# Treating Cesarean Birth Trauma During Infancy and Childhood1

**Author:** Emerson, William R, PhD

**Publication info:** Journal of Prenatal & Perinatal Psychology & Health 15. 3 (Spring 2001): 177-192.
ProQuest document link

**Abstract:** None available.

**Full Text:** Headnote ABSTRACT: Twenty years of clinical and behavioral observation indicate that cesarean births cause considerable trauma to babies. The physical and psychological effects are subtle and powerful, occurring at the unconscious level of the infant psyche. Negative impact includes excessive crying, feeding difficulties, sleeping difficulties, colic, and tactile defensiveness. There also may be long-term psychological effects such as rescue complexes, inferiority complexes, poor self-esteem, and other dysfunctional behaviors and feelings. This article describes Emerson's treatment methods for a baby girl who will be referred to by one of her initials, M. She was treated during infancy and childhood and is among 155 infants treated for birth trauma and systematically followed-up on through childhood. The immediate and long-range results of M's treatments are also described. INTRODUCTION M's case was selected for this article because the treatment procedures are representative of those commonly used, and her outcomes were also typical. She was evaluated for birth trauma during infancy using behavioral and symptomatic observations. Once trauma was detected, she was treated with birth-simulating massage, a gentle process and baby-friendly process that helps infants connect with birth memories. Birth-simulating massage is a pleasurable and relaxing process for babies with no birth trauma and a pleasurable but gently activating process for babies with birth trauma (the massage process is therefore diagnostic of birth trauma). During her birth-simulating massages, M was continually monitored for signs of resistance or refusal, and was continually offered other choices such as breast or bottle feeding, rocking, interesting mobiles and rattles. Later as a toddler and child, she was reevaluated for any remaining birth trauma and treated with a series of birth games. Birth games are created in conjunction with birth-traumatized children and their parents, are designed to meet the developmental needs of children, and are conducted in ways that make children feel safe (safety promotes depth of exploration). The games are designed to be fun, to allow for exploration, and to promote self-discovery. They are also designed to lead children to the edges of their birth memories and provide them with options to accept or decline their memories at any time. Children are continually offered other choices such as playing in sand trays, drawing pictures, making clay figures, working in playhouses, or engaging in other play activities. The most common birth games are the following: 1) Parents gently massage their babies and children in ways that simulate the birth passage, thereby activating birth memories and feelings. Children with no birth trauma experience the massage process as relaxing and pleasurable, whereas children with birth trauma tend to play games with the massaging hands (i.e. ducking, dodging, pushing, pulling, yanking and slapping), accessing unresolved birth feelings and memories in the process; 2) Parents form a slide by propping their legs up on a footrest, encouraging the infant or child to slide down while gentle feather-tip pressure is applied to the sides of the head to simulate the birth passage; 3) Parents form tunnels by kneeling on their hands and knees with backs arched toward the ceiling, allowing their children to crawl of their own volition through the resulting tunnels; 4) Parents sit face to face on the floor with legs and arms gently intertwined. Toddlers and children climb in and out of the resulting space while parents offer gentle resistance according to their children's wishes. These games and others like them are very effective and, when they are used, it is common for babies and children to recall emotions and sensations associated with their births. Sometimes sensations are out of proportion to the level of simulation. For example, children who were delivered by forceps may report a "painful and clamping" pressures on their heads during birth games, even though only gentle feather-tip pressures are used. They may also fail to contextualize or interpret the clamping pressures in terms of their instrument-assisted deliveries. In either case treatment procedures are

