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Shoulder Dystocia: How the Body Holds the Experience and How the Psyche Resolves it

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Abstract: Birthing professionals are charged with the responsibility of freeing the baby whose head appears but whose shoulders remain stuck. How they manage this stressful obstacle and how the experience imprints the baby both physiologically and psychologically are examined in this paper through the application of body-centered therapy.

Keywords: Shoulder dystocia, medical maneuvers, psychological imprints, physical imprints

Introduction

As a body-centered therapist, I have always been curious about people who reach an impasse in their lives where they feel stuck. Others around them often can easily see the person's next step, but for the one who is stuck, an emotional panic takes over and with that tidal wave, a set of frightening beliefs accompanies the feeling, "I can't do this . . . I don't want to . . . I'm too scared . . . too incompetent . . . . Everything is happening too fast . . . I don't have enough time . . . There's no one to help me . . . I don't know which way to turn . . . I can't move." Sometimes the sensation of being stuck is the result of an accident, injury, or mysterious and painful dysfunction in the body which actually reinforces the feeling of being stuck, "I hurt my arm, so now I can't . . ."

The correlation between the residual postpartal as a result of shoulder dystocia occurring and later life perception, sensation, and experiences of being "stuck," along with the obstetrical medical interventions used to remedy the problem, will be addressed in this

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article. Case interventions will be given as examples of how the body holds trauma and, with effective interventions, how the psyche can resolve it.

Stuck

The sensation of being stuck in life is often traceable to a birth scenario in which the client was actually physically stuck. One of the most common of these experiences involves the shoulders. Medical practitioners refer to this birth complication as "shoulder dystocia," when the baby's head moves successfully out of the vagina and then one or both of the shoulders seem to be unable to be delivered. The medical literature defines this condition as "any birth in which maneuvers in addition to lateral traction and episiotomy are required to deliver the shoulders after the head has appeared" (Meenan, Gaskin, Hunt, & Ball, n.d.).

Since the baby naturally rotates toward freedom, the failure of one of the shoulders to rotate under the bones of the mother's pelvis, preventing the infant's body from moving further forward, can cause a trauma memory of being stuck. Although there have been many attempts to predict shoulder dystocia, what causes one baby to get stuck and another's shoulders to move freely is unknown (Gross, Sokol, Williams, & Thompson, 1987). Numerous medical research teams have explored this phenomenon extensively. They have tried to measure the bodies of mothers and babies without solving the problem. They have looked into the womb with ultrasound (Cohen et al., 1996).

Babies who are likely to get stuck often have larger than average heads and shoulders (O'Leary & Leonetti, 1990). Generally some factors have been noticed such as overweight mothers or a large baby past the predicted due date (O'Leary & Leonetti, 1990). It has been noted that diabetic mothers are more at risk. Shoulders are known to grow faster than the baby's head in diabetic mothers (Gross et al., 1987). A mother who has previously delivered a baby with shoulder dystocia is also at risk for it happening with subsequent babies (Cohen et al., 1996).

Labor patterns also seem to affect the likelihood of shoulder dystocia, especially in the cases of a long second stage of labor or one in which the labor, after going along well, decelerates and seems to lack energy for the completion of the birth (Gross et al. 1987).

Research has yielded only one conclusion: that while shoulder dystocia seems to be likely in these studied instances, babies' shoulders can get stuck in any birth process (Gross et al, 1987). Trying to predict shoulder dystocia has led the medical world to admit that,

while the C-section would take care of the problem, trying to guess which baby would get stuck would lead to far more unnecessary C-sections. Since C-sections are more risky to both mother and child, vaginal birth is encouraged by these researchers (Gross et al., 1987). Where medical professionals have been successful has been with the use of a variety of maneuvers to release the baby's shoulders. Good medical practices dictate that persons on hand to deliver babies be well versed in these techniques and prepared to use them in the event they are needed (Gross et al., 1987). When the baby's head has successfully emerged and it is determined that one or both shoulders are stuck, calmness, caution, and patience are advised. Waiting for the next contraction and gently tractioning with the peak of the push may be all that is necessary to dislodge the shoulder (Gross et al., 1987).

Unfortunately, in Western hospitals, most deliveries take place with the mother on her back. When this is the case, the McRoberts maneuver is the easiest first option. In this maneuver, the mother's legs are hyperflexed onto her abdomen, which straightens the maternal sacrum in relation to the lumbar spine (Gherman et al., 1997) and rotates the pubic bone, allowing the baby's trapped shoulders to be released. If this fails, the Gaskin maneuver (Meenan et al., n.d.) is the next least invasive move to be tried. Ina May Gaskin would turn the laboring mother over onto her hands and knees, again changing the relationship of the baby's body to the passageway. This is often enough to free the shoulders. The mother needs to be free of fetal monitor belts and IV tubes in order to be able to turn over easily. It also helps if she is free of epidurals and other anesthetics. With the mother on her hands and knees more space is available in the event that further intervention is necessary. The practitioner's hand can be more easily inserted to release the posterior shoulder (the Woods or Rubin maneuvers), to fold both of the shoulders toward the chest, to rotate the baby slightly, or to draw the baby's arm across the chest, delivering the hand, arm, and stuck shoulder without the weight of the baby's body impinging on the arm (Meenan et al., n.d.).

