

CAESAREAN BIRTH: PSYCHOLOGICAL ASPECTS IN ADULTS

Rien Verdult

Psycholoog-psychotherapeut

ABSTRACT

The number of c-sections is rising all over the world. Non-medical reasons play a major role in these rising figures. Diagnostic criteria are more and more broadened. Maternal reactions to giving birth by caesarean depend on the mother's attitude towards her motherhood. Emergency c-sections are mostly experienced as traumatic. Birth and caesarean birth can have long lasting effects on personality. There seem to be indications for a caesarean personality. In prenatal psychotherapy with adult themes connected to being born caesarean can be distinguished and can be treated.

Keywords: caesarean birth; indications; personality; psychotherapy

Introduction.

Technologically assisted reproduction is changing the traditional sequence and meaning of conception, labour and delivery. C-section can be considered one the earliest forms of modern birth technology. In many countries all over the world c-section birth rates are rising. In some countries, like Brazil or Taiwan, caesarean birth rates are skyrocketing up to 60%, because giving birth this way is considered to be fashionable. In the USA more than one million women , 1 in 3, give birth by caesarean every year. In 2007 the Belgian medical profession was very 'proud and delighted' because in 2007 the average c-section rates dropped from 17.5% to 17%. For many years the WHO is warning against the rising caesarean births. The WHO has stated that about 10 to 15% of all births should be c-sections (Wagner, 1994). This raises the question about what factors play a role in rising c-section rates and in these differences. There are multiple reasons for the rise of c-section rates. According to Kennare (2003) factors that influence the growing c-section rates are: the growing average age on which women get there first baby: the older the woman the more c-sections; the reduction of the average number of children a fertile woman gives birth to: the

fewer children the more c-sections; better insured woman get more c-sections; the higher the socio-economic status of the woman the higher the c-section rate; medical protocols like: once c-section always c-section, or breech is equal to c-section, or the growing rates of epidural anaesthesia; electronic foetal monitoring giving cause to more 'false alarms'; more induction lead to more c-sections; multiple pregnancies as a result of IVF and other artificial reproductive techniques; growing health problems in women, f.e. diabetes and obesity; woman are (being made) more afraid to give birth vaginally; more prenatal stress is linked to more birth complications including c-sections; women are choosing more and more for 'the easy and comfortable way'; role models like media stars who choose a c-section as a 'lifestyle choice'; women and their partners want to keep the 'honeymoon vagina' intact; the larger the hospital the higher the c-section rates; the older the doctor the more c-sections; and the growing number of law suits against obstetricians; the c-section is supposed to protect the doctor, because they can then be said to have done everything they can to save the baby. Medical developments have made the procedure more safe, especially with the introduction of the low-segmental technique. The safety of a caesarean is comparable to the safety of the vaginal route. But safety is not the primary reason for the widespread use of c-section. Social cultural, non medical reasons seem to be of more weight than pure medical indications. The conclusion is that the growing caesarean birth rates are not only caused by clinical medical practise, but also by non medical, cultural, psychosocial and socio-economic factors. More and more do market driven solutions drive birth decisions and do superstars act as a role model for elective c-sections. Instead of empowering women, - trusting their female instincts, feeling strong and comfortable on giving birth vaginally in the privacy of a quiet and safe environment -, women are being made anxious to give birth outside the hospital and more hospital births give rise to more c-sections. The rising rates of c-section births goes together with the medicalisation of pregnancy and birth. There is a strange contradiction in medical practise: pregnancy and birth are more and more seen as a disease, while caesarean birth is seen a normal, routine healthy operation.