modified to lessen the degree of pressure and to provide contextualization. Gentle emotional releases combined with successful completion of games are considered important aspects of the treatment process. So is child-centered control. Babies and children are always "in charge" during birth games, and games are stopped or altered in the direction of their wishes the moment subtle or overt signs of resistance or refusal are noted. M was offered a variety of games to play and she usually chose tunnel games, going under tunnels made by the parents (as described above) or through tunnels made of chairs or couches, placed in rows. While she consistently chose tunnel games, she was also ambivalent about them. She would consistently go around, over, or partially through them with hesitancy and anxiety (babies who are not traumatized have no such difficulties). Eventually she crawled through a birth tunnel, but it took her eight sessions before she did so. Cesarean babies need the experience of successfully crawling through birth tunnels because their own efforts during birth were frustrated and/or frustrated. Success or failure during birth underlies important attitudes about life. Success breeds the attitude of success, and failure the attitude of failure. In one study, cesarean born children were found to use the words "I can't" four times more frequently than vaginally born children (Emerson, 1993) resulting in less confidence and lower self esteem. M's healing required that we understand and empathize with her reluctance and her fears, realize their origin in the birth process, and acknowledge her efforts and accomplishments in sucessfully navigating birth tunnels. M's cesarean birth was unplanned. Unplanned sections are usually more traumatizing than planned ones because they occur when births deviate from established norms and when there are significant birth complications. The birth was extremely stressful and difficult for M's mother. She was in the hospital for three days. During the first nineteen hours of labor, she failed to dilate fully and was in extreme pain, which made her anxious and frightened. After many more hours of excruciating labor, she was administered an epidural to reduce the pain. Cervical dilation arrested at 8 cm and labor was augmented with pitocin, however no further dilation occurred. M's mother became exhausted and she agreed to a cesarean section. During the birth, fetal distress occurred and M aspirated fluids. Immediate suctioning of M's airways resulted in active infant cries. M weighed 8.5 pounds with an estimated gestational age of 40-41 weeks. After birth, M's parents were concerned about a number of symptoms: her relative lack of eye contact; her tactile defensiveness (she recoiled from certain kinds of touch, even though it was gentle and loving); her nocturnal awakening (two to three times a night); and her breastfeeding difficulties (it was difficult to breastfeed her because of constant agitation). M was first seen for treatment at three weeks of age and received ten weekly sessions. THE TREATMENT MODEL: ESSENTIAL CONDITIONS The treatment model for cesarean birth trauma is the same used for all birth traumas, incorporating certain conditions essential for successful treatment: * Catharsis (infants and children release painful memories through crying and other nonverbal behavior). * Empathy (parents and practitioners provide compassionate responses). * Empowerment (infants and children are encouraged to display vocal, verbal, physical, and emotional power). * Choice (infants and children are led to the edge of their memories and given the option to engage in or decline these memories). * Boundaries (infants and children are invited to say "no" to any or all treatment procedures and to halt or modify treatment at any time). The preceding conditions apply to infants, children, and adults, although specific techniques vary for various age groups and various traumas. Establishing boundaries requires special care, and the following conditions are routinely followed: 1) practitioners clarify the verbal and nonverbal ways that clients, especially babies, communicate resistance or refusal; 2) practitioners are taught to accurately perceive signs of resistance or refusal, with special training for nonverbal signs in babies; and 3) clients are given a special language phrase which indicates their desire to stop, and are assured that this phrase will be honored without exception (for example, children are usually given the phrase "1, 2, 3, stop"); practitioners are taught to stop treatment whenever boundary communications occur, and to modify any subsequent process in line with client's wishes (in the case of babies, in line with parent's wishes). The overall aim is to access painful memories while fortifying the client's ability to maintain boundaries and control the treatment process. Whenever M communicated resistance to a particular therapeutic technique, her treatment was immediately stopped and

