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CONTENTS

JOURNAL OF PRENATAL AND PERINATAL PSYCHOLOGY AND HEALTH publishes findings from the cutting edge of the rapidly growing science of prenatal and perinatal psychology and health. The journal, published quarterly since 1986, is dedicated to the in-depth exploration of the psychological dimension of human reproduction and pregnancy and the mental and emotional development of the unborn and newborn child. It is intended to provide a forum for the many disciplines involved such as psychology, psychiatry, midwifery, nursing, obstetrics, prenatal education, perinatology, pediatrics, law and ethology. The journal also deals with the numerous ethical and legal dilemmas which are emerging as society re-evaluates its attitudes toward adoption and abortion or strives to establish moral positions on hightech obstetrics and third-party conception. The opinions expressed in articles and claims made in advertisements are those of the authors and advertisers, respectively, and do not imply endorsements by APPPAH or the printer, Allen Press, Inc.

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Editorial

This edition of JOPPPAH begins with an update from Rupert Linder, MD, reporting on his work in Germany, addressing issues of prematurity using an integrated approach combining gynecology, obstetrics, and psychotherapy. Dr. Linder's approach is based on solution-oriented, salutogenetic, and system-oriented approaches, which brings new energy to our field.

Next we have contributions from two PhD candidates in prenatal and perinatal psychology. These students are representative of the many new faces in our field, from whom I'm sure we will be hearing more in the future.

Student contributor, Peggy Phillips, presents an overview of the effects of omega-3 fatty acids on the duration of pregnancy, incidence of pregnancy-induced hypertension, fetal growth and development, including birth weight, neurocognitive and visual development in the infant, and postpartum depression in the mother.

The second student contribution comes from Kimberly Mascaro, giving us a brief overview of the issue of male circumcision. This contribution explores the historical roots of circumcision and where the procedure stands today, from both practical and ethical perspectives. This exploration is presented clearly as the viewpoint of a prenatal and perinatal psychology student grappling with as issue that brings up deep feelings and reactions.

And, closing out this issue with a vision of the future, we welcome Dr. Michel Odent back to our journal pages with his depiction of "Childbirth in the Land of Utopia." In this creative look into the future, Dr. Odent envisions a future in which giving birth without medical intervention is deemed to be ideal. Dr. Odent's vision is a springboard for each of us to explore and share our own dreams of "Utopia."

The book reviews cover a broad spectrum of works you may want to explore, bringing you a bonus of seven reviews. This bonus book review section also constitutes a farewell to our book review editor, Bronwyn Chambers, who has made the difficult decision to focus on other endeavours and leave behind her work as book review editor for

JOPPPAH. Bronwyn has served the journal well in this capacity and we wish her all the best as she moves on. Please see her farewell message below.

Jeane Rhodes, PhD
Editor-in-Chief

Thank you for the wonderful experience with JOPPPAH. It is with fond memories that I'm moving on from my position as Book Review Editor to focus on my practice. I'd like to say a special thank you to all the PPN practitioners and avid readers who contributed their time and thoughts to the journal and I'm especially grateful to Bobbi-Jo Lyman and Jeane Rhodes for their stewardship and hard work in bringing this voice of the community to print.

Bronwyn Chambers, MA

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Overcoming Somatic and Psychological Difficulties: New Experiences from an Integrated Linkage of Obstetrics and Psychotherapy

Rupert Linder, MD

Abstract: In recent years it has been shown that an integrated linkage of gynecology, obstetrics, and psychotherapy resulted in an astoundingly low rate of premature births among the pregnant women cared for. Many physical problems in pregnancy should be regarded within the entirety of physical and emotional processes. Symptoms are not regarded as problems that have to be got rid of, but are rather to be interpreted as signals and signposts that point towards more appropriate modes of behaviour and lead to insights into the inner emotional history of the mother and previous burdens, arising from her own or her ancestors' early history.

This leads to suggestions for primary prevention, the encouragement of the expectant mother to improve her inner emotional and physical state, and to get her unborn child free from the mother's so far unconscious impairments. This can be achieved by early dialogue between mother, father, and (unborn) child, but also including the child on conscious and unconscious levels between the parents and their "inner child."

Knowledge about these interconnections is of great importance for all professionals in the fields of gynecology, obstetrics, and psychotherapy, for their work and the general improvement of care of pregnancy. Five different methodological levels within prenatal psychology and the importance of their inclusion into care of pregnancy are presented. This psychosomatic and psychotherapeutic access will help to prevent and treat pregnancy difficulties on an emotional and somatic level.

Keywords: Gynecology, obstetrics, psychotherapy, pregnancy, psychosomatic interventions, trans-generational issues

INTRODUCTION

In the following contribution, I report practical experiences from my daily work which demonstrates how trans-generational aspects

Rupert Linder, MD is a practicing gynecologist, obstetrician, and specialist in medical psychotherapy in Birkenfeld near Pforzheim, Germany. Dr. Linder has published research and papers on various aspects of psychosomatics in obstetrics since 1990, as well as the psychosomatics of the threat of premature birth, post-term birth, obstetrics in non-hospital settings, and supportive antenatal care issues since 2002. He can be contacted via e-mail at post@dr-linder.de or via regular mail at Goethestr. 9, 75217 - Birkenfeld, Germany.

can profoundly influence the situation during pregnancy and birth. In doing so, I illustrate how observation of methodological levels, which were presented during the ISPPM's conference in September 2007, can be helpful in prenatal psychology. This also holds true for dealing with psychosomatically significant illness during pregnancy, about which I report more fully.

To make understanding easier, it is necessary to know something about the situation of my practice/surgery. I have been practicing in Birkenfeld, near Pforzheim, Germany for 24 years and specialize in gynecology and obstetrics as well as in psychosomatics and psychotherapy. I work on the basis of psychodynamic psychotherapy and I endeavor to fundamentally integrate these two sides in my daily work. Birkenfeld is a village with a population of 10,000, situated at the north of the Black Forest amidst woods with the small river Enz flowing through the valley below. The town of Pforzheim is just next to it. In the course of my psychotherapeutic training, I have gathered a lot of experience in single and group psychoanalysis and have also concerned myself intensively with body psychotherapy, in particular with 'Funktionelle Entspannung' (functional relaxation, according to Marianne Fuchs). Of particular interest to me are solution-oriented, salutogenetic, and system-oriented approaches.

Scientifically, I have worked principally with the psychosomatics and treatment of premature birth (Linder, 1997, 2006). Supportive maternity care and assisting at home births are further priorities in my work (Linder, 1994, 1996).

My understanding of the trans-generational aspects of problems during pregnancy and birth was increased by the conference "Liebe, Schwangerschaft, Konflikt und Lösung – zur Psychodynamik des Schwangerschaftskonfliktes" (*Love, Pregnancy, Conflict and Solution – on the psychodynamics of conflict during pregnancy*) which was held in Heidelberg in 2006 (Linder, 2008). This dealt with the deep-seated background sources of conflict during pregnancy, the survival of attempted abortion, ambivalence in contraception, and the origins of these conflicts, which can make themselves felt over many generations. I wish to tell you about examples from my practical experience, of which none are simple, as is often the case in reality; somewhere between black and white, as life mostly is. It will become clear how important the extended prior history is in evaluating the problems in the current pregnancy situation. Here, the observations in gynecological practice correspond exactly with those of bonding analysis. What bonding analysis observes on the inside, as it were, reveals itself to the gynecologist on the outside with all the

complexities of a real life situation.

Due to this complexity, the conclusions of the ISPPM conference in 2007 on the *methodological levels in prenatal psychology* are helpful. The starting point was the need or requirement that it is necessary to analyse which levels we are dealing with in prenatal psychology and at which level we are working. The clarification of the methodological levels is important not only for working with pregnant women but also for working with infants or adults regardless of whether in the field of psychotherapy, medical situations, the work of midwives, or other socio-therapeutic or socio-medical fields. It was important to identify these levels and to consider their significance. There are five of these levels:

1. The quantitative level
2. The qualitative level
3. The level of empathic insight
4. The level of practical knowledge of professional groups
5. The level of cultural psychological comparison.

In practice, it is of utmost importance for the unborn child's interests that the carers take into account and balance all five of these essential levels in their work in order to do justice to the reality of the child's life. The subsequent case histories will demonstrate how these levels are always present simultaneously and have to be newly balanced according to the situation. First, however, as background information I would like to identify the most important psychosomatic problem areas that the gynecologist has to take into consideration.

Physical Illnesses During Pregnancy With Psychosomatic Aspects

In the following psychosomatic problem areas, psychological aspects play a greater or lesser role in each case. It is necessary to clarify these individually in order to gauge the possibilities of psychotherapeutic/ psychosomatic treatment:

1. Threatened miscarriage
2. Status after recurrent miscarriage
3. Morning sickness
4. Premature contractions/premature birth
5. Preeclampsia
6. HELLP-syndrome

7. "Symphysial slackening," pelvic pains
8. Breech presentation
9. Dealing with overdue delivery
10. Postpartum mastitis

In dealing with women after recurrent miscarriages, I thank Dr. Zeeb for the following literature extracts, which show that the chances of a woman carrying the child to term increase by more intensive accompaniment/supportive care from 30% to over 70%, (Stray-Pederson & Stray-Pederson, 1984, Lidell, Pattison, & Zanderigo, 1991, Clifford, Rai, & Regan, 1997).

Premature contractions and threatened premature birth are of particular interest due to their importance in health policies, as almost half of all perinatal complications and child deaths are due to premature birth. Consequent implementation of psychosomatic-psychotherapeutic possibilities of treatment, as outlined elsewhere (Linder 1997, 2006), could be of great significance here.

Morning sickness, which is often difficult to access psychotherapeutically, is mostly alleviated by drip-feeding and supportive care.

The diagnostic consideration of preeclampsia and HELLP-syndrome as a psychosomatic illness is important because we are dealing here with really life-threatening illnesses for mother and child that can only be treated by emergency caesarean section. However, in my experience there are strong indications pointing to psychosomatic factors for which a therapy can be considered in advance of a new pregnancy.

Dealing psychosomatically with overdue birth is a delicate subject and requires the integral consideration of psychological and physical aspects.

The understanding of postpartum mastitis as a typical psychosomatic illness, resulting from the inability to cope with excessive psychological and physical demands, is now common to many obstetricians and midwives.

A new insight is the psychosomatic background to symphysial slackening or pelvic pain. Here, profound conflicts in the relationship between the pregnant woman and her mother, stemming from the embryonic and fetal stages, can play a role.

When ascertaining psychosomatic interrelations in gynecological consultation, it is important to have a particular attitude which is open for every methodological level and in particular for the dimension of pre-verbal life. Here is a short explanation of this.