There seems to be a 'caesarean temptation' (Odent, 2004) that is to say the temptation to make the caesarean the most common way to give birth. The caesarean birth is no longer a rare rescue operation. Caesarean birth tends to become the norm, at least in some countries. The right to choose is becoming acceptable and we are entering the area of caesarean on demand. A pro-caesarean culture is spreading. In most industrialised countries, about 5% of all births were caesarean sections in 1970. In the eighties this figure was more than twice. By 1985 the figure was 15-20% in a number of industrialised countries. The situation on rising c-section rates is even alarming in developing countries (Wagner, 1994). According to Michel Odent (2004) the main reason for the increasing rates is an universal lack of understanding the basic needs of women in labour. And I would like to add : and a basic lack of understanding the long term psychological consequences for the baby. The safety of the caesarean birth tends to reinforce a traditional lack of interest for birth physiology and

secondly tends to reinforce the lack of psychological knowledge about pregnancy and birth within the medical profession.

Medical risks and broadening diagnostic criteria.

C-sections can be life saving for both mother and child. This is the primary justification for c-sections. C-section has undoubted benefits for certain complications of pregnancy and birth. There is no discussion about these life saving c-sections, although we need to become more aware that the baby has to pay an emotional price for this way of entering the world, as we shall see later on. The discussion is about c-section deliveries for which there was no evidence based necessity. C-sections have become a safe surgical procedure, although it remains a major abdominal surgery. The medical risks of c-sections are: complications with the anaesthesia; complication by infections; post surgery complications like peritonitis, embolism, pneumonia, infection of the scar, anemia; lower subsequent fertility; damage to the urinary bladder, causing incontinence; complications in breastfeeding; death of the mother and/or baby; more complication in the next pregnancy and birth. Even today about 1 to 2% of women giving birth by c-section die from or after c-section. This risk is 4 to 12 times higher than in vaginally childbearing. Death by c-section is extremely under documented. According to WHO c-sections do not reduce the rates of perinatal mortality. The increase in the number of operative deliveries will, at best, only have a very small impact on perinatal mortality rates (Wagner, 1994). Wagner (1994) gives the following explanation for this phenomenon: "As the indications for the procedure broaden and rates go up, lives are being saved in a smaller and smaller proportion of all the caesarean section cases. But the risks of the procedure do not decrease with increasing rates. Eventually it is only logical that a point is reached at which the procedure kills almost as many babies as it saves. This possibility is, for most part, invisible to obstetricians; they may experience the cases in which babies' lives are saved, but very often may not see the death of a baby, for example from a respiratory distress syndrome in a neonatal intensive care unit, hours or days after caesarean section".

There has been an evolution in the diagnostic criteria for c-section. Now a distinction can be made between absolute indications and debatable indications (Odent, 2004). Absolute indications are: cord collapse, real placenta praevia, placenta abruption, a brow presentation, a transverse lie or shoulder presentation, cardiac arrest. Debatable indications: previous caesarean, failure to progress, cephalopelvic disproportion, foetal distress, fibroids and ovary cysts, breech presentation, twin birth, vulnerable babies (premature or small-to-date). In order to prevent more babies and later adults suffering psychologically from caesarean birth a critical evaluation of debatable diagnostic criteria is necessary. An example of this position is the medical policy in breech delivery.

Term breech delivery.

In 2000 the result of the 'Term breech trial' were published (Hannah, e.o., 2000). In this international study morbidity rates and mortality rates of breech presentation were compared between c-section delivery and vaginal birth. The conclusion of this study was that caesarean birth was far most safest procedure for breech presentation. Although the research received much criticism it influenced obstetric policies in many countries and hospitals (Verhoeven e.o, 2005; Rietberg, 2006). In the Netherlands the c-section rates in breech presentation raised from 50% o 80% in the two months after the publication of the Term Breech Trial research. The Dutch society of Obstetrics and Gynaecology changed its policy: c-section become a 'responsible' intervention in breech presentation. In four years time 8700 extra elective c-sections were performed. Although a lower perinatal mortality rates and morbidity rates were shown in the same period, there were higher maternal death rates and higher morbidity rates as a complication of the c-section and in future pregnancies. In this four year period about 19 babies stayed alive that would have died if they would not have been born caesarean. In the period four mothers died from the complications of the c-section and about 140 women has serious and potential life threatening complications or were expected to have serious complications in the next pregnancy. This raises the question if c-section in breech presentation should become the standard procedure (Verhoeven, e.o, 2005). Vaginal birth in breech presentation is still possible and criteria for c-section in breech presentation should be restricted. External repositioning of the foetus can be a safe procedure to reduce the number of babies in breech position.