modified in some important way, usually by changing the technique or reducing its intensity. When treating birth trauma, it is important that techniques be gentle and respectful, especially with infants and children who are often vulnerable, compliant, and less able to stand up for themselves than adults. In addition, infants and children have primitive psychological defenses, and are less able to defend themselves against psychological pain than adults. For these reasons, treatment procedures for infants and children emphasize choice, self control, and empowerment. If treatment is conducted properly, with enough support for feelings and defenses, then infants and children will ordinarily lead the treatment process and initiate treatment procedures that re-stimulate birth memories. They do so by pointing to or rubbing trauma sites on their bodies, rubbing places that were wounded or bruised during birth, reenacting the movements and postures of birth, and/or initiating techniques used in prior sessions. M's BIRTH TRAUMA SYMPTOMS Tactile Defensiveness Tactile defensiveness is defined as a resistance to touch. Birth is a highly tactile experience for all babies, and when touch is associated with trauma it results in a certain kind of ambivalence or defensiveness toward touching. This is particularly true for unplanned (sometimes called emergency) cesarean sections where complications are typical, risk factors are high, and interventions must occur in a short period of time to assure the health and safety of the baby. In such situations, handling by medical personnel may be the first kind of touch that babies receive, and it is likely that the quality of touching may not be as gentle as newborns require. This is corroborated by the descriptions of cesarean-born adults, who report that they experienced their first touching as sudden, hurried, rough, or painful. As a result, cesarean-delivered babies may dislike or withdraw from touching or cuddling, may be sensitive to touch on the head, torso, or feet, and may be anxious about physical contact with their parents. M exhibited many of these symptoms. She was sensitive to being picked up and to being held firmly by her parents. When they attempted to pick her up and hold her, she would typically tighten up, twist away, or cry. She recoiled when many areas of her body were touched and was particularly sensitive to being touched on top of the head. The heads of cesarean delivered babies tend to be most sensitive when labor has occurred and when the pelvis is unyielding during labor, such as in cephalo-pelvic disproportion (the diagnosis in M's birth). A good example of tactile defensiveness occurred during the sixth session. Gentle contact was made with M's head, using the amount of pressure that one would use in pushing a paperback book across a table. The intention was to comfort her, and babies who are not traumatized experience gentle cranial contact as soothing and pleasurable. But this was not the case with M. She exhibited severe agitation and she spit up, illustrating the severity of her birth traumatization. Breastfeeding Difficulties While breastfeeding, M would grow agitated and squirm, kick, turn away, and cry. Such difficulties are common in babies with fluid traumas. Fluid traumas occur when fluids are ingested or aspirated (i.e., inhaled via primitive breathing reflexes) during or after birth. Ingestion and aspiration may be terrifying to many babies, and if so, they are likely to become anxious and distracted when subjected to fluids during infancy and childhood. This is because liquids symbolize and trigger traumatic memories of fluid trauma during birth. Other symptoms include resistance to water on or around the face, a dislike of bathing, and difficulty with breast or bottle-feeding. This was the case with M. When she initially encountered her mother's nipples, particularly when there was an ample supply of breast milk, it restimulated memories of fluid ingestion and aspiration. M's breastfeeding difficulties were also exacerbated by her tactile defensiveness. TREATMENT TECHNIQUES Cathartic Techniques In M's case, six cathartic and three empowerment techniques were used. The six cathartic techniques were trauma posturing, birth simulating massage, section lodging, section dislodging, section rotating, and section lifting. All of these involve gentle simulations of the birth process. For example, section lifting was carried out by placing M on a floor mat in a prone position and progressively lifting M's head and torso off of the floor and into a sitting position, with her buttocks remaining on the mat throughout the lifting. Each time she showed the slightest agitation, the lifting was stopped until she was ready to progress. At several places in the lifting, she became highly agitated and cried. She exhibited the deepest catharsis (she cried the hardest) during the section lifting, deeper than during any other technique, and she also expelled fluids and mucous. The expulsions represented