Perceptive Attitude In Gynecological Practice

Prenatal psychology has taught us how important the early pre-speech stage is. Pre-verbal experience can express itself in dreams, emotions, moods, bodily sensations, and feelings, as well as in scenic realization. Here, I want to expressly include associations and re-stimulation. We know from the experience of Balint groups (groups of physicians who meet regularly and present clinical cases in order to better understand the physician-patient relationship) that the background of a problematic situation can reveal itself in the group. And it is exactly these aspects, which are sometimes seen as chaotic and perhaps hard to digest, that are of psychodynamic importance. They are, therefore, an important diagnostic instrument.

This can also be observed in the subsequent case histories. There aren't always instant right answers; some questions remain open. Sometimes it isn't possible to pigeonhole things. This is why openness, enduring not knowing, and repeated appointments are so important. What might remain unclear in one session can be understood in a later one. What isn't possible in one session can happen of its own accord in a later one. Gynecological action can only arise from an understanding of the whole situation based on the interactions of the relationships in consultation. Here the fundamental setting of gynecological practice is analogous to free-floating attention in psychoanalysis, although there the patient brings into the session the totality of a concrete life situation in free association with different levels of their communications and behavior, including bodily expressions. As a result of the great responsibility in understanding and taking action, a special intensity develops in the diagnostic and therapeutic situation. This exceeds the bounds of the normal psychotherapeutic situation and requires of the gynecologist great presence and the ongoing re-evaluation of experiences and perceptions.

Case Histories

Case-histories deal with ongoing therapies, as interconnections can then be more vividly and authentically described. I would like to point out that I have to present the complexity of the cases as they exist so that you can comprehend how it is eventually possible to distinguish the really important dynamically effective aspects which then facilitate sensible action.

This happens in a kind of circular process. When one particular aspect becomes comprehensible the therapist can then provide a

stimulus relating to it, creating a new situation that facilitates new possibilities of understanding, and this in turn activates a further level. This process repeats itself several times. The whole thing has similarities with the mechanisms of a psychotherapeutic process, only all levels of reality are present. In addition, it could almost be said that the structure of this process is similar to the dialectic process described by Hegel with the progression from thesis to antithesis and then to synthesis, which in turn becomes the starting point for a new dialectic triple step.

Case History I: Denial of Pregnancy in Prior History and Its Repercussions

Mrs A, in the second half of her twenties, lived together with her friend. She came to me in the 24th week of pregnancy with severe morning sickness requiring a certificate of illness. She was in her third year of nursing training. It soon became obvious that she also had a drug problem. She had smoked a lot of marijuana. In passing, she said that she had always had problems concluding things. This was a spontaneous statement, the significance of which would later become clear from her biography.

To begin with, I gave her a certificate of illness in order to take pressure off her. She wasn't able to give up smoking for the whole length of the pregnancy. We kept talking about it; sometimes it seemed as if she had managed to stop, then it was clear that she hadn't. Luckily, this point turned out to be not that important as the child was developing well. The ultrasound examinations never revealed any developmental deficits. I gave her an anamnesis questionnaire about her biography to fill in. These questions appeared on it:

1. Particularities during the pregnancy (your mother with you)?
2. How did the birth progress?
3. What about the months afterward?
4. What do you know about your parents' relationship at the time?

The prior history of this patient is really interesting because on the questionnaire she described how she had been conceived. Her mother had had her first child at seventeen years of age. She was the second child, conceived during a chance encounter with a man at a summer festival 200 km away from her home. Her mother had denied the existence of the pregnancy, although she had already had a child and

must have been familiar with all the changes and the child's movements within her. Apparently, no one around her had noticed anything. There must have been some awareness somewhere, but it had quickly vanished. In the end, she went to hospital with suspected appendicitis. This was the birth of the woman who was now herself pregnant. Therefore, it was fitting that she said "I can't conclude things." I find this very logical in view of the mother's transference when seen from the trans-generational viewpoint.

Now, this is how it continued: unfortunately, she developed severe gestational diabetes. I am not depicting this from a theoretical viewpoint, but from the practical viewpoint as things developed in my practice where all the background elements of the different levels are always present and significant: the quantitative, qualitative, empathetic, the level of practical knowledge of professional groups, and the level of cultural psychological comparison. Mrs A had in many respects, as could be expected from her prior history, a way of refusing to believe things. She visited the diabetes doctor irregularly (I worked together with an internist-diabetologist). She also had difficulties keeping agreements and missed appointments because "her mother or friend hadn't given her a lift." These are the kind of things that frequently happen when there is a background problem with drugs. To begin with, she often didn't have the sheets with her daily blood sugar measurements with her. She gradually managed to improve measuring and bringing the results with her.

For a long time, she was undecided if she wanted to have a home birth or not. But in the end, the diabetes and the necessity of intensive monitoring of the child made delivery in the clinic advisable.

The delivery date was one week overdue which, in the case of diabetes, required greatly increased attention and patience. However, the delivery went well and Mrs A was really very happy and contented.

I have to add here that it wasn't possible for the patient to come to terms critically with her mother because she was too dependent in reality on her mother and her support. I did, however, keep bringing up the subject cautiously.

I hope it has become clear that the whole situation of the patient and the supportive care during pregnancy was overshadowed by the denial situation in the time before her birth. Knowing about this facilitated caring for her as well as possible under the given circumstances. Without this holistic approach, there was a danger that individual aspects could cause one-sided interventions which in their turn would cause a chain of further reactions which could have had severe consequences.

Case History II: Repercussions of Being Unwanted in the Prior History

Mrs B was 43 years old when she came under my treatment two years ago, newly pregnant. It was her second pregnancy. Her first child, a daughter, had been born seventeen years earlier. She required prenatal diagnosis on account of her age. Due to anomalies in the region of the neck, I advised further clarification by standardised ultrasound screening with a colleague. He then calculated her risk factor. Going by age alone, this was 1:25 that the child had Morbus Down (Down's syndrome) and after the examination 1:15, i.e. even higher. We then discussed the matter, and after a detailed process of information she wanted no further diagnosis carried out. It was noticeable that she always had a radiant smile on her face when she believed in the intactness of her child. Parallel to this, there was a serious crisis with her partner that led to a separation. She had to go through a lot during that process. In relation to this, premature contractions set in, which, however, disappeared after the strain had been relieved by the discussions and temporary certification of illness.

She was always able to regain courage and bore the child normally. The collapse came 6 months after the birth. She then had a mental breakdown and I made an application for formal psychotherapy. In this context, it first became apparent to what extent the issue of being unwanted was important to her: she was the fourth child; the mother had got pregnant against her will by the child's alcoholic father. She kept arriving at the point where her feeling of security threatened to breakdown, which resulted in her feeling that she simply wasn't able to look after her child. She said she sat in her flat and could do nothing – regardless of whether the child cried or not. She had also started smoking heavily again and wasn't eating regularly so that she finally weighed less than 50 kilos. This depressive psychosomatic reaction had been triggered by the fact that the father of her child had promised her a certain sum of money and not kept to it. She felt that she was just hanging in mid-air. The non-appearance of the money had triggered her own prior history of being unwanted.

Another impression was that when she railed against the father in her distress, often the child was with her and always screamed. We were then able to discuss this and she was able to understand it. Of course, she still has much to come to terms with and that can happen in the continuing psychotherapy.

Case History III: Pregnancy After Endometriosis

Mrs C, 36 years of age, came for the first time to my gynecological practice, on the recommendation of relatives, after missing a period. She was a very well-groomed if somewhat emotionally reserved woman who had worked for more than 12 years in a higher grade of the civil service. She complained of dizzy spells and nausea. While going for walks she had to stop over and over again, "It's as if my feet were being pulled out from under me." A sick line was issued for her. Her previous history: 5 years earlier she had undergone months' long hormonal treatment (artificial change to the menopause) due to extreme endometriosis (dispersion of endometrial mucosa in the abdomen). During several operations in one year the foci in and around the ovaries as well as part of the large intestine had been removed. It had even been necessary to give blood transfusions during the operation. In an earlier marriage she had not become pregnant despite the wish to have children, especially on the partner's side. Now, in a new partnership and marriage in which she feels very happy, the pregnancy had occurred without further treatment. After one week bleeding had started. An ultrasound examination showed an intact pregnancy. Prescription of a homeopathic remedy (Crocus) was given. This recurrent bleeding remained a problem during the next weeks. Naturally further sick lines were required (this remained so until the start of maternity protection). There was, however, reason for definite concern, calling for ascertainment of biographical anamnesis (medical history). This included again the anamnesis questionnaire with the aforementioned questions (see above – case 1).

Her past history was unique: her mother had also suffered from severe endometriosis 7 years before her birth. During the operation her mother's ovaries had been so reduced that only part of one ovary remained. She had been told at the time that a pregnancy was not possible after this operation as the remaining ovary was only capable of a minimal hormonal function. Unexpectedly, she became pregnant with Mrs C. There was also recurrent bleeding at the beginning of the pregnancy (threatened miscarriage). Inpatient treatment in the hospital and hormone injections were necessary to maintain the pregnancy.

Mrs C's birth was absolutely normal, although her mother had problems in breathing through the contractions due to the pains in her lower abdomen. Four months after her birth a hip dysplasia was diagnosed which required wearing a splint for a long time.

Mrs C's education and social development progressed well through

her early years. From the past history it should also be mentioned that her father has for a long time been mentally affected by depression, which puts her under mental strain. Noteworthy in her father's past history is the very early loss of his father in the war as well as the later loss of his mother through suicide.

To return to Mrs C's pregnancy: the bleeding occurred on and off until the 13th week of pregnancy. At the same time we were involved in discussion of her own situation as an embryo, her own endangerment during this time. Her mother's astonishment at becoming pregnant so surprisingly similar to her own, adding to the anxiety about whether everything would go well. Later, in the 30th week of pregnancy, she developed a much shortened cervix: ultrasound length of cervix 26 mm. Therefore an Arabin cerclage pessary was inserted which she tolerated well.

In a discussion with her husband, a prenatal and perinatal traumatic experience also emerged from his past history: his mother conceived him at a very early age. At the same time a pregnancy among his relatives ended unhappily in the death of the child. He himself was born 6 weeks too early weighing 1500 grams (also small for the date) and lost a further 200 grams after birth.

Mrs C was introduced early to the chief physician of the obstetric clinic. This proceeding is particularly to be recommended in more complicated cases. The background personal history was mentioned candidly and the hospital colleague related in his very careful and empathic discussion report the plans to enable everything during the birth to proceed as normally as possible. Further progress was normal, with removal of the Arabin cerclage pessary in the 36th week of pregnancy. However, a positive test for B-streptococcus in the vagina presented a complication. Mrs C reported many dreams with birth scenes in which, although labor progressed rapidly, she would reach the clinic in time.

The pregnancy exceeded the arithmetical birth date. At this time a noticeable drop in the heart sounds (to 85 beats per minute) in the cardiotocograph (CTG) caused some alarm. After faxing the data to hospital colleagues and resulting discussion, we came to the conclusion that this occurrence could be interpreted as being caused by a simultaneous continuous contraction of the womb. The next day, Mrs C was examined in the hospital thoroughly and in detail with ultrasound. The plan remained to continue close supervision, but no action.