Little or no research is done on the maternal emotional conditions leading to breech position. Clinical reports suggest that conscious and unconscious aggression in the mother can lead to breech position of the foetus (f.e.: Noble, 1993). If the medical profession will become more aware of the psychological consequences for babies and in the long term for adults, than a change in policy can be expected to develop. Unfortunately, at this moment the medical paradigm excludes the prenatal psyche (Chaimberlain & Arms, 1999).

Maternal reactions to caesarean birth.

There is a debate about the emotional scars of a caesarean birth. Some researchers suggest that the negative psychosocial effects of caesarean births can be significant and far-reaching for some women (Mutryn, 1993). Others found no evidence that elective caesarean section altered the odds of postnatal depression compared with planned vaginal delivery, neither does elective c-section protect against postnatal depression, nor does it prevent a 'baby blues' (Patel e.a., 2005).

A distinction must be made between emotional effects of a planned 'elective' caesarean when the woman can anticipate the operation and decide how it shall be conducted, and on the other side an emergency c-section with no preparation. Different mothers seem to have different experiences and make different choices. It seems evident that women who 'choose' for a c-section delivery are more satisfied by the result and complain less about the disadvantages. However, according to reports by De Jong and Kemmler (2003) women who prepared for a natural birth and were not expecting a c-section often have complaints like: not having given birth themselves; losing control over the birth process; not being a complete woman having failed to give birth vaginally and having ruined something precious like natural birth; mixed emotions: happiness because of the baby being delivered and sadness because of the way the baby was born; feelings of guilt; fears about the health and well being of their babies. Oblasser, Ebner and Wesp (2008) interviewed and photographed 162 women who have given birth by c-section. Not only most women thought that the media minimize caesarean birth as a painless experience, but most of them also reported that the caesarean birth of their children was a disappointing, not natural, birth experience, that was necessary to save the lives of mother and child, but also a failure in motherhood that needs to be grieved.

Because c-section can be an extremely painful experience, often associated with feelings of being out of control and a lowered self-esteem, it is understandable that some women experience caesarean birth as a psychological trauma (Reynolds, 1997). Stress response symptoms include: intrusive thoughts about damaging effects of c-section, avoidance of hospitals and obstetricians, numbing of emotion and a sense of increased arousal. C-section mothers experience more post-traumatic stress symptoms than vaginally delivering women. Emergency c-sections (EmCS) have a deleterious effect on maternal well-being. Healthy pregnant women with a serious fear of childbirth appeared to be at greater risk. The degree of fear for childbirth seems to be the best predictor of the degree of maternal well-being after EmCS. Emergency c-section is often a traumatic experience for the mother with more symptoms of post-traumatic stress disorder (Ryding, 1998). A disproportionately number of women who had a caesarean birth report symptoms of postpartum depression, as compared to women who gave birth vaginally (Boyce and Todd, 1992; Brown, 1994). In the reports by Oblasser et al. (2008) almost half of the women experienced problems in the bonding process after c-section. Only about 50% of the women had seen the baby during the surgery. Due to the medical procedures the first body contact between mother and baby after birth was delayed in most c-section births for several hours. The importance of direct bonding after birth has been established for a long time, yet medical procedure does not seem to recognize this important moment of imprinting immediately after birth. In an f-MRI research Swain et al. (2007) found more activity in areas linked to motivation and emotions in those who had a vaginal birth compared with c-section birth. The hormones generated by birth could explain the differences. During contraction of vaginal birth trigger the release of

the hormone oxytocin. Undergoing a caesarean does not trigger the release of this hormone in the same way. Oxytocin plays a key role in shaping maternal attachment behaviour. Swain and his colleagues conclude that variations in delivery conditions such as with caesarean section, which alters the neurohormonal experiences of birth, might decrease the responsiveness of the human maternal brain in the early postpartum (Swain e.a., 2007). In their Doula book Klaus, Kennell and Klaus (2002) that women that were physically and mentally supported during delivery by a doula and received tender loving care during delivery showed less need for pain killing medication, had more positive better feelings about their delivery, had better bonding relationships to their child, and showed less postpartum depression. This doula support and care is not possible during c)section procedures.