her body memories from birth when she aspirated and ingested fluids. After the section-lifting was completed, there were dramatic changes in her presenting symptoms. In particular, her breastfeeding difficulty ceased altogether, and her tactile defensiveness diminished greatly. Empowerment Techniques In order to heal birth traumas, babies need to undergo corrective experiences that allow them to use their bodies in confident ways. This process is called empowerment. Empowerment first involves the identification of specific movement patterns that were impotent or ineffectual during birth. In M's case, her legs were rendered useless during birth because her leg-pushing could not result in any significant descent. In addition, she pushed between rather than with contractions, a relatively ineffectual process. Parents and practitioners next help infants and children articulate powerful movement patterns and also aid them as they push through simulated birth tunnels. Empowerment of M's legs involved the following techniques. Her legs were massaged so she could clearly feel them, and she was then encouraged to push down her mother's legs, which were slightly inclined and covered with massage oil. Every push, no matter how minute, was acknowledged and acclaimed. Gradually she began to push with her legs. When leg-pushing became stable, gentle simulations of contractions were applied to her chest, and she was asked to leg-push while the "contractions" were in progress. Gradually she learned to push when "contractions" were applied. Three other empowerment techniques were also used with M, focusing on her arms and hands, her torso, and her gross motor movements. At birth, M's hands and arms were pinned down and unable to ward off the grabbing and lifting that occurred during her section delivery. In the first empowering technique, then, M was placed in her birth posture and encouraged to push her mother's hands away, physically and symbolically resisting the grabbing and lifting that had occurred during birth. In the second, M was gently lifted up by her arms rather than by her neck, as she was during birth, and was supported in lifting herself up. This provided impotent muscle and tissue groups the opportunity to show their effectiveness. In the third technique, gross motor movements were empowered in two ways, first by placing M in her birth posture and helping her crawl into her mother's arms, and second by inviting M to push through a tunnel made by her mother's body (the hands and knee position described earlier). M's mother repeated and reinforced the empowerment techniques at home. Overall, empowerment was an engaging and exciting experience for M, as it is for most babies, but it also restimulated traumatic memories. When memories are reactivated, it is important to honor feelings that emerge, to encourage catharses that follow, and to provide empathy for feelings and behaviors that are expressed. Empowerment is important for all cesarean babies, but is particularly important for unplanned cesareans. When c-sections are unplanned, this means that babies are expected to be born "naturally" (without surgery), but complications necessitate the use of surgical interventions. Research indicates that mothers and babies are likely to feel as though they have somehow failed in such circumstances, especially when natural birth is a desired goal. For mothers, failure means that they were unable to give birth according to their value systems, and for babies, failure means that they were unable to successfully push through the birth canal and be born. For infants, failure during birth may translate into feelings of physical and psychological impotence during childhood and adulthood, as well as feelings of personal inadequacy and low self esteem. EVALUATION M's mother was interviewed throughout the treatment process to ascertain symptomatic changes in her daughter. Some of the symptomatic changes were immediate, and others were gradual. Most changes were clearly associated with cathartic releases and with powerful empowerment sessions. M's nocturnal awakening is a good example of this. Early in the treatment period, M awoke frequently during the night, presumably because of hunger. We were working with the section lodge technique at the time, where she experienced herself descending into the pelvis to the point where she needed to be sectioned. The further she descended in the pelvis, the more terrified she became, and this pattern seemed to occur at night as well: the further she dropped into sleep, the more frightened and agitated she became. Some children associate depth of descent with darkness, and this may have occurred with M (as night time proceeds it gets darker). Once she cathartically released her traumatization about descent, her sleep patterns improved dramatically. Her eye contact improved as well. M was followed up at regular intervals to ascertain the status of her presenting and