Three days later a healthy boy of over 3600 grams was born spontaneously. However, due to an infection, he had to be transferred

with his mother to a neighboring hospital with a pediatric clinic. There the inflammation values went down within a few days and Mrs A was able to be discharged in good health within a week and went home with a healthy child.

She was very happy about this outcome and was radiant at the first follow-up examination. The child had gained weight well and she obviously had good contact to him. Breast feeding had, however, not been greatly successful, only partial and for a total of four weeks.

In reply to criticism on this point regarding the short duration of breast feeding, I would point out how many critical obstacles Mrs A, her son, and her husband had been able to master well despite the very difficult past history. In order to lessen mental stress, I consider it counterproductive to turn the question of breastfeeding into a problem. Perhaps in the case of another pregnancy she can still achieve progress in this respect.

Case History IV: The Effects of a Lost Twin in Prior History

Mrs D was 27 and had got pregnant unexpectedly. She hadn't expected it because she suffers from Crohn's disease and had had 20 operations on her abdomen and intestines—including an anal extirpation - and lived with a stoma. She came recently, in the 24th week of pregnancy, complaining of stomach pains and wanting a certificate of illness. This seemed to me to be a sensible way of relieving strain as she seemed to be overstressed and there was a suspicion of premature contractions despite her fundamentally marked commitment to the pregnancy. The emotional and/or physical overtaxing of women is the most frequent cause of premature birth, and this is often underestimated. After two weeks everything had calmed down.

Mrs. D's record revealed that she had previously suffered from pronounced neurodermatitis and it transpired that her mother had assumed she had had a miscarriage due to bleeding early in the pregnancy with Mrs. D and thought the pregnancy was over. The mother had turned out to be wrong and in the end the patient had then been born. The situation of the lost twin and her own endangerment was discussed with her at length. She had made it, but her twin had not. She was able to take in the interconnections. I think that the therapeutic efficacy of this work lies in the fact that people can talk about the traumas and share the feeling. So it was in this particular case and this is why I'm not really worried about the further progress of the pregnancy. She is now in the 34th week of pregnancy.

The question of the form of birth, i.e. how she is going to deliver the child is still unresolved. Her surgeon, in whom she has great confidence due to her years of illness, has voted for a caesarean section due to the scarring caused by the operations for Crohn's disease. My idea is rather this: the womb is the only undamaged organ so why subject it to this operation? I have now spoken to the chief physician of one of our gynecological clinics – in this situation you're always the go-between - with whom it was possible to discuss the situation. He agreed with my opinion. It is, however, possible that the patient herself will want to have the caesarean section due to the traumatization of the many operations, in the assumption that her maltreated pelvic floor would be the better spared. There is to be further discussion here.

Outcome Data From Application Of This Method

For the Cheek Memorial Lecture at the 2009 APPPAH it was possible for me to present my own results. Data from 1,165 pregnant women, taken receiving prenatal care in the years 1986 – 2008 were collected retrospectively. Since it was done in a single center study they were compared concerning the prematurity rate with accessible data of Germany or Baden-Württemberg.

The **place of birth** was 30% at home and 67% in the hospital. Three percent of the mothers giving birth at home were transferred into the hospital.

The **method of delivery** was 82% spontaneous vaginal birth, 12% caesarean section and 6% vaginal-operative.

Fully breast-feeding after 6 weeks were 83%, 17% not.

According the prematurity rate we have to consider, that there are two definitions existing:

1. By the time of duration of the pregnancy (before end of the 37th week)
2. By the birth weight of the newborn less than 2500 Grams.

In our group, the prematurity rate (by duration) was 4% (n = 48 from 1165). These, however, were mainly spread among the higher gestational weeks:

Table 1
Comparison of Prematurity Rates by Duration

	Our Results	Baden-Württemberg	Risk Reduction To
Duration <37 weeks >33 weeks	4%	10%	40%
Duration <33 weeks	0.34%	10%	14%

Note: Newborns born before the end of the 33rd week are considered as very early premature births.

By birth weight there are 22 in our group weighing less than 2500 grams, 2 of these weighed less than 1500 grams (very low birthweight).

Table 2
Comparison of Birth Weights

	Our Results	Germany	Risk Reduction To
Weight <2500 Grams	1.89%	8%	14%
Weight <1500 Grams	0.17%	2.50%	7%

Additionally it seems remarkable that there was not one premature born baby with a five minutes Apgar of less than 8!

From these results the impression is arising that within the own collective there seems to be fewer children with intrauterine growth retardation. The risk reduction by weight is much higher than by the pure duration of pregnancy. This can be a result of the same intervention measures, which obviously are effective against premature labor, but seems also to be reducing impairment of

placental perfusion and intrauterine growth retardation. This issue should undergo future investigation.

Concluding Remarks

An important observation in bonding analysis is that burdens in the prior history of the expectant mother and her mother are of far greater significance in the ongoing situation than is assumed in the normal view of maternity care, which is so confined to the present situation. This observation can be fully confirmed from the viewpoint of the psychotherapeutic-psychosomatic gynecological practice, only here there is even more complexity in the consequences of burdens from the patient's own prior history as well as the mother's, among others in the prevailing corporeality. It is evident that the early burdens shape the whole life situation of the expectant mother and the arrangement of her relationships. The awareness of the trans-generational depth of the prevailing situation makes it possible for the gynecologist to take into consideration the different existential and methodological levels and so find a new balance between these levels. This is what makes possible holistic understanding of the patient's complex reality and so undertake appropriate action.

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Omega-3 Fatty Acids in Maternal and Child Health

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Abstract: This paper presents an overview of the effects of omega-3 fatty acids on the duration of pregnancy, incidence of pregnancy-induced hypertension, fetal growth and development, including birth weight, neurocognitive and visual development in the infant, and postpartum depression in the mother. A brief introduction to the role of nutrition on the outcome of pregnancy provides a context for the review of the literature which follows. Much of the research is preliminary and includes epidemiological, animal, and human studies. The clinical applications of omega-3 fatty acid supplementation during pregnancy and breastfeeding are currently controversial due to mixed findings in the research. However, this nutritional factor warrants further study because of the clear physiological basis, strong epidemiological evidence, and positive clinical outcomes and because of the potential for improved physical and behavioral health.

Keywords: Omega-3 fatty acids, maternal health, child health, postpartum depression, pregnancy, nutrition, hypertension, neurocognitive development

INTRODUCTION

The effect of nutrition on the outcome of pregnancy has been studied since the Nazi imposed Dutch Hunger Winter in late 1944 when severe food rationing was imposed on the entire population for seven months. It was discovered that when the maternal food intake was below 800 calories per day fetal growth was negatively impacted (Lumey et al, 2007).

The emphasis on macronutrients, such as calories and protein, remained the focus of nutritional advice until recently, when studies of micronutrients produced significant public health recommendations. Most notably, the connection between folic acid deficiency and neural

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tube defects such as spina bifida is an example of the important role of specific vitamins and minerals in optimal nutrition for pregnancy. Recently, attention has turned to the role of a specific class of lipids, omega-3 fatty acids, and their role in contributing to the health of the mother, fetus, and infant. The range of potential effects includes the length of pregnancy, hypertension, pre-eclampsia, and postpartum depression in the mother, fetal growth and birth weight, as well as brain, nervous system, and visual development of the infant. The physiological mechanisms for these effects is based on omega-3 fatty acid metabolism in the mother and baby. This particular macronutrient provides an exciting interplay between the physical nurturing of the mother and her psychological and physiological status. The cascading effects for the fetus and infant lay down the foundation for permanent cognitive and behavioral consequences. The question now facing clinicians and public health officials is: are less than optimal pregnancy outcomes the result of a deficiency in omega-3 fatty acid ingestion?

Omega-3 Fatty Acids-Metabolism And Dietary Intake

Omega-3 fatty acids belong to the dietary class of lipids, commonly known as fats. Along with carbohydrates and protein, fats constitute the third classification of macronutrients which provide calories for energy. Fats are further divided into two types; saturated and unsaturated. The distinction between these two types of fat can be recognized by noticing whether the fat is solid at room temperature (saturated) or liquid at room temperature (unsaturated). Omega-3 fatty acids belong to the unsaturated fat group and further delineation of this group pinpoints its characteristics. Unsaturated fats are either monounsaturated or polyunsaturated. Chemically, monounsaturated fats have one point of unsaturation (one double bond between carbon molecules) and foods of this type will thicken at refrigerator temperatures. Examples of monounsaturated fatty acids are olive oil, canola oil, and peanut oil. When a fat is polyunsaturated it has two or more double bonds between carbon molecules and it remains liquid at refrigerator temperature. Examples of polyunsaturated fats include soybean oil and walnut oil. The commercial production of hydrogenated oils changes the stability of the polyunsaturated fat and in the case of soybean oil, when it is processed in this way it will remain solid at room temperature.

Polyunsaturated fatty acids (PUFA) are structurally distinguished as either omega-3 fatty acids or omega-6 fatty acids on the basis of

where the first double bond occurs on the carbon chain. In food, there are two fatty acids which occur that cannot be synthesized in the human body. They are called "essential fatty acids" because without them certain physiological functions cannot occur. Alpha-linolenic acid (ALA) and linoleic acid (LA) are the names for the essential fatty acids which are found in food.

Alpha-linolenic acid is found in leafy green vegetables, walnut oil, and flaxseed oil. Safflower oil, sunflower oil, and corn oil are good sources of linoleic acid. The ratio of omega-6 to omega-3 was about 1 to 2:1 in the North American diet as recent as 200 years ago and now it is estimated at 16:1 (Simonopoulos, 2002). It is believed that the current ratio of these two fatty acids is not conducive to the healthy functioning of the body and the results may be seen in the various effects on pregnancy and infants.

Eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA) are long chain fatty acids which are produced in the liver from the omega-3 fatty acids found in food. There are further complexities which affect this conversion in the body. Fish is the primary food source for EPA. An important metabolic pathway converts omega-3 fatty acids to prostaglandins. Prostaglandins are hormone-like substances that are produced in the cells and regulate processes such as the movement of calcium in and out of cells, dilation and contraction of muscles, inhibition and promotion of blood clotting, hormone secretion regulation and fertility, and cell division and growth. Prostaglandins provide the mechanisms for the physiological effects of omega-3 fatty acids in pregnant women and the fetus and infant.