The conclusion must be that caesarean birth leads not only a psychological risk factor in women, but also in their bonding to their babies, and thereby becomes a risk factor to the baby as well.

Psychology of childbearing

In Raphael-Leff's model of childbearing a distinction is made between the reaction's on c-section of regulating mothers and facilitating mothers (Raphael-Leff, 1991). To describe the experience of motherhood Raphael-Leff writes about two 'styles' of mothering. She later proposed a third go-between style which made her model less clear in my opinion. On the one hand, she talks about the 'regulating' mother, who tends to teach and exercise her baby to adapt to the reality of his environment; on the other hand, she talks about the 'facilitating' mother, who assumes that her baby will communicate all his needs and desires to her, to which she has to adapt. Raphael-Leff describes these two different ways of mothering. The 'Facilitating mother' is described by her as followed: "At the moment she becomes a mother, the facilitating mother is striving to get to know her baby really well. She doesn't miss any of his signals and expressions. Her complete psychological attitude is subtly tuned in pointing and decoding his preverbal messages. Throughout identification with her baby and with the mother in her own early youth, she is strongly conscious of the confusing experiences of the baby, of his dependence on her, his helplessness regarding his uncomfortable feelings and his inability of holding, decreasing or removing penetrating stimuli. She intuitively pays much attention to assess rising needs to benefit the baby's well being. This implies a continuous contact and an attentive addressing to her baby, even when he is asleep; all this compels flexible arrangements in her own life and an empathetic support of her partner and/or mother enabling her to have such a spontaneity and freedom in her responses.

In the regulating mother, the naked emotions of the baby are likely to be suppressed and awakening feelings in herself are denied because these endanger her firm intention of

staying aloof and untouched (hence the fanatical and puritanical measures she is taking in self-defence). Also the fact that the baby is completely dependent on her, does re-awake the anxiety of becoming swamped by her own need for attachment and becoming the only one who has to care for this demanding little being. Being confronted with the dangers of a greedy, nasty and storming baby, the regulating mother is trying to have things under control, as she did during pregnancy. She develops a system making the inevitable needs of the baby predictable and explainable and keeping his demands within limits. This way she imposes comprehension, control and certainty on a potential incomprehensible oppressive situation. In contradistinction to the facilitating mother, the regulating mother can't identify herself neither with the greedy, helpless baby, nor with the quieting coming-to-assistance mother".

Raphael-Leff has summarized the two motherhood styles in a few schemes, of which the following table shows the most important issues.

Characteristics	Facilitating mothers	Regulating mothers
<i>Pregnancy</i>		
Personal identity	Enhancing of identity	Threatening of identity
Emotional experience	Heightened continuity	Emotional upheaval
Adaptation	Gives in to emotions	Holds out emotions; tries to keep equilibrium
<i>Birth</i>		
Emotional experience	A mutual transition	Induced, painful event
Ideal birth	Natural birth instrumental birth as a failure	Painkillers, local anesthesia instrumental birth as a solution
<i>First six hours (imprinting)</i>		
Attitude	Re-union / re-fusion	No interest
Emotional experience	Delighted	'Exhausted'
Baby	Intimate, familiar with baby	Separation, a stranger
<i>Early motherhood</i>		
Image of the baby	Vulnerable, dependent,	Powerful, (unsatisfied, sadist)
Feeding	Permissive, frequent	Scheduled, limited duration
Crying	Communication and/or appeal	'Real' versus 'fussing'
Communication	Empathetic code (symbol) intuitive interpretations	Limited code (signal) arranged meaning
Experience of motherhood	Stimulating, grateful,	Boring, exhausting, binding