potential symptoms. During all follow-up visits, M was evaluated against a list of symptoms for unresolved cesarean trauma. Her symptom progress was also compared with a control group of untreated, untraumatized cesarean babies. M was evaluated at the completion of treatment and later, at the ages of one, two, four, and eight. At the time she came for treatment, M exhibited four major presenting symptoms: diminished eye contact, tactile sensitivity, nocturnal awakening, and breastfeeding difficulties. The problems with eye contact and breastfeeding were resolved almost immediately, and other symptoms progressed throughout treatment. None of the symptoms recurred during the follow-up periods. During one of the follow-up visits, M's mother was asked what she thought was most helpful about treatment. She replied that the release of M's negative emotions and the regaining of M's power were the most helpful. Common Symptoms of Cesarean Born Children The following symptoms are common among cesarean born children with unresolved birth trauma. They often mirror what actually occurs during cesarean deliveries. Stuck and Unable to Move. Many cesarean sections occur because babies fail to progress. When these babies grow up and are asked about their births, they invariably say they felt "stuck and unable to move." When asked about their childhoods, they invariably say that they felt "stuck and unable to get going" during difficult developmental periods, major transitions, or difficult tasks. Giving Up. Many regressed adults report that they struggled during their births and eventually gave up. They indicated that this pattern of behavior plagued them in their adult lives, that they struggled in life and tended to give up in some important way after an extended period of striving. Intruded Upon and Misunderstood. A moderate percentage of regressed adults report that they felt intruded upon by their cesarean deliveries. They felt they were doing fine and that their birth situations were grossly misjudged by their parents and medical personnel. These feelings persisted into their adult lives. Rescue Fantasies. A small percentage of regressed adults report that they were in difficulty during their births and that cesarean procedures were relieving to them. Such adults also report that they frequently had rescue fantasies during their childhood daydreams and nocturnal dreams, i.e. ideas and wishes that they were in great difficulty and someone, especially a dear friend or spouse, would come and rescue them. They also report that they occasionally acted out these unconscious fantasies by getting themselves in serious difficulties and expecting or asking others to rescue them in various ways. M's Symptomatic Evaluation M's potential symptoms were rated by her mother, day care teacher, and classroom teacher when M was three and eight years old. The symptoms were rated according to a five point scale which indicated how frequently the potential symptoms appeared. The ratings for each symptom were then averaged into one score. An average rating of 1 means that the symptom never or almost never occurred; 2 that it seldom occurred; 3 that it occasionally occurred; 4 that it more-than-occasionally occurred; and 5 that it often occurred. Ratings were done at the ages of three and eight, and a low rating is best because it means that trauma has been resolved and a potential symptom averted. The mother's average rating for all symptoms was 2.14, the teacher's average rating was 2.19, and the day care teacher's average rating was 1.72. The average of these three ratings is 2.07, meaning that she seldom manifested potential symptoms. This compares to an average rating of 4.13 for untreated infants, meaning that they manifested potential symptoms more-than-occasionally. M's Positive Psychology Long term follow-up evaluations of treated babies indicate that they commonly exhibit positive qualities throughout childhood, and these qualities seem representative of qualities inherent in the treatment situation. Treated babies, when children, were often described in terms of the following ten qualities: emotionally aware and expressive, mutually communicative, empathie, bonded, nonaggressive, perceptive, loving, proficient (especially in terms of human potential, talents and abilities), trusting, and spiritual. M was rated on these qualities by her parents, her preschool teacher, her day care staff, and her classroom teacher, using the same five point rating scale described above. All ratings were averaged into one score. At three years of age, eight of the positive qualities were rated as 6 or higher (meaning that they were consistently manifested) and two of the qualities were rated as 5 (often but not consistently manifested). At eight years of age, six of the qualities were rated as 6 or higher, and four of the qualities were rated 5. Ratings for untreated babies were significantly lower in all cases and for all qualities. Following is a discussion of a few of these qualities. Bonding

