the trunk was maximally long, I let the client's legs slide down slowly, knees together as I hung on with my engaged hand. The result was a lengthened back wall of the trunk which was possible only because the front wall lengthened much more!

All of the above were Hans' suggestions and directions which I followed very carefully. Hans further states that he had the idea to call this place in back (all the way to the middle of the body) the lumbosacral dent. It appears that sometimes this dent can occupy and block the whole back half of the entrance into the pelvis which provokes the question: How could a 3.5 kg baby pass in the narrow front passage?

Now back to folding on the wall; especially in this case the legs should be rotated fairly medially. This takes the ischial tuberosities maximally out and distends the pelvic floor. This brings the ASIS (anterior superior iliac spine) in front to be more medial. The front wall can then lengthen more when it is not distended laterally. I did this with the client at the end of her 2nd session just prior to her going into labor/contractions for delivery. I also asked her to let her breath flow down on the inside of her front wall behind the sternum and over the pubes out the pelvic floor. I did make certain that the client sensed that the sternum (the manubrium)

and the chin were “hanging” slightly forward as though they belonged to the hands on the wall (and they do via fascia!).

Hans and I now have a new field: Structural Midwifery!

So here is the verdict: I did everything with every detail of which Hans wrote to me with every nuance of the breath and positioning subtleties. The session was long i.e. 1.5 hours but it seemed short to me. The client relaxed and fell asleep with easy even breathing even though the whole time I was gently engaging her with all the prompts of instruction to assist the process. Her ability to breathe easily and to fall asleep supported my perception of going in the direction of integration: breathing easy, even with full excursions.

The following day miraculously she easily went into labor having a natural birth without long laboring so typical of the first delivery. There were no complications whatsoever. The client and her husband were very happy to have a baby of their own making at this later age in life. All of this information was told to me by the Midwife who call me in the early afternoon of the next day. The Midwife stated that she had nothing to do but to attend the process of birthing. I gave the credit to Hans. The Midwife, her clients and their families all know who Hans is and are grateful to be spared surgery with its risks. The Midwife again stated that because it was an easy delivery that she only attended the birth and had nothing much to do.

Just recently I saw the client’s baby boy at 8 weeks of age (already 15 pounds!). He could turn his head only to the right and has been “fussy”. Seeing that he was cramped up on one side pressed up against the respiratory diaphragm for so long, I gave him some length with very broad strokes holding the entire body container in my hands. After 5 minutes, he could turn his head to the left and gave me a smile!

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