

Changing Birth ON Earth SM



TRANSCRIPT

Gail Tully (00:00:07):

Hi, I'm Gail Tully and by now we've spent a lot of time together while you've been reading my book, Changing Birth on Earth, the midwife and nurse's guide to using physiology to avoid another unnecessary caesarean.

I've really appreciated your trust in this process and joining me as we seek and explore ways of using physiology in our birth practice and also settling into our bodies, acknowledging and enhancing our own physiology, because this is where we live and this is where we work from. This is how we move through our lives is through our physiology. Yes, it's the function of our bodies, but it's also the state of our nervous system and in healing birth and changing birth on earth and teaching birth to others, then we want to be landed in our physiology.

(00:01:04):

So I just want to have this hour with you to go over the book.

(00:01:09):

Now, if you haven't read the book yet and you skipped to the end to get this link, well then, this hour can help you understand the book better. If you, like me, were seeking ways of addressing posterior laborers or other malpositions or just that labor that's not continuing for whatever reason, then this is a time of becoming more aware of our anatomy and how we can use stretch and jiggle techniques to enhance birth anatomy so that the baby can slip into the pelvis at the appropriate time before or with labor. When I started attending births many of the first births went very smoothly. There was no need for me to do anything but hold space, to be quietly and calmly enthusiastic. And then one birth, it was about 1986, there was a mother who had a caesarean for her first birth and the doctor said, well, look at your hips, it's because your baby was too big.

(00:02:18):

With hips like yours, how could you give birth to a baby this size? Your baby was 9 pounds, 12 ounces, which is well over 4,000 grams, if you're outside the US. With our next pregnancy, she wanted to reexamine that interpretation of her body. So, she got active, she learned about natural childbirth, she picked a nurse-midwife in the hospital, and she found a beautiful support system and really trusted her body. She said, Gail, I'm going to go into labor in the night and I'm going to give birth in the morning, but as that night went through and we tried hands and knees and rocking and going up and down the stairs sideways, and we were trusting and enthusiastic. But as the first dawn rose, the mother said, you know, let's go to the hospital, babies are born in the hospital. My baby will be born when I arrived at the hospital.

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(00:03:19):

And when we came to the hospital, we were greeted by warm staff. We had a nice big room to move around in. She had a rocking chair. She had food to eat and drink. And you know, it was comfortable setting for giving birth to a baby, but the labor still wasn't advancing. And so again, we tried pelvic tilting and walking the halls. She said, why, why won't my baby come? And the nurse invited her to sit in the rocking chair. This was in the days before there were birth balls and the rocking chair was a place to rest that was out of the bed. I slipped my hands through the slats of the rocking chair and rubbed her back and rubbed her back right over those sacroiliac joints and that sacrum that can be so throbbing and hot during labor. And she asked why, why won't my baby come?

(00:04:20):

I had heard about posterior labors, but I had never been at one that took so long. I was out of ideas. The nurse heard us, and the nurse said, your baby will come when your baby turns around.

Well, all I could do at that time was wait with the mother, wondering when, when was this baby going to turn? And the time went on and in the middle of the night, the nurse midwife came in and said, come on, let's go sit in the bathroom, sit on the porcelain birthing stool. We'll turn the lights down. We'll leave the door open.

So it's just a nice dim light in here. And the midwife sat on the edge of the tub and she put her elbows on her knees, and she sat with this birthing person as they came into their body and they were now in a new position with their pelvis tilted and their back straight, and in a place where they had been releasing all their lives, right since potty training, and we settled in. And very soon we heard the very strong contractions that seemed to rotate the baby right within our hearing and suddenly the mother's eyes got big and she got up off the toilet and she crawled over to the bed and she got onto her hands and knees and right then pushed out another 9 pound, 12 ounce baby, the same size as the oldest sibling.

And in the explanations of joy, I still had a wondering, what could I learn to have helped this family more readily? What could I learn about fetal positions? What could I learn about labor progress and why does one person determined to have an easy birth and goes about the exact same steps that this woman did?

Taking childbirth classes, taking walks, feeling confident, arranging a birth team that's supporting her and yet, not have the easy birth that was expected. Now this baby rotated and came out at 65% or more of posterior babies will do on their own. I have wondered what makes birth easier for one person compared to another, who had the exact same preparation, taking the childbirth classes, taking

the walks, arranging a birth team that was supportive and up-to-date, moving freely in labor, eating and drinking at will, and yet for some, the baby's not coming. Now in a couple of days and this baby came, it was a day and a night longer than this mother had expected and predicted for herself. It took her right past confidence into the unknown, into the mystery of meeting life's challenges. And yet, her baby did come into her pelvis, rotate, and she was able to push this child out into the world, completing that cycle of birth that she so intended to complete, it was such an inner need. And as a midwife and a doula, I really want to have some skills and awareness to answer that question of what makes one birth easier. So, I began on a journey. I collected techniques and ideas from babies and mothers, from midwives and nurses, from doctors, and even once a speech pathologist. Maybe you, too, are frustrated like I was frustrated and still can be frustrated at times, this isn't a hundred percent cure, this is just more awareness, a better collection of techniques and birth positions, but there's something special about Spinning Babies[®] that I'd like to share with you and that's the approach. It's the approach that is a mother-centered, a birth giver-centered approach within the body of the birth giver, the physiology of birth.