and Attachment When traumas are unresolved, bonding and attachment suffer because the integrity and depth of the bonding process is compromised by traumas. Infants whose pains and distresses are not perceived and acknowledged feel less bonded, in the same way that adults feel unbonded when they are inaccurately perceived or insufficiently acknowledged. Bonding and attachment were M's most highly rated skills, and this is an attestation to the success of the treatment process. She felt bonded, and she bonded to others. She received average ratings of 6.2 and 6.7 on bonding and attachment, indicating that she consistently felt and manifested these qualities in appropriate situations. Her high ratings are not surprising because bonding and attachment are typically accelerated in treated infants. There are two reasons for this. First, treated infants resolve their traumas and have no resistances to the bonding process. Second, the treatment process is a virtual training ground in bonding and attachment. Lifelong bonds occur when babies face their traumas and when parents and therapists respond with empathy, compassion, and understanding. Babies internalize the bonding and attachment process, and exhibit it throughout their lives. Treatment results in trusting and affectionate children who are able to attach and bond with people, and are able to discern trustworthiness in others. Mutuality Mutuality is the term given to the simultaneous and similar response of two people to an event or experience. For example, mutuality happens when a mother and baby laugh together over a tickle or become excited when grandmother walks through the door. In the early stages of treatment, instances of mutuality between M and her mother were sporadic, inconsistent, and infrequent. This was not surprising because unresolved traumas impede and obstruct the mutuality process. And as might be expected, there were noticeable and dramatic increases in mutuality between M and her mother as sessions progressed and as traumas were resolved, and these instances of mutuality carried over into childhood. For example, M pointed to a bird and tried to say the word "bird". She and her mother mutually experienced joy when M pointed and attempted to speak. When M was eight, the most common way she experienced mutuality was through humor and through vocalizing and singing. She liked to laugh with other people and to make other people laugh. She also liked to get on the same wave length as others by vocalizing and singing. She frequently sang with her mother, especially at bedtime. They attuned their voices to each other, got on the same wavelength and sang. This was joyful and affectionate for them both. M's childhood ratings on mutuality all reached 6 and above, indicating that she consistently exhibited mutuality in appropriate situations. Mutuality is an important developmental process because it prepares babies for the experience of empathy in childhood and adulthood. Empathy Mutuality and empathy are closely related. Mutuality is the ability to experience events with another person, and empathy the ability to compassionately experience the other person as the event. Empathic relating styles are almost universal among children treated as infants, occurring in over 90% of all cases, whereas empathic relating styles are uncommon in children who are not treated, occurring in under 20% of all cases. The ability to empathize may be due to the fact that trauma resolution opens up the heart and develops inner feelings of love and compassion toward oneself and toward others. It's also likely that the ability results from the empathie nature of the treatment process itself. During treatment, parents consistently respond to their babies with empathy, and babies internalize empathy as a normal and routine aspect of relationships. Parents also respond with empathy during childrearing, reinforcing what has happened during treatment. The old adage "children learn what they live" is appropriate here. M was first evaluated for empathy at three years of age, during which her mother was asked to name the quality that she liked most in M. Her mother responded with the following story: I just love her empathy. She is always empathie. I'll tell you a story. A child in M's preschool was sitting alone in the room, crying softly to himself. No one seemed to notice, but M did. She always noticed such things. M went over to the little boy, sat down next to him, and just hung out with him. Occasionally she said things like, "You're really sad; your feelings are hurt; I know you feel alone but I am here." M usually sat with children when they felt upset, and usually told them that she was there and they could talk to her if they wanted. She often just sat with them until they felt better. Her empathy went to adults and to social issues as well. For example M was very aware of homelessness in our society and insisted on learning about homeless people. M