Raphael-Leff's description of those two styles of mothering is of vital importance, because she is filling in what researchers often call 'education style'. From her experience as a psychoanalyst, specialised in the psychological aspects of human reproduction, she has made an in-depth study of unconscious aspects of motherhood. Moreover, and this is really new, she does not let motherhood start at birth, but she also shows how the attitude of the woman regarding her pregnancy, regarding birth and regarding first reception of the newborn baby are connected and differ according to the style of motherhood. According to me it can be expected that the mothering style is strongly related to the mother's own childhood experiences (Stroecken, 1994; Stroecken & Verdult, 2006). From this model Raphael-Leff describes different reactions to caesarean birth according to the different styles of mothering. A significant higher proportion of regulating mothers undergo instrumental deliveries like c-sections in comparison to facilitating mothers. Regulating mothers can decide to have a c-section hoping to avoid pain of labour, feeling it offers her more control, decreases the risk of 'her doing the wrong thing', seems to entail a lesser degree of emotional involvement, lessen the risk of her sexuality being affected by vaginal birth. A regulator might wish to abdicate responsibility for the birth, feeling that it is preferable to 'put herself out' and let the specialist take over. Planned c-section are not traumatic to them; emergency s-section can be a shock, but this is considered to be a rescue operation.

Facilitating mothers react different to c-sections. The sense of failure and disappointment at not having experienced a vaginal birth is greater among facilitating mothers than regulating mothers. They can have to grief over the loss of the birth they had desired. Facilitating mothers can have the idea that they have not given birth, but that the baby has been taken away from them. They may feel violate or robbed, her feminine pride being hurt. Facilitating mothers find it more important to be able to experience labour before c-section. The 'postnatal anticlimax' may be stronger in facilitating mothers. They are more at risk to postnatal depression. Emergency s-section are mostly traumatic to facilitating mothers. Conclusion: Caesarean deliveries can have powerful psychological effects on women and their ability to adjust to motherhood, depending on the mothering style she has developed on her own childhood experiences.

Conclusion: Birth by caesarean is an emotional experience, not just a medical procedure. C-sections can lead to emotional scars. Especially women who experienced emergency c-sections report symptoms of postpartum depression and/or posttraumatic stress syndrome.

Adult functioning after caesarean birth

There is growing evidence for a connection between birth experiences and infant, child and adult behaviour. When speaking on foundational trauma, like birth trauma's are, Anne McCarty (2002), founding chair of the Prenatal and Perinatal Program at the Santa Barbara Graduate Institute puts it this way: 'Our earliest experiences are embedded in our being and act as a natural filter of our perceptions and interpretations of situations, people and even sense of self'. Being born caesarean can be considered to be such an embedded experience that filters one's perceptions. According to William Emerson (1998) c-section birth can be recapitulated in adult life. Recapitulation is the process whereby people unconsciously recreate past events and traumatic experiences in their lives. They do so in an attempt to externalize traumas from the unconscious so that their traumas might be dealt with in the here-and-now reality, and be carthartically released from their systems. Four types of recapitulation can be distinguished: direct, avoidant-elimination, avoidant-identification and confrontive recapitulation. The bonding deficiencies that accompany c-section can be avoidantly recapitulated in tactile defensiveness. Adults being born caesarean can become totally withdraw from touching, hugging or sexual contact (Emmerson, 1998a). The caesarean shock, caused by the quickness of the transition and the invasive interventions by the medical staff, can be recapitulated in shock levels of the autonomic nervous system, which can be stored in the body for decades. For example: the parasympathetic nervous system can stay highly active, intricately balancing out any shock that might potentially be activated. Children and adults can be hyperalert as a result of the sudden, unexpected and frightening intrusions or changes of the caesarean birth, in which the baby losses control over his birth process. Invasion/control complex is the third group of related symptoms that Emerson distinguishes in birth trauma. Being felt interrupted can be the result of a direct recapitulation. A fascination with knives or abhorrences with cutting instruments can be a confrontive recapitulation. Adults being born caesarean can choose situations which involve interruptions or manipulated interruptions. From Emerson's long lasting clinical work it can be stated that children and adults being born caesarean create scenarios that reflect their birth experiences and from which their birth feelings can arise. Jane English (1985,1994, 2000) has described her personal process on being born non-labour caesarean. She started with a cause-effect research, than went into a non judgemental acceptance and ended in an expanded consciousness. From her personal research and from contact with many caesareans she concluded that non-labour caesareans have a different view of space and of time. Space refers to personal boundaries, which are not well developed in non-labour caesareans; they tend to let everything in. Time refers to pacing; non-labour caesareans have a tendency to complete some task quickly and in one movement. They can experience a deep sense of panic when thing can not be completed at once. Leverant (2000) formulated the following matrix of beliefs arising out of a labour caesarean birth. This includes beliefs such as: self support is not possible, completion is in someone else's hands, I expect to be rescued, life is an unconscious activity, violence is normal, I am fundament tally flawed, and through drugs I can return to life. In a phenomenological study