Omega-3 Fatty Acids And Maternal Outcome

The potential benefits of omega-3 fatty acids during pregnancy include improved gestation length and size of the infant, reduced maternal hypertension, and a possible role in reducing postpartum depression. In epidemiological studies of the Faroe Islands, diets high in fish oils were associated with increased birth weight, either by extending gestation or enhancing the fetal growth rate (Olsen, 1993). This effect may be due to the ability of prostaglandins to initiate labor or to enhance placental blood flow and decrease blood viscosity. Prostaglandins have been shown to initiate uterine contractions, cervical maturation, and rupture of membranes (Norwitz, Robinson, & Challis, 1999). Women who deliver prematurely have lower plasma omega-3 fatty acids and higher omega-6 fatty acids compared with women who deliver at term (Olsen, 1993, Reece, McGreggor, Allen, &

Harris, 1997). Fish oil supplementation from the 30th week of gestation has been shown to lower the risk of premature birth by 40 to 50%, increase the length of pregnancy by 5 days, and produce babies with a 100g higher birth weight (Olsen, 1993). Preterm birth occurs in 6% to 10% of pregnancies in the United States and is the most important cause of neonatal mortality and morbidity, long-term neurological problems and a low IQ (Saldeen & Saldeen, 2004). The link between a low consumption of seafood and premature delivery and low birth weight was shown in a study of 9,000 pregnant women in Denmark (Olsen, 1993).

Maternal hypertension occurs in approximately 6% to 8% of pregnancies and is the second leading cause of maternal deaths in the United States (NHLBI, 2000). There are varying degrees of severity including chronic hypertension, preeclampsia, and eclampsia. Omega-6 fatty acid derived prostaglandins such as thromboxane may enhance vasoconstriction and are found in maternal plasma and placental tissue of preeclamptic women (Mills et al., 1999). Inuit women who ate a diet rich in marine foods were 2.6 times less likely to develop hypertension during pregnancy (Popeski, Ebbeling, Brown, Hornstra, & Gerrard, 1991). It has been proposed that the most direct way to prevent preeclampsia is to consume fish (Odent, 2006). Further studies on the relationship between omega-3 fatty acids and hypertension in pregnancy are warranted.

The possibility of neurotoxic effects of mercury in fish is a concern for women wanting to increase their fish consumption during pregnancy. Both the American College of Obstetricians and Gynecologists and the Environmental Protection Agency recommend women of childbearing age consume 12 ounces of seafood per week from low mercury species (Greenberg, Bell, & Van Ausdal, 2008). Among the fish with the least mercury content are cod, salmon, herring, scallop, and shrimp (Hughner, Mayer, & Childs, 2008). The highest mercury content is found in king mackerel, shark, swordfish, and certain types of tuna.

While avoidance of fish with high mercury content is advisable, it is not wise to avoid all fish because approximately 73% of child-bearing women are not consuming enough low-mercury fish (Hughner et al, 2008).

Postpartum Depression

Postpartum depression (PPD), referred to in the DSM-IV as a major depressive episode with postpartum onset specifier, is a major

depressive episode that begins within 4 weeks of delivery. PPD may affect 10 to 15% of mothers and may impair attachment and bonding within the mother-infant relationship, as well as the cognitive and behavioral development in the infant. Mother-infant bonding disorders were present in 29% of the mothers diagnosed with PPD (Klier, 2006). There may be a thirteen times higher incidence of depression in children of depressed mothers (Verny, 2006). It has been shown that maternal stores of essential fatty acids progressively decline during pregnancy (Freeman, 2006). DHA levels in mothers can decrease to half during pregnancy and not be restored until 6 months after the birth (Saldeen & Saldeen, 2004). Epidemiological and preclinical data support a role of omega-3 fatty acids in both pre- and post-natal depression.

However, the evidence to date has been somewhat conflicting with some studies showing a link (Freeman, 2006; Hibbeln, 2002; Otto, deGroot, & Hornstra, 2003) and others not supporting this hypothesis (Browne, Scott, & Silvers, 2006; Marangell, Martinez, Zboyan, Chong, & Puryear, 2004; Llorente et al., 2003). In cross-national studies, a higher prevalence of both major depression in general and PPD in particular are associated with lower per capita seafood consumption (Hibbeln, 2002). Whereas the incidence of PPD averages 12% in North American women, in Japan where fish consumption is high the incidence is about 2% (Hibbeln, 2002). Lower DHA content in mothers' milk has also been associated with higher rates of postpartum depression (Hibbeln, 2002). Although further studies are needed, the role of DHA as a preventative or adjunct treatment for postpartum depression appears promising.

Omega-3 Fatty Acids And Child Health

The potential benefit to children exposed to sufficient levels of omega-3 fatty acids during prenatal and early postnatal life include brain function, central nervous system, and visual development. Rapid growth and development of neural tissues continues during the first 18 months after birth and the accumulation of DHA in the brain is 3 times greater that the relative increase in brain weight (Martinez, 1992). DHA accretion in the human retina begins in the third trimester and peaks at 36 to 40 weeks gestation (Martinez, 1992). Improved intelligence quotients and mental processing scores at 4-years-of-age were shown in offspring of mothers who consumed cod liver oil in late pregnancy and early lactation (Helland, Smith, Saaren, Sougstad & Drevon, 2003). Fatty acid levels were shown to be lower in

children with attention-deficit hyperactivity disorder (Stevens et al., 1995). A randomized clinical trial with British children receiving fish oil supplements showed improvement in their reading skills compared to the controls (Richardson & Montgomery, 2005). One randomized controlled study which fed healthy term infants formula supplemented with DHA showed improvement in both cognitive and motor test results (Birch, Garfield, Hoffman, Uauy, & Birch, 2000). In animal studies, omega-3 fatty acids were shown to alter the metabolism of dopamine and serotonin in the brain and this may infer a role in cognitive functions such as attention, motivation, and visual pathways (de la Pressa & Innis, 1999). DHA has been identified as a structural component of phospholipids of brain gray matter and in the outer segments of the retina's rods and cones (Connor & Neuringer, 1998).

There is concern that changes caused by early deprivation during critical periods of retinal development may be irreversible despite later correction of DHA status (Conner & Neuringer, 1998). Observational studies have shown that breast-fed infants have improved neurocognitive development compared to formula fed infants, possibly due to differences in DHA content (Anderson, Johnstone, & Remley, 1999).

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Conclusion

In light of the compelling findings relating omega-3 fatty acids with maternal and child health, there remain several important questions:

1) Should omega-3 fatty acid supplements (such as fish oil capsules) be given during pregnancy and lactation?
2) If fish oil supplements are taken, should they be purified to eliminate potential toxicity from heavy metals, dioxins, or other contaminants?
3) Should infant formulas be supplemented with DHA to optimize neurodevelopment?

Dietary recommendations for pregnancy have already recognized the potential for toxicity from contaminated seafood. Further studies could be conducted to clarify the safety of consuming seafood during pregnancy.

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Circumcision: A Brief Overview

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Abstract: Currently, the rate of circumcision is declining in the United States (The Circumcision Reference Library, n.d.). Estimates vary from one in six men circumcised worldwide (Dunsmuir and Gordon, 1999) to one in three according to a 2008 report from the World Health Organization. This paper explores the historical roots of circumcision and where the procedure stands today, from a practical and an ethical perspective. The current debate over whether to circumcise or not to circumcise young males is explored through the lens of a prenatal and perinatal psychology student.

Keywords: Male circumcision, circumcision rates

Introduction

This paper provides information to be considered in addressing the issue of infant male circumcision. The premise is advanced that circumcision as an unnecessary and potentially dangerous procedure in today's modern world. This paper will cover the following aspects: a brief history of circumcision, viewpoints from recent literature, and concluding arguments from the lens of pre- and perinatal psychology.

Brief History

Circumcision is an ancient surgical procedure with roots dating back to pre-biblical times. Circumcision was first practiced in Africa - the oldest history we have comes from the oral tradition of the Dogon tribe in Western Africa (deMeo, 1989). Later it was practiced by the Egyptians on their priestly casts for cleanliness and their slaves for

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identification. It may be safe to say that circumcision was introduced as a cultural practice. To this day, anthropologists do not agree on the origins of circumcision and suspect that the ritual surfaced in many of the world's cultures around the same time. Little is known about the beliefs of circumcision back then. Although more recently, "the techniques and controversies…have evolved since the operation has become medicalized" (Dunsmuir and Gordon, 1999, p.1). The infiltration of circumcision into western medicine has also been documented by Frederick M Hodges (1996) in his paper "A Short History of the Institutionalization of Involuntary Sexual Mutilation in the United States."

Dated medical texts offer somewhat detailed accounts regarding the practice of circumcision. At the same time, it is much more difficult to find historical reflections and controversies relating to this ritual. By the early 19th century, adult male circumcision is mentioned in various textbooks, but with little detail compared to today's texts. Justifications for circumcision included "impotence, nocturnal enuresis, sterility, excess masturbation, night terrors epilepsy, etc." (Dunsmuir and Gordon, 1999, p.9).

At that time, circumcision had not been suggested as a procedure for infants, medically speaking. Again, minimal amounts of information are known coupling religious circumcision practices and infants, except that Genesis 15 was probably the first covenant between God and Abraham and it did not mention circumcision, however, the P text, the work of the priestly class, which emerged in the late sixth century some thirteen centuries after Abraham's lifetime, does mention it (Glick, 2005). What becomes increasingly clear is the recommended technique in the 19th century texts, along with the possible long-term benefits of circumcision. Little has changed, in terms of technique, since that time. Dunsmuir and Gordon (1999) state, "The turn of the 19th century was also an important time in laying the foundations of surgical technique" (p. 4).

By the latter part of the 19th century, requests for newborn circumcision had greatly increased. All the while, the procedure had risks associated with it, particularly infection, hemorrhage, and surgical mishap. A variety of clamping and crushing instruments were created in response to this risk and the last 100 years has seen an evolution of such instruments. (Dunsmuir and Gordon, 1999). Warnings came forth regarding the risk of injury to the glans (head of the penis), by the 1930s, and ever more instruments were created.

Current Considerations

For the past three decades members of the allopathic medical community have increasingly questioned circumcision, specifically the purpose and function of the prepuce, or foreskin. One anonymous doctor suggested the following analogy: the prepuce is to the glans what the eyelid is to the eye (Dunsmuir and Gordon, 1999). The foreskin serves to cover and protect the urinary meatus (the urinary tract is meant to be sterile) and the glans penis, keeping it soft and moist once the foreskin becomes retractile. The foreskin provides skin to accommodate a full erection, and circumcised males complain of tight, painful erections, tearing, and bleeding at the scar. Thanks to the work of Canadian pathologist and researcher, Dr. John Taylor (2007), we now understand that the foreskin houses somewhere between 20,000 and 70,000 specialized, erogenous nerve endings in the ridged band that encircles the opening of the foreskin.

A current topic gaining much attention relates to the spread of HIV among the uncircumcised population. Specifically, "there has recently been startling evidence that HIV infection is significantly associated with the uncircumcised status" (Dunsmuir and Gordon, 1999, p.9). On the more extreme side, there has been the promotion of routine world-wide neonatal circumcision to try to control HIV and AIDS. This radical view has not existed without scrutiny. Even with widespread sexually transmitted diseases, the American Academy of Pediatrics (AAP) has concluded that there is no strong valid indication for circumcision. They report:

> Scientific studies show some medical benefits of circumcision. However, these benefits are not sufficient for the AAP to recommend that all infant boys be circumcised. Because circumcision is not essential to a child's health, parents should choose what is best for their child by looking at the benefits and risks. (American Academy of Pediatrics, 2007)

Additional research is needed to accurately determine whether circumcision is worth the risks and to determine the degree to which it truly reduces the risks of spreading sexually transmitted diseases. Infant circumcision in the United States has slowly declined over the past decade (Birth News, 2000).