expressed compassion toward them and insisted that we help them. She gave some of her own hard earned money. During a follow-up evaluation, M's day care teacher was asked to list any exceptional characteristics that M possessed. The teacher replied that M was very pensive, introspective, and able to tune into other people's perceptions and feelings. This is a classic definition of empathy. M's third grade teacher also had high esteem for M's empathie skills and said, "M's consciousness extends past herself to the consciousness of others; she has empathy in a high degree." Human Potential Treated infants were found to manifest spontaneous attentional preferences during or shortly after the resolution phase of treatment. This means that infants' attentions moved from general to specific, and focused on certain objects or classes of objects, or on certain activities or classes of activities. For example, during the period when M was resolving her fluid trauma (probably the most severe trauma she faced), she began to make sounds, to engage in extensive and long periods of vocalization. The change was sudden and was obvious to all who knew her. Research with other infants reveals that these attentional preferences emerge when significant traumas are resolved and that they are consistently associated with periods of trauma resolution. These patterns become relatively permanent aspects of the infant's personality, are sustained into childhood, and often develop into exceptionality. The theoretical framework for understanding this process rests in the postulation that the basic instincts for human potential are stored at relatively the same depths in the unconscious and at the same locations in the central nervous system as unresolved traumas, and are obscured by the traumas. In this framework, trauma resolution opens infants to the depths of their beings, thereby accessing the basic impulses and instincts that guide and govern human potential. During M's period of trauma resolution, there was a spontaneous and profound increase in the frequency and longevity of her vocalizations. Vocalizing refers to the ability of infants to communicate their feelings and perceptions through voice tones rather than crying. Initially, M's unusual and prolonged vocalizations appeared to be telling what happened during her birth and how she felt about it. Once those were understood and empathized with, she continued with creative and expressive vocalizations on a daily basis and whether or not anyone was listening. It was obvious that she enjoyed vocalizing. The resilience and joy that were observed in M seem to be characteristic of the individuation process in babies (that of finding and expressing their inner talents and abilities), and it typically extends into childhood and adulthood. It was anticipated that M would be verbose and articulate, and would excel in verbal activities like speaking, vocabulary, and reading. As is true with all treatment cases, these possibilities were not mentioned to the parents in order to avoid bias in the research results. Follow-up observations indicated that M was very active and talented in verbal activities and skills. M's preschool teacher said that M was very verbose, and that while she worked hard not to intrude on or disrupt anyone, she loved to talk and did so at every possible opportunity. Everyone interviewed, without exception, described M as an articulate and verbal person, or used analogous words. Her mother said, "M does not stop talking. She can really articulate what she wants to say and is beyond her years in how she uses and understands words." As a child, one of M's favorite activities was finding out the meaning of concepts and words, and playing word games. Her favorite game was Junior Pictionary, which emphasizes vocabulary skills. She was tested on vocabulary at school and received a score better than 94% of her peers on national scales. In addition to crossword puzzles and vocabulary games, reading was another of M's favorite pastimes. M had another trait that emerged shortly after a second major period of trauma resolution. Whereas she had previously been "girlish" and soft, she suddenly became a devoted tomboy. She was squeamish about frilly baby clothes, paid little or no attention to dolls, hated to wear dresses or lacy things, disliked grooming and primping, loved to play sports, and loved to wear jeans and overalls. As with all other traits that emerge during treatment, her "tomboyishness" will be followed up to see if it translates into adult human potential. Spirituality Treated infants are more spiritually inclined than untreated infants, and this was a surprising finding. Subtle signs of spirituality are first noticed during infancy and become obvious during childhood. Spirituality is defined in terms of internal characteristics rather than religious involvement. Some of the many qualities used to define spirituality are: the presence of light in the eyes, the occurrence of