on caesarean-born adults Milliken (2007) described three main themes in adult functioning: difficulties in being interrupted, a strong motivation to achieve as a compensation for not successfully initiating or being an active participant in their births, and a pattern of offering help even when it is not requested. These basic patterns can be associated with the experience of caesarean birth.

According to Thomas Verny (2002) the psychological profile of 'elective' (non labour) caesareans consists of a triad of characteristics. First, because they missed out on the contractions massage phase of delivery, they are predisposed to seek out physical contact. Second, they tend to get themselves in difficult situations and hope to be rescued. Third, they are prone to be hypersensitive about issues of separation and abandonment. The c-section babies who have experienced some contractions (labour caesarean) are likely to demonstrate these three characteristics plus strong feelings of block, a sense that they are unable to complete or succeed at a task.

The conclusion can be that being born caesarean can create unconscious scenarios (Emerson), a matrix of beliefs (Leverant) or a psychological profile (Verny). All clinical research on long term effects indicates that c-section birth can have subtle changes in personality. This not to say that all caesarean adult are functioning pathologically, but they can experience vulnerabilities resulting from being born through the different doorway.

Prenatal psychotherapy: a case example.

A 36 years old woman came to see me because she was suffering from migraine, which severely interfered with her personal and professional life. When she has her migraine attacks it was 'like hell, unable to survive'. She was married and had three children. As an engineer she was a production manager in an industrial company with a brilliant professional career. According to her own statement 'she had everything to be happy', but she felt depressed and she had periods in which she felt like being dead, lying in her bed for days, not wanting to be disturbed by anybody. These symptoms seem to refer to a parasympathetic shock activation. She was perfectionist and a 'control freak', pushing herself over the limits of her emotional and relational capabilities, so far that she collapses. She felt that she was more in a 'surviving modus' than vitally living her life. She was professionally working in overdrive and very competitive. Her high levels of self induced stress seems to be a way of staying out of her shock pattern. She had a tendency to get involved in symbiotic relationships, in which she loses her own strength. She had a tactile defensiveness, leading to a more distant relationship to her partner and to friends. She was primary a regulating mother showing an avoidant attachment pattern.

In our private practice we use a psychodynamic body oriented psychotherapy. Unconscious aspects of painful early childhood experiences (including prenatal and perinatal experiences) are regressively worked through. Different levels of processing are used: bodily expression of painful memories and verbal exploration of bodily felt meaning are combined (Stroecken, 1994; Stroecken and Verdult, 2006). Body oriented interventions and giving words to re-experienced childhood situations are essential parts of the treatment. Although different levels in her functioning were met with during psychotherapeutic treatment, I discuss her only the aspects of her caesarean birth. During the treatment the following quotes refer to her caesarean birth with full anaesthesia, after which her mother did not have body contact with her for two days. She as a baby stayed in a incubator. The client repeatedly uses frames like:

- 'I am always afraid that I can't come out of situation, that I can't deal with them.'
- I can't stand violence on television, can't handle with violence when being confronted with it in real life'

- It makes me sad to see that I don't experience a close relation to my mother. It feels as if she has dropped me'

- I can't deal with sudden unexpected changes in my plans or schedules; I can panic'
- 'I have strong feeling that my mother has abandoned me, although I know that this is not the case. I can feel abandoned easily'.