Literature Review Of The Current Debate

The current circumcision debate is not as straightforward as it may initially appear. The obvious "to circumcise or not to circumcise" decision is at the forefront. The issue of consent has surfaced, as an infant cannot consent to such a life-altering procedure. In addition, statistics indicate that only a percentage of infants receive pain-relief during the procedure. A clinical report published by the AAP (2004) states, "…our youngest patients are at the highest risk of receiving inadequate analgesia" (p.1348). According to a 1999 article in Time magazine, "45% of U.S. circumcisions are still carried out without analgesia" (Gorman, 1999, p.100).

In the past there was great controversy over whether neonates could feel pain. It was also believed (Gardner, 1994) that their immature central nervous systems were incapable of perceiving pain. "The myths that children do not feel pain the same way adults do and that pain has no untoward consequences in children still exist" (Zempsky and Cravero, 2004, p.1349). According to these misleading perceptions, pain relief was not considered necessary. Zempsky and Cravero (2004) report that only recently has clinical staff have been educated in pain management. Furthermore, the reports of "back-street" circumcisions have become an issue due to certain insurance companies' unwillingness to cover the procedure, as it is not considered a medical necessity. These concerns make the circumcision debate multi-layered. While neither this section, nor this paper, will cover this final issue, it must be recognized, nonetheless. Finally, there are too many possible negative outcomes of the actual circumcision procedure itself (e.g. excessive swelling, hemorrhaging, infection, etc.), to name here. Medical texts, such as Comprehensive Pediatric Nursing, as well as online sources are available for further inquiry into these outcomes.

According to the American Academy of Pediatrics (AAP), there are several things to consider when making the circumcision decision. Minimal reduction of rare diseases and infections, cultural or religious tradition, hygiene, and wanting a son that looks like the other males in the family are the top reasons for circumcising infant males.

On the other end, avoiding surgical risks of circumcision, increase in adult sexual satisfaction (due to maintained sensation), not wanting to surgically alter genitalia, and desiring to spare a newborn son a painful introduction to life, are the top reasons for not circumcising infant males.

Whatever the choice made by the parents, one thing is certain; the

AAP (1999), states in their Circumcision Policy Statement that "adequate analgesia should be provided if neonatal circumcision is performed." In addition, the policy statement also states:

> There is considerable evidence that newborns who are circumcised without analgesia experience pain and physiologic stress. Neotatal physiologic responses to circumcision pain include change in heart rate, blood pressure, oxygen saturation, and cortisol levels. One report has noted that circumcised infants exhibit a stronger pain response to subsequent routine immunization than do uncircumcised infants. (p. 688)

The 2004 AAP clinical report continues to remind pediatricians of the value of pain control. "Inadequate sedation and pain control has negative implications for pediatric patients. Neonates who undergo procedures with inadequate analgesia have long-standing alternations in their response to and perceptions of painful experiences" (p. 1348).

Knowing that so many infants are circumcised without adequate analgesia, that circumcision is painful, interferes with the maternal/infant bond, disrupts breastfeeding and normal sleep patterns, and undermines the baby's first developmental task of establishing trust raises the question as to whether such a procedure should be done without the consent of the child. Is it acceptable that a parent decide for their baby that he must endure such intense physiological reaction and stress? What about potential long-term consequences? Since infants do not speak verbally, we could wait until they can make an informed decision when they have reached the age of majority (usually 18-years-of-age). Behaviorally speaking, their screams and cries before, during, and after the circumcision procedure is an infant's only way of protesting. And, if we are to seriously accept an infant's movement, facial expressions, and overall behavior as genuine communication, then their bodily protest to circumcision should be enough to tell us that the procedure is unwanted. To view this surgical procedure both youtube.com and the film *Birth As We Know It* are fine sources.

While we are considering the informed consent, stress, and pain debate, it is interesting to remember that only recently has the allopathic medical community acknowledged that infants actually feel pain. In the past, it was "believed that they have no memory of pain and that pain cannot be assessed objectively in nonverbal patients" (Gardner, 1994, p.85). The whole idea of an infant's ability to remember stress and trauma has yet to be fully accepted by the majority of

allopathic medical practitioners. Seasoned trauma therapists as well as those in the field of prenatal and perinatal psychology understand this to be true, as the nervous system and implicit memory faculties are functioning at birth (Siegel, 1999).

One source that promoted infant circumcision listed many health and hygiene benefits without showing the low percentage difference between the circumcised and uncircumcised. Medicirc.org states that "circumcision performed after the newborn period is more complicated and traumatic, there are fewer qualified operators and general anesthesia may be used, increasing the risk of complications" (Schoen, 2007). Concern has been expressed about claims that circumcision after the newborn period is more traumatic. There seems to be nothing available to support these claims.

Professor of Pediatrics, Dr. KJS Anand (2008), in his Canadian Medical Association Journal publication regarding vaccinations, circumcision, and other trauma, makes the following statement, "Acute pain caused by skin-breaking procedures can lead to physiological instability and behavioural distress, and it has downstream effects on subsequent pain processing, development, and stress responsivity ….prevention of pain are worthwhile clinical goals" (p.11). When circumcision cannot be prevented altogether, pain relief is crucial for neonates. EMLA, a local anesthetic, is reported to be safe for use with newborns, and skin-to-skin contact with the mother during a procedure decreases pain behaviors associated with painful stimuli (Zempsky and Cravero, 2004).

Gardner (1994) wrote a wonderful article, Pain and Pain Relief in the Neonate, to provide nurses the signs of stress and pain in neonates. She provides lists and charts to help people understand the responses they are seeing in a neonate and determine appropriate and effective treatment. Reinforcing Anand's findings, Gardner states:

> Neonates, full-term and premature, exhibit physiologic, hormonal, metabolic, and behavioral responses to surgical procedures that are similar to, but more intense, than adult responses. Pain relief benefits the neonate by decreasing physiologic instability, hormonal and metabolic stress, and the behavioral reactions accompanying painful procedures. (p.85)

In summary, this short review of the literature demonstrates that infants have the capacity to feel pain, and that avoiding the experience of painful events is recommended. The circumcision decision should not be taken lightly. It is a major surgical procedure. Since the

allopathic medical community does not deem circumcision to be absolutely necessary, it is up to each family to decide how they will approach the issue. This takes into account the decision to include or ignore the individual choice of the infant.

Discussion

In regards to circumcision, what are the possible greater outcomes of one such decision? If we are to accept that an infant remembers, as research findings continuously demonstrate, then we must also accept that there may be developmental consequences regarding early events. Among those of the Jewish faith, circumcision is performed on the eighth day after birth. While still very young, the infant's nervous system and non-declarative memory processes are functioning (Siegel, 1999).

Can early experiences affect developing attitudes, fears, expectations, and anxieties? Pre- and perinatal psychologists would claim they do. Early experiences pave the way for future interactions; they form patterns and imprints. This is not only psychological, but neuro-biological and physiological as well.

All systems are inter-related. For example, the physiological stress of surgery floods the body with adrenaline hormones, thus affecting neurological and endocrine systems: one's biology. Mental perceptions are then formed based on the experience and outcomes of that experience. Siegel (1999) reminds us that brain "structure and function are directly shaped by interpersonal experience" (p.1). This impacts behavior and future relationships. The potential lack of attachment formation, and unconscious and unresolved emotional issues are just the tip of the iceberg of the impact stress and trauma can have.

Conclusion

It is my suggestion that we strongly reevaluate the meaning of our current practices and determine the long-term impact of common cultural and medical rituals. Is circumcision worth it? From having just examined a variety of sources, it appears to be unnecessary and risky business. If circumcising a newborn is the desired outcome, I advise the parents to request that a local anesthetic be used to provide pain relief, and to be in proximity to the child during the procedure, so that a gentle voice and touch is simultaneously experienced.

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Childbirth in the Land of Utopia

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Abstract: In this creative look into the future, the author offers a scenario in which giving birth without medical intervention is deemed to be ideal. The scene starts in the year 2010 with an interdisciplinary conference to discuss the need to control the rate of caesarean birth. The effects of the Utopian attitude are evaluated in 2031. Interestingly, outsiders had been at the root of the miraculous solutions unanimously adopted in this country. This essay presents a thought-provoking approach that will have you creating your own version of Utopia.

Keywords: Caesarean, primal health, birth psychology

As everybody knows, our country - Utopia - is an independent territory.

In spite of our high scientific and technological level, we have maintained, and even developed further, our main cultural characteristics. In particular, we have developed our capacity to make unrealistic projects and to transcend the limits of political correctness. We shall illustrate the specific details of the Utopian with the history of childbirth.

In 2010 two local celebrities had chosen to give birth by caesarean. This is how childbirth suddenly became one of the main topics for discussion in the media. Everyone realized that every year the rate of caesareans was higher than the year before. The dominant opinion was in favour of authoritarian guidelines by the Utopian Health Organization (UHO). To face such an unprecedented situation the

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Editor's Note: This essay is reprinted with permission of Michel Odent, MD, Director, Primal Health Research Center in London and Editor of the newsletter Primal Health Research, published in North and South America by Birth Works, Inc., Medford NJ. APPPAH is pleased to support increased circulation by reprinting Dr. Odent's essays as a feature in the pages of this journal. Free access to the Primal Health Research Data Bank is provided at www.primalhealthresearch.com. Email for Dr. Odent is: modent@aol.com

Head of the UHO decided to organize a multidisciplinary meeting. A statistician spoke first. He presented impressive graphs, starting in 1950, when the low segmental technique of caesarean replaced the classical technique. According to his extrapolations it was highly probable that after 2020 the caesarean will be the most common way to give birth. A well-known obstetrician felt obliged to immediately comment on this data. He claimed that we should look at the positive aspect of this new phenomenon. He explained how the caesarean had become an easy, fast, and safe operation. He was convinced that in the near future most women would prefer to avoid the risks associated with a delivery by the vaginal route. To support his point of view about the safety of the caesarean, he presented a Canadian study, published in 2007, of more than 46,000 elective caesareans for breech presentation at 39 weeks with zero maternal death, and an American study, published in 2009, of 24,000 repeated caesareans with one neonatal death. He explained that, in many situations, an elective pre-labor caesarean was by far the safest way to have a baby. While concluding that "we cannot stop progress," a midwife's body language suggested, that there was something the doctor had not understood.

A very articulate woman, the president of BWL (Association for Birth With Love) immediately reacted to the conclusion by the doctor. She first asked him which criteria he was using to evaluate the safety of the caesarean. Of course he mentioned just perinatal mortality/morbidity rates and maternal mortality/morbidity rates. Then the president of BWL explained that this limited list of criteria had been established long ago, before the 21st century, and that a great diversity of developing scientific disciplines was now suggesting a list of new criteria to evaluate the practices of obstetrics and midwifery. This was the turning point of this historical multidisciplinary meeting.