When all else fails, the Zavanelli maneuver (Sandberg, 1988) in conjunction with an immediate C-section has saved babies' lives. In this maneuver, which can easily be begun with the mother on her hands and knees, the baby's head is gently returned into the vagina, the mother turned on her back, and the C-section delivery completed.

While attending medical professionals have many concerns, the most pressing is of course to deliver a live, healthy, and uninjured child in a way that is acceptable to the mother. Another is to avoid the litigation that surrounds shoulder dystocia in the delivery of the baby.

Professionals do not cause shoulder dystocia (Gross et al., 1987); however several procedures need to be examined in the elimination of this complication.

The more interference that is offered, the more stressed the mother and baby team may feel. Epidurals and anesthesia stress the baby. They slow labor down. Deceleration in the second stage of labor is a factor in shoulder dystocia. Inducing drugs like pitocin to try to speed things up push the baby and may cause fear of and resistance to the contractions. The baby may be forced into an unready space with the pelvis and cervix not yet open to their fullest capacities. It has been noted in the research that with interventions like epidurals and saddle block anesthesias it is more likely that the baby will get stuck at the shoulders (O'Leary & Leonetti, 1990). Vacuum extractions and midforceps deliveries are also implicated. Thinking how these interventions must feel to the arriving newborn, as well as the long-term impact on his/her life, is not usually a part of the awareness or concerns during a hospital delivery.

It is well-known that when animals birth their young the birthing place and situation have to be stress free or the labor can stop altogether. It is imperative that those of us working with laboring mothers provide a stress free environment. The mother needs to trust the individuals working with her. She needs to be free to move about the space—to squat, to stand, to walk, to soak or shower, to labor in the most comfortable and productive positions. She needs free access to food and water and bathroom facilities. She needs appropriate and comforting touch and an optimistic and reassuring, knowledgeable staff who are confident of her abilities and truthful about her progress.

Medical staff relies on APGAR scores and close examination to determine if the newborn has sustained injury in the birth process. Brachial plexus injuries are a concern if there is too much pressure, pushing, or pulling on the baby in the birth process. Stressing or tearing of muscle tissue or nerve endings can leave a baby with a temporary or permanent injury to the shoulder, neck, and/or arm (Acker, Sachs, & Friedman, 1986). Cases of hypoxic-ischemic encephalopathy, Erb's palsy, or multiple injuries can result (Hoffman et al., 2011).

Sometimes a deliberate or accidental breaking of collarbones, shoulder, or arm bones becomes part of the injury syndrome. While these can heal, the trauma pattern remains in the baby's body. While the medical team attending the birth can assess that the baby is fine, long term physical and psychological issues can show up much later. Memory of the trauma is held in the body.

Case Histories

The following 3 case histories provide examples of the long-term and ongoing trauma of shoulder dystocia and interventions used by the therapist to remedy the problem and facilitate a smoother birthing process, as well as effective interventions used to support and facilitate the psyche in releasing the trauma.

Case History I

I visited a three-week-old baby boy at his home. The birth attendants had broken his right collarbone to extricate his shoulder. The mother described him as fearful and cranky. He was hard to handle when she held him or tried to dress him. He clenched his right arm close to his body. I seated the mother on a comfortable couch. She offered him the breast so that he nursed with his left side pressed to her body. I held his right shoulder and collarbone between my two hands until I felt a slow myofascial release and relaxation of the soft tissue. He relaxed his shoulder. Keeping my left hand over his collarbone, I took his right hand in mine and infinitesimally slowly drew his arm out from his body, only moving as the tissue released. Three times he pulled his arm back and I let him protect it. Then I would take his hand and draw his arm out again. By the fourth time, I was able to find free range of motion in the arm and shoulder. It took about 45 minutes. The next day his mother called me to say that he was no longer clutching his arm to his chest. He was reaching up to touch her face with his right arm and stretching it over his head. He was no longer cranky when she dressed or held him.

Case History II

A four-month-old baby girl was brought in to my practice having suffered a shoulder dystocia during her birth. She was a second child; her mother was experienced in natural vaginal birth but had gone twelve days past her due date. The situation was complicated by the trauma of a bad rainstorm that had washed out the road, leaving the mother unsure that she could get to the hospital when her labor began. By the time of birth the child weighed 10 lbs.