- It is difficult for me to be touched. It feels like losing control and I am afraid to be hurt'

When we start to do regressions to her birth experiences, she used to go and sit on the floor, in the corner of my practise, holding herself tightly. In this cocoon she was creating she could not feel any connecting to her body. It felt like a perinatal survival strategy: completely withdrawn and completely catatonic. It felt like a complete splitting in an unbearable situation. Any movement could bring her in a more dangerous situation, threatening her survival. A perinatal parasympathetic shock seems to be activated. In this position she was losing her strength to cope with the situation, expecting someone to rescue her, get her out of this position. She could get strongly tactile defensive in this vulnerable position of recapitulation. Especially touching her head and face, even gently without manipulation, activated a lot of anger. In several sessions we worked on resourcing by simulating a vaginal birth as a safe way out of the womb. In regaining some strength she was able to confront herself with the painful memory of her caesarean birth with complete anaesthesia. In regressions we worked on her body sensations that were linked to the caesarean procedure. The anaesthesia shock felt like being invaded by a sudden attack and made her nausea leading to intense coughing. An outer source of power overwhelmed her. The delivery of the head and manipulation of the head during the surgery gave rise to intense anxiety which was followed by a collapse. The parasympathetic shock was activated. During the regressions she could not find contact with her mother, felt not supported or carried by

anyone. She felt an intense loneliness, desolateness. These feelings continued after birth. Her mother thought for two days that her baby had died during birth. The client was in a incubator recovering from the birth for one week.

After working through her birth trauma prenatal traumas were activated. Her mother was depressed during her pregnancy and took tranquilizers. The mother had had two previous miscarriages and was afraid of losing this child too.

Closing remarks

Less industrialization of pregnancy and birth (term by Odent) is necessary in order to prevent more babies and in the long term adults from suffering from a traumatic birth, which c-section is. In order to achieve this primary prevention strategy, a rediscovery of the basic needs of women in labour is advisable. As many women as possible give birth vaginally thanks to an undisturbed flow of love hormones, a critical evaluation of performed c-sections and more awareness by parents and doctors that birth is a major transition for the baby. More awareness by the medical staff of the baby's suffering during c-section birth, so that c-section procedures can be adapted more to the experiential world of the baby, so that the ideal c-section, as suggested by Robert Oliver (2000) can become possible.

Literature.

Boyce, P.M. & Todd, A.L. (1992). Increased risk of postnatal depression after emergency caesarean section. *Medical journal of Australia*, 157(3), 172 – 174.

Brown, S. (1994). Birth events, birth experiences and social differences in postnatal depression. *Australian journal of Public Health*, 18(2), 176-184.

Chamberlain, D.B. & Arms, S. (1999). Obstetrics and the prenatal psyche. *Journal of Prenatal and Perinatal Psychology and Health*, 14 (1-2), 97 – 118.

De Jong, T.M. & Kremmler, G. (2003) *Kaiserschnitt; wie Narben an Bauch und Seele heilen können*. München: Kösel Verlag.

Emerson, W.R. (1998). Birth trauma: the psychological effects of obstetrical interventions. *Journal of Prenatal and Perinatal Psychology and Health*, 13 (1), 11 – 44.

English, J. (1985). *Different doorway; adventures of a caesarean born*. Point Reyes Station: Earth heart.

English, J. (1994). Being born caesarean: physical and psychological aspects. *International journal of Prenatal and Perinatal Psychology and Medicine*, 6(3), 381-394.

English, J. (2000). Four perspectives on being born Caesarean. *Journal of Prenatal and Perinatal Psychology and Health*, 14 (3-4), 299 –308.