The Professor of hormonology immediately echoed this eloquent and convincing comment. After referring to an accumulation of data regarding the behavioral effects of hormones involved in childbirth, he could easily convince the audience to conclude that, to have babies, women had been programmed to release a real "cocktail of love hormones." During the hour following birth, he illuminated how the maternal and fetal hormones released during the birth process are not yet eliminated and each of them has a specific role to play in the interaction between mother and neonate. In other words, he added, thanks to the hormonal perspective, we can now interpret the concept of critical periods introduced by behavioral scientists: some pioneers in this field had understood, as early as in the middle of the twentieth century, that among all mammals there is, immediately after birth, a

transient period of time that will never happen again and that is critical in mother-baby attachment. He dared to conclude that, by combining the data he had provided with the result of countless epidemiological studies suggesting that the way we are born has life-long consequences, it was clear that the capacity to love develops to a great extent in the perinatal period. The obstetrician was gaping at him.

After such conclusions by the Professor of Hormonology, the head of the department of epidemiology of UHO could no longer remain silent. This epidemiologist had a special interest in "Primal Health Research." He had collected in particular hundreds of published studies detecting risks factors in the perinatal period for a great diversity of pathological conditions in adulthood, adolescence, or childhood. He offered an overview of the most valuable studies, particularly those involving huge number of subjects. He summarized the results of his enquiries by noticing that when researchers study, from a Primal Health Research perspective, pathological conditions that can be interpreted as different sorts of impaired capacity to love (to love others or to love oneself), they always detect risk factors in the perinatal period. Referring to the comments by the president of BWL about the needs for new criteria to evaluate the practices of obstetrics and midwifery, he emphasized the need to think long term. Finally, he presented the Primal Health Research Databank as a tool to train ourselves to think long term.

Then a geneticist impatiently raised her hand. She presented the concept of "gene expression" as another way to interpret the life-long consequences of pre- and perinatal events. She explained that among the genetic material human beings receive at conception, some genes will become silent without disappearing. The gene expression phenomenon is influenced in particular by environmental factors during the pre- and perinatal periods. The obstetrician was more and more attentive and curious, as if discovering a new topic. One of his judicious questions about the genesis of pathological conditions and personality traits gave the geneticist the opportunity to explain that the nature of an environmental factor is often less important than the time of the interaction. She explained the concept of critical period for gene-environment interaction. The presentation by the geneticist induced a fruitful interdisciplinary conversation. The epidemiologist jumped on a question by a general practitioner to provide more details about one of the new functions of the Primal Health Research Database, which is to give some clues about the critical period for gene-environment interaction regarding different pathological conditions or

personality traits.

A bacteriologist, who had kept a low profile since the beginning of the session, emphasized that the minutes following birth are critical from his perspective as well. Few people had previously understood that at the very time of birth the newborn baby is germ-free and that some hours later millions of microbes will have colonised its body. Because the antibodies called IgG cross easily the human placenta he explained that the microbes familiar for the mother are already familiar for the germ free newborn baby, and therefore friendly. If the baby is immediately invaded by friendly germs carried by the mother, it is protected against unfamiliar and therefore potentially dangerous microbes. He commented that when babies are born via the perineum, it is a guarantee that they are first contaminated by a multitude of germs carried by the mother, compared with babies born by caesarean. In order to stress the importance of the question, he mentioned that our gut flora is, to a great extent, established during the minutes following birth: useful considerations at a time when we are learning that this intestinal flora represents 80% of our immune system.

The bacteriologist agreed, when an infant-feeding adviser added that, in the right environment, if mother and newborn baby are not separated at all, there is a high probability that the baby will find the breast during the hour following birth and will consume the early colostrum with its friendly germs, specific local antibodies, and anti-infectious substances. The consumption of early colostrum probably has long-term consequences, at least by influencing the way the gut flora is established.

The head of UHO was obviously happy with the progress of the interdisciplinary meeting he had organized. He asked an old philosopher, considered the wise man of the community, to conclude. The philosopher explained that we should not ignore a specifically human dimension and that we must, first and foremost, think in terms of civilisation. He referred to the data provided by the epidemiologist. Among the studies he presented, huge numbers had often been necessary to detect tendencies and statistically significant effects. This is a reminder that, where human beings are concerned, we must often forget individuals, anecdotes and particular cases, and reach the collective and, therefore, cultural dimension. From what had been heard during this meeting, it was clear that humanity was in an unprecedented situation that he summarised in a very concise way. Today, he said, the number of women who give birth to babies and placentas thanks to the release of what is a real cocktail of love hormones is approaching zero. What will happen in terms of

civilisation if we go on that way? What will happen after two or three generations if love hormones are made useless during the critical period surrounding birth?

After such an eloquent conclusion the head of the UHO asked the participants their point of view about the necessity to control the rates of caesarean. Everybody, including the obstetrician, found the need for action necessary, even urgent.

This is how a second meeting was planned in order to find effective solutions.

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At the beginning of the second meeting the head of UHO asked the participants if they had solutions to suggest in order to control the rates of caesareans and other obstetrical interventions. The obstetrician presented a project "to assess the effectiveness of a multifaceted strategy for improving the appropriateness of indications for caesarean." Nobody paid attention. A recently graduated young doctor spoke about the need to reconsider the education of medical and midwifery students. The head of the midwifery school immediately replied that all over the world there have been many attempts to renew the education of midwives and doctors, including specialised doctors, without any significant positive effects on birth outcomes. Several participants spoke about financial incentives to decrease the rates of obstetrical intervention. The head of UHO intervened and stressed that, since this solution had been unsuccessfully tried in several countries and, furthermore, that the rates of c-sections were increasing in all countries whatever the health system: we should therefore look at other factors. He added that the risk would be to increase the incidence of long and difficult births by the vaginal route with an overuse of pharmacological substitutes for the natural hormones. This effect would be unacceptable at a time when the c-section has become such an easy and fast operation. The priority should be to try first to make the births as easy as possible in order to reduce the need for obstetrical interventions in general.

Unexpectedly, the turning point in the discussion occurred when a neurophysiologist - internationally known for her studies of the behavior of mantis religiosa, a variety of praying mantis - intervened for the first time. She explained that by mixing her scientific studies and her experience as a mother, she had acquired a clear understanding of the basic needs of laboring women. In general, she said, the messages sent by the central nervous system to the genitalia

are inhibitory. She understood this simple rule when studying the mating behavior of *mantis religiosa*. During sexual intercourse in this species the female often eats the head of the male, a radical way to eliminate inhibitory messages! Then the sexual activity of the male is dramatically reinforced and the chances for offspring conception are increased. She had understood that the inhibitory effect of the central nervous system on all episodes of sexual life is a general rule. She had many occasions to confirm this rule and, interestingly, she understood that still more clearly after giving birth to her first baby. She is convinced that the reduction of her neocortical activity was the main reason why this birth was so easy and fast. She recalled that human beings are characterised by the enormous development of this part of the central nervous system called the neocortex. Her neocortex was obviously at complete rest when she was in established labor, since she had completely forgotten many details about the place where she gave birth. She remembers vaguely that she was in a rather dark place, and that there was nobody around but a midwife sitting in a corner and knitting. She also remembers that at a certain phase of labor she was vomiting and the midwife just said, "this happened to me when I had my second baby, it's normal." Although this is imprecise in her memory, she is convinced that this discreet comment with a whispering motherly voice had facilitated the progress of labor. With this experienced and calm mother figure she could feel perfectly secure. She can understand in retrospect that all the conditions were met to reduce the activity of her neocortex. She could feel secure without feeling observed, in semi-darkness and silence. So, her practical suggestion, after combining what she learned as a neurophysiologist and what she learned as a mother, was to reconsider the criteria used to select the midwifery students. The prerequisite, to enter a midwifery school of the future, would be to have a personal experience of giving birth without any medical intervention and to consider this birth as a positive experience.

The obstetrician was not comfortable with this suggestion, claiming that he had been working with wonderful midwives who were not mothers. The head of the midwifery school retorted that everybody knows good midwives who are not mothers. However, her duty is to offer the guarantee that the midwives graduated in her school share such personality traits that their presence close to a birthing woman will disturb the progress of labor as little as possible. This is why she cannot imagine better criteria than those suggested by the neurophysiologist. *Because this suggestion was outside the usual limits of political correctness, it was immediately considered by almost*

everybody as acceptable in the land of Utopia.

Then a male voice was heard from a corner of the room. It was the voice of the young technician whose role was to record the session: "As an outsider, can I ask a naïve question? What if the prerequisite to be qualified as an obstetrician would also be to have a personal experience of giving birth without any medical intervention and to consider this birth as a positive experience"?

At that time it was as if everybody in the room was in the situation of Archimedes shouting 'Eureka!'…An unforgettable collective enthusiasm! It was immediately obvious for all the participants that such a project was unrealistic enough to be adopted without any further discussion and without any delay in the land of Utopia.

A committee was immediately set up, in order to organise a 15-year period of transition.

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Today, in January, 2031, we can offer valuable statistics, since the period of transition was over in 2024. These statistics are impressive.

The perinatal mortality rates are as low as in all countries with similar standards of living. The rates of transfers to paediatric units have dramatically decreased. There has not been one case of forceps delivery for four years. Since the priority is to avoid long and difficult labors by the vaginal route, the use of ventouse and the use of drugs are exceptionally rare. More importantly, the rates of caesareans are three times lower than before the period of transition. The rate of breastfeeding at six months is above 90%. A paedopsychiatrist has already mentioned that autism is less common than in the past. If the respected philosopher – the wise man of the community – was still alive, he would state that now, in the land of Utopia, most women give birth to babies and placentas thanks to the release of a "cocktail of love hormones."

The new head of UHO and his teams prepared articles for different sorts of international media. They launched a "call for 5-words slogans," in order to urgently spread the word in a concise and effective way. This is the selected slogan:

ONLY UTOPIA CAN SAVE HUMANITY!

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Book Reviews

The Emotional World of the Fetus. By Gajanan Kelkar (2009). Lonavla, Maharashtra State, India: Manashanti New Way Ashram (http://www.manashakti.org)

An entertaining and inspirational handbook on *The Emotional World of the Fetus* by Gajanan Kelkar (2009) has been born at the unique Manashakti Research Center, in Lonavla, India where the author directs one of the most popular programs of prenatal education in the world today. The program which has been developing during the last 25 years weds a classical tradition of mind cultivation with modern principles of prenatal psychology and uses systematic measurements to verify the benefits and rewards which come to parents and babies alike.

Highly favored courses include a 3-day residential study course on Fetal Potential which began in 1994 and grew in the first six years to include 36 classes for over 7,000 participants; it is now taught six times a year at the Research Center. The Prenatal Education Workshop for couples which began in 2002 and has already grown to 270 workshops and involved 13,500 couples; this course is offered monthly in more than twenty towns throughout the State of Maharashtra and is taught in both the local language and in English.