The baby was alert and I placed her on her back and tested her feet for equal pressure. As she pushed against my hands she turned her head to the left, a typical move in a baby about to reenact her birth. She began to turn her body to the left and stopped when she felt her left shoulder begin to be in the way of the turn. I let her experience this

several times. She seemed determined to turn face down; her mother said she had not tried to turn over at home. On her third try, I facilitated the turn. She was distressed that the left shoulder felt trapped. I freed it for her and she immediately began a forward motion on her belly, pushing against my hands at her feet. I encouraged her off the edge of the treatment table into her mother's arms. Her mother caught her upside down and then cradled her wide-eyed child. We repeated the exercise and she freed her own shoulder the second time and shot forward off the table into her mother's arms. Repatterning the birth difficulty seemed to have freed her cellular memory from holding that fearful stuck memory in her shoulder.

Case History III

A fourteen-year-old boy was brought into my practice by his father. The boy had been complaining of debilitating headaches that kept him out of school. Medical examinations had found nothing physical causing them. As he lay on the table on his back, I scanned his body. He lay like a wooden soldier with his right shoulder pulled up and his head tilted toward the right. In the course of the body-centered therapy treatment it was revealed that his right shoulder had been very stuck at birth.

At the conclusion of the treatment I decided to repattern his body through his birth. I asked him to turn his head to one side (either side). He turned it to the left. I then asked him to let his body follow the turn and come into a fetal position on his left side. His legs and his pelvis turned, but his upper back and right shoulder remained flat on the table. He literally could not lift them. I facilitated the shoulder and back to complete the fetal position. When I asked him to push himself forward against my hands at his feet, he waited a long time before actually attempting it. I felt very little strength in his legs. His father and I received his body as he pushed off the table; we lowered him onto the padding on the floor. He lay on his belly, with his legs straight out, like a person in a coma, definitely anesthetized. His reintegration took at least fifteen minutes.

At the close of the session I asked him to think about the ways he let others make decisions for him and to see if he could identify what he really wanted in his life.

One month later, I saw him again. This time during the body therapy session I focused on releasing his right arm to full range of motion. We talked about babies forming beliefs during their birth. Together we came up with some beliefs he felt he might have formed

at that time. "I don't trust my own intuition; I always second-guess myself. I am afraid to try things I want to do because I might get hurt or it may be too hard. I let other people tell me what to do; I'm not self motivated. I sometimes get fired up about something, but I self-sabotage before I finish it." He told me that during the month he had thought about what he wanted. He was unhappy at school because he felt his teachers were not really teaching anything and he was experiencing a desire to change schools.

At the end of the session, his father and I birthed him off the table again. This time when he turned his head, his whole body turned. His shoulder was fully mobile. He pushed off with more energy in his legs and ended curled up in a fetal position facing left. From that position he was able to demonstrate full range of motion in his arm and shoulder. His headaches have become minor irritations now and then, and he has been able to express his desires to others.

Conclusion

When infants are held back in the birth process by getting stuck during the experience, several psychological birth imprints can reveal themselves as the children mature. They may feel that their mothers hold them back, or that they hold themselves back because of the fear of life experiences. They may not trust their own instincts and feel incompetent to move forward in their own lives. They may feel afraid, reluctant, or resistant to do what they really want to do. Depression may result. If they have actually been injured in the process of birthing they may be frightened of their own choices, yet help from anyone may feel unsafe. If, like children saved by the Zavanelli maneuver, they were actually forced back from the birth canal into the womb to be delivered via cesarean surgery, their own life successes may be followed by disasters in which all they gained on their own is taken away. Forward motion in their lives feels wrong and terrifying.

Many C-section babies feel disempowered, but those who have followed the instincts toward birthing, successfully pushing their heads through to the outside only to be pushed back and pulled out backwards can suffer major damage to their self-esteem and their belief system.

The imprint these events create in their lives may be magnified in their life-long experience. Repatterning the body to achieve successful forward motion is psychologically and physiologically imperative as soon as possible. Telling babies their true birth stories with compassion and empathy, and acknowledging and validating how

terrifying this experience has been for them is absolutely necessary for any child's physical, emotional, and mental well-being in the future.

Shoulder dystocia could become a trauma of the past, not by delivering every baby by cesarean surgery, but by preparing parents to care for themselves with good nutrition, exercise in a clean environment, and good health care, physical, mental, and emotional. Mothers need to be kept as stress free as possible, and more baby-centered birthing environments need to be developed. As the mother is nurtured, loved, and supported by her partner, her family, and her birth assistants, so birth can be a calm and safe experience. A perfectly empowered and relaxed mother can move about and open fully to help her baby be born.

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