Hannah ME, Hannah WJ, Hewson SA, Hodnett ED, Saigal S, Willan AR. (2000). Planned caesarean section versus planned vaginal birth for breech presentation at term: a randomisedmulticentre trial. Term breech Trial collaborative Group. *Lancet*, 356, 1375-1383.

- Kennare, R. (2003). Why is the caesarean rate rising? *Midwifery Digest*, 13(4), 503-508.
- Klaus, MH, Kennell JH & Klaus, PH (2002). *The doula book*. Cambridge, Mass: Perseus Publishing.
- Leverant, R. (2000). Ruminations on being labor cesarean born. *Journal of Prenatal and Perinatal Psychology and Health*, 14 (3-4), 309 –315.
- McCarty, A. (2002). Keys to healing and preventing foundational trauma: what are babies teaching us. *Bridges- ISSSEEM Magazine*, 13(4), 8-12.
- Milliken, L.D. (2007). Cesarean birth stories. *Journal of Prenatal and Perinatal Psychology and Health*, 22 (2), 129 – 147.
- Mutryn, C.S. (1993). Psychosocial impact of caesarean section on the family: a literature review. *Social Science and Medicine*, 37(10), 1271 – 1281.
- Noble, E. (1993). *Primal connections*. New York: Simon&Schuster.
- Oblasser, C., Ebner, U. & Wesp, G. (2008). *Der Kaiserschnitt hat kein Gesicht*. Salzburg: Edition Riedenburg
- Odent, M. (2004). *The caesarean*. London: Free Associations Books.
- Oliver, R. (2000). The ideal cesarean birth. *Journal of Prenatal and Perinatal Psychology and Health*, 14 (3-4), 331 –343.
- Patel, RR, Murphy DJ, Peters, TJ (2005). Operative delivery and postnatal depression: a cohort study. *British Medical Journal*, 330: 879-885.
- Raphael-Leff, J. (1991). *The psychological process of childbearing*. London: Chapman&Hall.
- Reynolds, J.L. (1997). Posttraumatic stress disorder after childbirth: the phenomena of traumatic birth. *Canadian Medical Association Journal*, 156(6), 831-835.
- Rietberg, C.C.T. (2006). *Term breech delivery in The Netherlands*. Utrecht: University of Utrecht doctoral thesis.
- Ryding, E.L. (1998). Psychological impact of emergency cesarean section in comparison with elective cesarean section, instrumental and normal vaginal delivery. *Journal of Psychosomatic Obstetrics and gynaecology*, 19(3), 135-144.
- Stroecken, G. (1994). *Het miskende kind in onszelf*. Leuven: ACCO.
- Stroecken, G. & Verdult, R. (2006), *De mythe van de gelukkige kindertijd; zoektocht nar het miskende kind in onszelf*, Antwerpen: Garant/Cyclus.
- Swain, JE, Tasgin, E, Mayes, LC, Feldman, R, Constable, RT & Leckman, JF (2007). Maternal brain response to own baby-cry is affected by caesarean section delivery. *Journal of child Psychology and Psychiatry*, 49(10), pg 1042-1052.
- Verhoeven, A.T., De Leeuw, J.P. & Bruinse, H.W. (2005). Aterme stuitligging: onterechte keus voor de electieve keizersnede als standaardbehandeling vanwege te hoge risico's voor de moeder en haar volgende kinderen. *Nederlands tijdschrift voor Geneeskunde* 140(40), 2207-2210.
- Verny, Th. (2002). *Tomorrow's baby*. New York: Simon&Schuster.
- Wagner, M. (1994). *Pursuing the birth machine; the search for appropriate birth technology*. Camperdown: ACE Graphics.

Correspondence.

Rien Verdult

Post: Opleeuwstraat 59, 3840 Gors-Opleeuw (Borgloon), Belgium

Phone: + 32 12 67 19 35 (mon-wed-fri: 8h00 – 9h30; mon-wed: 16h00 – 18h00)

Email: rien.verdult@skynet.be

Website: www.stroeckenverdult.be