The handbook, just published, joins an innovative Prenatal Education Kit, packed with eight resources including an audio CD of music for the unborn, a video CD of Yoga exercises to be performed during pregnancy, a booklet of classic prayers and blessings, a Prenatal Record Book, and other illuminating articles about enlightened parenting in India.

Kelkar's manual of 156 pages is remarkably compact, comprehensive, and readable, yet soundly based on up-to-date principles and understandings of birth psychology. The Appendix of five documents contains detailed information about their programs, research projects and findings, measuring instruments, tests,

questionnaires, AND a page of photos of some of their happy babies!

For prices, availability, and other information, you can email the author and director at: gsk@manashakti.org or kelkar@mac.com.

Reviewed by David B. Chamberlain

The Secret Life of Babies: How Decoding the Cultures of Birth, Love, and Violence Begins with Recovering the People We Once Were, by Mia Kalef. 2008. Vancouver, B.C.: Emerging Families (www.emergingfamilies.com). 299 pp. ISBN: 978-0-557-00793-6.

Here's the deal: The public's reaction to *The Secret Life Of Babies* will depend on the needs and intentions of individual readers.

Dr. Kalef's book is a work of art. It is full of tales that ring true, that make sense, that are full of heart, and that smack of authenticity. It will support ideas about early experience—fledgling or well-formed—that already resonate in the reader.

What this marvelous piece of storytelling and testimony is not is a scientific treatise. It will not convince the doubting. And it could have used a good copy editor, who might have eliminated the distracting errors in spelling, punctuation, grammar, and syntax.

This is a letdown only to those of us with one leg in science and one leg in clinical practice, who have been waiting for a book in pre- and perinatal psychology that can change minds, that can capture the attention (and respect, perhaps) of the medical/scientific/left brain world that wields such power over the lives of babies and their mothers and fathers.

If the reader has different expectations from this book, it sings. The author writes, on her website, "This fascinating collection of scientific data and case studies reflects the very real need for culture to revamp how it views infant intelligence." There is no bait-and-switch here, for this is exactly what Dr. Kalef delivers, in sweet, literary, delightful, and compelling forms.

Indeed, the author anticipates the issue by spending the first several pages in a clever tale about a time when *The Scientific* and *The Experience* were great lovers. Alas, they were separated, each huddling in its own world, temporarily forgetting—or defensively resisting—the other. She suggests that the time has come for a reunion; only then will each notice *The Knowledge* between them.

It will dawn on the reader, part-way through, that this book is about grownups, not babies—or, more precisely, about *grownups who*

were once babies, which pretty much takes care of all of us. The author does not hide the fact: "In truth, this book is not just about Babies… It's about me and you, and how our earliest experiences not only shape our health, but also collectively shape this powerful and delicate world we inhabit. If we can get the 'secret' out of the lives of babies, I suspect we will live in a world we've all been waiting for."

Kalef masterfully mixes personal and clinical experience with current literature throughout, saturating the reader with a sense of the continuity of our lives and the meaningfulness of our adult behavior. Consciousness, imprinting, memory, birth practices, neurology, body chemistry, anthropology (the discussion of the "Dominance Culture," with implications for our relationship with each other, and with nature, is worth the price of admission, all by itself) and even ethology are brought into conversations about suicide, war, pain, attachment, and healing. Not content to let us simply sit around the fire with her, considering these matters of soul and development, the author brings it home with a careful and systematic description of *What To Do*. Her Intuitive Recovery Project—an avenue into understanding and trusting ourselves, so we can understand and support babies—is rolled out in forms both logical and lyrical, and always convincing. No one will be left wondering about what the necessary courses of healing look like: from recapitulation to owning one's own life; from an infant's display of an imprint to release from it (with gentle story-telling, play, and other loving support from a parent); from unconsciousness of one's early experience through awareness, full-bodied grief, reconciliation, and relief.

Kalef's final lines make clear the point of the book: "Let's start at the beginning when we go to foster what we want to see in the world. And if it was missed, let's go back to the beginning to where it happened and love that place in ourselves until the last drops of tears are soaked in love." She guides us well.

Reviewed by Michael Trout

The Art of Giving Birth by Frederick Leboyer (2006). Rochester, Vermont: Healing Arts Press. ISB N-13: 978-1-59477-276-4.

I've admired Frederick Leboyer for years. His earlier book, *Birth Without Violence* (1975), has had lasting impact on pre & perinatal issues, not only did it help change the way many people viewed babies' experiences of coming into the world, but also helped the birthing

community begin to rethink their methodology. He advocated making birth a more humane experience for both the mother and newborn. While the conversational tone might seem dated, *Birth Without Violence* is a must read. When *Birth Without Violence* was first published, it was assumed that infants had no emotional life, and that what was done to them would have no bearing on their long-term wellness. What Dr. Leboyer helped to do, was introduce the radical notion that babies have feelings and what we do to them affects them.

That being said, upon reading Dr. Leboyer's book, *The Art of Giving Birth* (2006), I am struck by how many years of fighting the good fight (he is 92-years-old this year) seems to have worn down his patience for the mother's process. The beginning of the book includes letters written to Dr. Leboyer by mothers either asking questions or expressing gratitude. There were a few moments, while reading this that I was startled by his tone. Several of his responses are short tempered, and condescending, i.e., "Your partner's hand in yours? No! Do you need your mother when you're lying in your lover's arms? The first time, perhaps, you were a little anxious. But you didn't shout out 'Help! Mom!' did you?"

However, in spite of the tone of this one section, overall Dr. Leboyer provides some vital tools for birth. The techniques laid out in *The Art of Giving Birth* are foundational concepts, which are easy to manage during one of the most primal moments a woman experiences in her life. *The Art of Giving Birth* is a quick read, which will appeal to new parents who are often overloaded with reading recommendations during their pregnancy. Something that is easy to absorb is often a relief, while providing valuable tools for managing pain during labor. Dr. Leboyer provides chanting, breathing, and movement methods for regulating both pain and the body's processes. Chanting and breath control are forms of meditation that can create an altered state of consciousness that lowers the production of stress hormones, like cortisol, which helps modulate the mother's experience of pain. The CD (a recording of the tambura, a drone instrument that encourages the altered state of consciousness) included with the book is an excellent soundtrack to use both for practice and during labor – it has two tracks on it, one to practice along with and one to use during your labor. Like all birthing techniques, using chanting to regulate pain relies on having practiced ahead of time and having the CD along with the pictures makes that easy.

When I recommend this book to my clients, I usually add a disclaimer as I have had a few of them come back to me offended by his tone. I suggest saving the letter section for last as I believe Dr.

Leboyer has created a straightforward and accessible tool that is absolutely worth reading. It provides supportive techniques that are easy to understand and practice, while the tone can at times seem harsh, the information will indeed help women have better, healthier birth experiences, and families will be better off for it.

Reviewed by Sabrina Roberson

The Art of Conscious Parenting – The natural way to give birth, bond with, and raise healthy children by Jeffrey L., Ph.D, with Dalit Fine, M.S. (2009) Rochester-Vermont: Healing Arts Press. ISBN-13: 978-1-59477-322-8

The name of this book says everything – conscious parenting is indeed a kind of art, which demands patience, sensitivity, feeling, intuition, study, techniques, and lots of practice from parents. Most of all, in order to master the art of parenting, parents need to be aware that the baby is going to become an adult someday, who will develop skills and emotional patterns based on his early and primary experiences in life.

Experts in Humanistic Psychology, Dr. Jeffrey and Dalit Fine were motivated to write this book based on their personal experiences as parents. The book is full of references to their journey in becoming conscious parents. They reveal what motivated them to give birth to their son Keseem, who is now 10 years old, and their decision to raise him in a completely different way from what is commonly seen in our society today. They wanted to share their experiences, observations, and learning about what conscious parenting is and why natural approaches in the beginning of a child's life are so important. The fact that the authors share many of their personal experiences and other parents' positive experiences at different developmental stages makes it easy for the readers to relate to. Not only as parents but also as human beings, readers learn how they can apply what the authors suggest in their own lives.

The authors provide excellent information on emotional development – linking between experiences during early childhood and the consequences for the future adult. The authors talk about the importance of planning and preparing to become a parent. They also explain that the period between conception and the first years of the child is the most important phase of life. It is a unique and very specific biological moment that only happens once in a lifetime thus

determining the basis for an individual's physical and mental health, his capacity for love and many other emotional skills. One of the most interesting topics presented in the book is the notion of education beginning in the womb and exploring the abilities the fetus can develop during this period. Since we are educating the human beings who will be responsible for building our next generations, the authors help us to consider the potential of how our way of parenting and every choice we make as parents, contributes to society. They call this approach "green parenting." At the end of the book, the reader will find many suggestions for further research such as books, websites, and videos, divided and related to the main subjects presented.

This book is a great gift for people who are thinking about having children. It is perhaps best read before conception, since it can help people to reflect on what it really means to become a parent and on the responsibility of raising a child. As a Prenatal and Childbirth Educator, I consider this book a must-read, parents or not, as it provides great information and insight on the effects of parenting on the whole. Considering that families and children are central in our lives, the authors' message empowers readers to better understand and contribute to what is unfolding in our world.

Dr. Jeffrey and Dalit Fine also have a website called "The New Parenting Club" (www.thenewparentingclub.com), where they talk about their work as therapists and also offer many articles about the subject of parenting. As a Prenatal and Perinatal Psychologist, I am very thankful to Dr. Jeffrey and Dalit Fine for sharing their experience and knowledge with us and I hope that conscious parenting becomes a common reality.

Reviewed by Josie Zecchinelli

The Tibetan Art of Parenting - From Before Conception through Early Childhood by Anne Maiden Brown, Farwell, E., and Nyerongsha, D. (2008). Wisdom Publications, Boston USA 2008. ISBN 0-86171-579-9.

It seems so apt that this fascinating book is the product of a dream that came in the night to Anne Maiden Brown telling her that it is time for the world to know about Tibetan birth. This worthy project was further fuelled by the same author's need to heal from the (all too common) trauma of giving birth, western obstetrics style, at hospital in the USA.

The authors' information is drawn largely through intimate contact with Tibetan refugee communities, mainly in Dharamsala, northern India, where traditional Tibetan practices were free from Chinese Communist domination found in much of current-day Tibet. It is also drawn from traditional Tibetan medical texts, some dating back to eleventh century, and their interpretation by modern day practitioners of traditional Tibetan medicine. Some of these ancient texts detailed the unborn child's anatomy, function, and development with astonishing accuracy – prescientient of modern technology's images by centuries. The overall narrative follows seven stages of development, from preconception to early childhood, as determined by Tibetan wisdom.