spontaneous meditation (blank, open eyed staring), the daily occurrence of peaceful feelings, the manifestation of presence (as defined in psychological literature), an age appropriate understanding of synchronicity, and a belief in or experience of a higher power. There are many qualities which reflect spirituality, and it is rare for children to manifest them all. M's spirituality became evident during the treatment process, as her traumas were released and repatterned, and manifested in terms of an inner light, a deep presence, a contemplative attitude, and an inner knowing (these were ways she was consistently described by others). M received high ratings on spirituality during all follow-up evaluations and from all evaluators. Her average rating on spirituality at three years of age was 6.5 out of a possible 7, and her average rating at eight years of age was 6.3, meaning that she consistently manifested spirituality in her daily life. M's mother first detected M's spirituality during the resolution phase of treatment and noted that M's spiritual qualities and spiritual interests continued into childhood. This was partly evident in her attitude about going to church. M's parents did not attend church, but M consistently inquired about going. When her parents took up nonreligious meditation, M continually inquired about that, and eventually took it up on her own. During subsequent follow-up evaluations, it was discovered that M had a persistent interest in religion. This is interesting because neither her parents nor grandparents were religiously inclined. Upon further evaluation, it was found that treated children have more of a proclivity toward religion than their parents, and more of a proclivity toward religion than untreated children, in spite of the religious values of their parents. Other spiritual qualities were also noted in M, contemplative depth being the most consistent. Using this as a criterion of spirituality, all of her ratings were 6 except for the day care teacher's, which was a 7 (the highest possible rating on spirituality). The day care teacher said that M was the most spiritual person that she had ever met, and that included all of her friends in her spiritual community. CONCLUSION Dr. Stanislov Grof, who has spent a major portion of his professional life studying birth and death, concluded that birth has profound impacts on life. He discovered that the way a person is born is closely related to one's general attitude toward life, to the ratio of optimism to pessimism, to how people relate, and to one's ability to confront challenges and conduct projects. As indicated in this article, cesareanborn children display particular attitudes and personality traits that vaginally-born children are less likely to have. They are more likely to suffer from low self esteem, to have difficulties with task completion, to "get stuck," to experience tactile defensiveness, and to exhibit rescue complexes. The therapeutic work with M and other babies indicates that these negative possibilities can be ameliorated and resolved by means of specific treatments during infancy and childhood. It is common in this culture to believe that babies are unconscious and unaware, and that they unaffected by their births. The effect of cesarean deliveries is exemplified in the following description, obtained from an eighty-five-year-old woman who remembered her cesarean birth during an Emerson workshop. Well, it came to me as clear as a bell. My blessed mother, bless her heart, was cut open and they yanked me out, and hard at that. I didn't know I was born that way. But I checked mother's diary, and sure enough I was. Now I know why I've been so afraid of people my whole life and why I've never been a touchy person. Don't like to be touched at all. My first touch by humans was utterly shocking, just disgusting. It wasn't right. And I've been mighty frightened of people and particular about touching ever since. I never realized I could learn such things about my birth. It feels much better now, though, thanks to you. I even took a hug from Rev. Parsons the other day. Imagine that. He was as shocked as I was. M displayed a similar tactile defensiveness. Prior to her treatment, M had a nonverbal but similar attitude about people, and a nonverbal but similar attitude about touching and holding. She distanced herself from her mother through tactile defensiveness and through low level eye contact. As her birth traumas were resolved, the tactile defensiveness and distancing dissipated. M became an expressive and affectionate child, and has remained so to this day, and herein lies the hope and the purpose of treatment: to liberate babies and children so that they are able to experience and express the love, the joy, the compassion, and the uniqueness that are their birthrights. Footnote 1 This article is an edited transcription of Dr. Emerson's video with the same title. Labor cesareans, rather than non-labor cesareans, are primarily discussed in this transcript. Direct correspondence to: 4940 Bodega Avenue, Petaluma, California 94952 Tel: 707-763-7024

email: starvapor@aol.com References REFERENCES Emerson, W. (1993). Treating birth trauma during infancy: Dynamic outcomes. CA: Emerson Training Seminars. Emerson, W. (1996). Treating birth trauma during infancy: Cord trauma. [Video-tape]. CA: Emerson Training Seminars English, J. (1985). Different doorway. Adventures of a cesarean born. CA: Earth Heart Press. Grof, S. (1998). Realms of the human unconscious. New York: Viking Press. AuthorAffiliation William R. Emerson, Ph.D.

**Publication title:** Journal of Prenatal&Perinatal Psychology&Health

**Volume:** 15

**Issue:** 3

**Pages:** 177-192

**Number of pages:** 16

**Publication year:** 2001

**Publication date:** Spring 2001

**Year:** 2001

**Publisher:** Association for Pre&Perinatal Psychology and Health

**Place of publication:** Forestville

**Country of publication:** United States

**Journal subject:** Medical Sciences--Obstetrics And Gynecology, Psychology, Birth Control

**ISSN:** 10978003

**Source type:** Scholarly Journals

**Language of publication:** English

**Document type:** General Information

**ProQuest document ID:** 198696299

**Document URL:** http://search.proquest.com/docview/198696299?accountid=36557



**Last updated:** 2010-06-06

**Database:** ProQuest Public Health