At times, Western parenting appears almost dismissive when contrasted to the attentiveness of Tibetans, even before their child is conceived. The reader is treated to a delicate and elaborate array of traditional and spiritual preparations, enacted by Tibetan would-be parents, aimed at inviting a new soul into the womb. There are obvious health and psychological benefits of eating more nourishing and healthier foods, reciting special mantras, and taking part in special rituals. What is particularly moving is the Tibetan commitment to dialogue with the unborn right from the beginning. This is a desperately needed lesson in the West, where until very recently the unborn and infants were not seen as persons; thought to have no mind or memory, and thought to feel no emotion and no pain. Tibetans have for centuries intuited what in the West we have depended on scientists to confirm.

Given the lavishness of Tibetan purification rites during and before gestation, it is clear that Tibetan children are deeply wanted and considered a privilege. Parents adopt a deep sense of karmic purpose, as the soul of each child is said to choose them specifically before birth. An assumption of rightness and destiny makes every birth a welcome one. What a magnificent way for any individual to begin a new life!

I could not help comparing the Western propensity for a relationship to the fetus that is often intrusive and medical; we look for malformations and imperfections rather than seeking to nurture and converse with the in-utero presence. I read with envy of Tibet's ancient recognition of a totally functioning individual consciousness from the 21st to 25th week of gestation – a fact that Western science has flatly (and catastrophically) denied until recently. Tibetan intuitive sciences have foretold modern developmental neuropsychology.

Tibetans have valued healthy gestation because they see how this produces compassionate, wise, and caring individuals. Pregnant

mothers are treated to massage and bathing, a surely pleasurable and nurturing program. Tibetan governments of old would assist by providing community- based care and naturally fortifying medicines. Birth is considered natural, and of profound religious importance. It was never considered a terrifying ordeal fraught with medical perils as it has been in the West. Mothers at labor are free to move around, squat, or kneel for the delivery, as Tibetan midwives understand that such natural and spontaneous movement can ease and hasten labor. Most Tibetan babies are born at home, aided by midwives, family, and even siblings. Fathers are welcome at birth, and in fact their role is considered sacred. As soon as a Tibetan child is born, he or she benefits from full recognition and dialogue, unlike so many Western babies whose cries are methodically and casually ignored.

Many Tibetan ritual practices aimed at protecting the children from "bad spirits," and the preoccupation with good and bad omens surrounding birth and early childhood would seem puzzling and superstitious to the Western mind. Perhaps such "superstitions" act as a focus for parental anxieties; a way to rationalize the real possibility of illness and loss. It might be tempting to dismiss the colorful plethora of Tibetan superstitions as quaint and infantile - until we look at the obscene over-medicalization of birth in the West, with our absurd rates of cesarean section, our frantic over-reliance on drug cocktails, and our violently unnatural interventions. Which of our cultures is the more superstitious? Birth is precarious everywhere, and human fear can lead to all kinds of obsessions.

I was relieved to discover that this book sidesteps the all-too common trap of romanticizing and idealizing the ancient and the traditional. Not all is rosy in Tibetan parenting lore. For instance, in parts of Tibet parents once customarily denied their infants colostrum, as it was deemed impure. This surprising practice has been documented in dozens of cultures around the world, despite the critical immunological and psychological purpose of immediate post-natal breastfeeding. Some Tibetan witch-lore is disturbingly misogynist and harmful to women. The natural intensity of children's emotion is distrusted by Tibetans, passion is quelled and anger is devalued and suppressed in the belief that this will reduce conflict and violence. It is hugely ironic that, in the name of "discipline," Tibetans rely on spanking and other forms of corporal punishment. While espousing a respect for all life forms and an abhorrence of violence, just as in the West, Tibetans justify their own violence when it is aimed at children. Nevertheless, when viewed through the lens of healthy infant attachment, Tibetan parenting on the whole seems exemplary, and

would fulfill the requirements of any modern attachment handbook for optimal neurological, immunological, and psychological development. From birth, babies remain in close contact with their mothers, and are, thereafter, continuously carried and worn on an adult's body. Babies sleep close to their parents and are massaged daily. Breastfeeding is on demand and continues for years. Fathers are closely involved and hands-on from the beginning. Children are rocked, sung to, encouraged to play, and held securely in a web of loving community.

At the root of this comparatively gentle and profoundly attentive parenting style is the Tibetan belief that children are born in a state of purity – a view diametrically opposed to the Judeo-Christian concept of original sin that has animated harsh Western child-rearing practices to this day. The fruits of these two polarized assumptions are easily contrasted: which of the two parenting approaches have produced the more gentle culture?

The Tibetan Art of Parenting is full of inspiration and affirmation for parents and practitioners everywhere who seek examples of compassionate and natural approaches to child-rearing. In following their prophetic dream, the authors have delivered an invaluable gift.

Reviewed by Robin Grille

Get me out: A History of Childbirth from the Garden of Eden to the Sperm Bank by Randi Hutter Epstein, M.D. (2010). NY, WW Norton and Company, Inc., 302 pages, ISBN 978-0-393-06458-2

Having been immersed in birth psychology studies for the past three years, I was delighted to happen upon a National Public Radio program where the interviewer was engaged with Randi Hutter Epstein regarding her new book on the history of childbirth. This book covers a vast amount of history, or *Herstory*, if you will, and contains mind-boggling facts about obstetrical and gynecological practices, discoveries, contraptions, devices, and interventions. While those of us involved in the field of birth psychology may be dismayed with much of what goes on in today's Western world regarding conception, pregnancy, and birth, the detailed chronology of past ideas, views, and interventions often makes many of today's interventions seem like a cake walk! Thankfully, the author has a wonderful ability to write with doses of appropriately placed humor to give the reader a chance to recover a bit from the rather gruesome history she covers.

It is not clear how much Hutter Epstein is aware of in regard to

birth psychology. She makes scant reference to various professionals believing that babies are conscious in the womb, but does not delve further into this arena in her book. However, at this point in time, when the original Baby Boomers are having their own second generation baby boom, there is a huge audience for such a highly accessible book.

Subjects that are covered in great detail in this book include: birth history from antiquity through the Middle Ages, tools used from the 1600s to the 1800s, contributions of enslaved women to gynecology, maternal mortality in the 20th century, the transition from home-birthing to hospitals and maternity wards, how twilight sleep came into vogue as part of the early feminist movement, toxic interventions such as DES and radiation, the advent of cesarean section, Freebirthers, the explosion of ultrasound, donor insemination, egg and embryo freezing, and more.

In her chapter outlining the advent of the cesarean section, we learn about the disturbing earliest attempts performed on kitchen tables. She clarifies that this major surgery in fact has nothing to do with the Roman ruler it is named for, and that it was re-named "section," rather than surgery, to make it more appealing to women. We learn that elective cesareans became popularized in the 1990's thanks to a well-known British pop star, who made headlines asking for one.

The author talks about *euthagenesis* referring to "good origin" – a word that was coined by Pat Carter, leader of the *Freebirthing* movement of the 1950s. After having her first babies delivered in hospitals with doctors and nurses in attendance, Carter opted to birth her following child at home without the regulations, restrictions, and humiliations she felt encumbered modern birth practices at that time. While Carter seems like a woman PPN professionals might champion, we also learn that she advocated for smoking, drinking highballs, minimizing calcium to make the baby's bones softer, and boned corsets during the pregnancy. Another woman to revolutionize pregnancy and childbirth was Lithuanian immigrant, Lane Bryant, of plus-size women's clothing fame. In the early 1900's Bryant created the first line of maternity wear, which was a welcome alternative to the popular tight corset fashions of the day. An interesting side note, since the word *maternity* was considered obscene it took some time for Bryant to find a way to advertise her line of clothing.

We learn that in 1836 childbed fever was treated with laxatives, chloride douches, and leeches, which sometimes got lost in the womb. A *suffocated* womb could not keep a pregnancy and it was thought that scaring the uterus into position would help. One method of scaring the

uterus involved creating a horrible stench by inserting animal dung and menstrual blood into the vagina, while a more pleasant method involved visiting an obstetrix who brought the woman to orgasm.

Men were not ignored in Hutter-Epstein's book either. Once hormones were discovered it seems that in the later 1800's men injected themselves with guinea pig and dog testicles for hormone rejuvenation, and that later in the 1920's, goat testicles were used for male virility. At one point, men sipped monkey sperm as a "pick me up." How these animal parts were procured and formulated for injections or cocktails we are not told.

All in all, I applaud Hutter Epstein for a book that proves to be a great read for people in the PPN field as well as the general public. We see how humans throughout time are full of creative ideas, contradictions, folly, and greed, and we see the persistent wish to ease pain in childbirth even though many of the devices and methods created over time may seem ridiculous or horrifying to a contemporary reader.

Reviewed by Ellynne Skove

The Birth of Hope by Jeane Rhodes, PhD (2009) 359 pages. Lakewood, CO: CreateSpace. ISBN 978-1449506551.

This is the story of Justin and Tasha, two teens in the foster care system who find each other while in high school and become friends through their common interest in books. One day their mutual need for closeness leads to an exploration of sex. They soon discover that they are going to have a baby. The story takes the reader through Tasha's struggle to summon the courage to tell her foster parents and her social worker in the foster care system that she is pregnant. The reader is able to experience Tasha's world of feelings, concerns, and fears through the words in her journal. Her therapist introduces her to prenatal and perinatal information and encourages bonding exercises with her baby. The baby, who Tasha and Justin decide to name Hope, becomes the symbol of hope not only for the teen parents but also for their foster families.

The story provides a lens into the foster care system and the vital importance of a supportive community for teens who are pregnant, and their foster parents. The narrative takes us through Tasha's complicated life and the numerous roles she has had to take on in the short span of her childhood and teen years. We learn about her role as

a mother figure for two of her younger siblings while in foster care, her determination to see her pregnancy through, her desire to become a mother and a wife, and her continued role as a student attempting to complete her education.

Through Tasha's experience we gain insight about Hope's coming to be in this world, her first movement, and her continued growth until delivery. Justin and Tasha, in spite of their young age and many challenges, work to gain knowledge regarding the resources available to them through the foster care system and their foster parents. In the process of finding support and increasing respect from others for their desires, the teens learn to make informed and thoughtful decisions – including difficult choices about their life as well as the life of Hope.

The story provokes the reader to think about the importance of prenatal and perinatal care and the impact of care on the development of the baby while in utero. Complicated topics of abuse, multi-generational teen pregnancy, and the loss of Justin and Tasha's parents are addressed throughout. The significance of working through these difficult topics with a therapist takes on greater meaning as it helps the teen parents increase their ability to attune to their unborn child and their own wants and needs.

Rhodes effectively invites the reader into the thinking process and the emotional dimensions of teens. She helps us to think about their need for guidance and assistance in creating the slowed down mind set required for making life-altering decisions. The story is moving, informative, and dynamic. It creates a sense of possibility for what any professional would want for their teen clients as well as parents of children within the foster care system. The reader will come to respect and admire the teens and their families. Through Justin and Tasha, we are given the opportunity to share in the experience and struggles of life and loss and to celebrate the birth of Hope.

Reviewed by Margaret Matson

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