They are the result of thousands of generations who've given birth and if indeed this person themselves was born by cesarean, have they really changed their DNA to not be able to give birth vaginally to the child they carry? I don't think so. I don't think so. When it's provider centered, it's what we do to another, that either encourages safety, protects the way, or overcomes an obstacle in birth. When we are birth giver-centered, mother-baby-centered, we're tuning into that physiology. We're becoming aware of whole new worlds and new perspectives. We're becoming aware of the birth anatomy in ways that were never taught in school. In fact, it's lateral intelligence. It's, it's going to another profession, the side, the profession of obstetrics or midwifery or nursing, to gather some information that we weave into this paradigm of physiology before force.

(00:10:05):

And I invite you to come on this journey with me. I invite you to come through the pages of Changing Birth on Earth, and we're going to look at a particular group of chapters.

The 'How To' chapters you could say that I gave the acronym BIRTH process. I know that's kind of bold and kind of corny, but bear with me because I wanted to make this book easy to follow, enjoyable for you, and really an introduction that you yourself are going to fill in. I bet after reading this book, you now know why your favorite techniques are your favorites, because as we put our attention into a good question, doors begin to open, ideas begin to land. We notice things that we never noticed before. What was invisible is now visible. What seemed impossible is now right in front of us.

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You know, in 1904, Maria Montessori, the great doctor and educator of Italy, said in a hundred years, babies will talk. Well, had you taken my Montessori training shortly before a hundred years was up, I anticipated, what were we going to see? Were babies going to be able to talk upon birth? And what actually happened is we began to have the capacity to listen.

(00:11:41):

We began to understand the six states of the newborn, Parexal and Wolf studied newborn behavior and showed us that babies are not randomly behaving, but are following patterns of their nervous system. They're learning and they're responding to their environment, and most especially to those that love them. We, too, are going to have worlds open up to us that were once invisible but are now very visible.

And in fact, the relationship with the newborn in your care is going to be gloriously revealed to you. Once you start to see more newborns born after more easier births. Now, what's easy? Not too hard, not too traumatic, parents and babies are not exhausted, stunned, or needing resuscitation. Okay, let's just make this practical and reasonable to obtain. But what we're looking for is also the intact hormonal experience, the intact physiology. So, what begins in the body, flows through the body, and completes this bodily function, which then gives messages to the brain of capability and abilities to connect mother-baby to this baby that this birthgiver just gave birth to.

(00:13:10):

This is essential for developing the kinds of relationships that carry us into this whole new future that the world has. Intact physiology has never been more important than it is today and nurses and midwives are so important in that course of early parenting. You're there when the parent greets the baby and the state the parent greets the baby in imprints in their feeling and their physiology of parenting. From that second, there is no future parenting, there is parenting now. When this person's giving birth and the baby is taken away, it's not about, "We'll get the baby back to right away so you can start your bonding." Bonding is happening right now and it's been disrupted. So, easier birth is to protect that moment of skin-to-skin contact of the reunion back to the most important and most optimal position for the baby. It's no longer a fetal position, it's a baby positioned skin-to-skin, this optimal skin-to-skin position of the baby restores the relationship that's been going on for hopefully nine months, maybe shorter, sometimes longer, and the continuation of this generation of this family is occurring. So, when we help that moment be filled with love, confidence, and simply embodied in our physiology, we are protecting generations to come.

This moment is now, this moment is the future, and you are the keepers of the future. That's why I'm so honored to be with you as we go through these chapters, the 'How To' chapters of Changing Birth on Earth: the midwife and nurses guide to using physiology to avoid another unnecessary cesarean. Let's look at the chapters B I R T H and the chapter process. Let's look at chapter four, Balance First. B for balance first, is about body balancing for comfort and ease with activating the physiology of the birth anatomy.

Body balancing uses stretch and jiggle techniques to help muscles, and especially the fascia, restore balance in the body. What's balanced? Not too tight, not too loose, and not too twisty, because we want the baby to have a clear open channel from the uterus through the lower uterus, through the cervix, into the vagina, but into the embrace of the pelvis so that all of the organs move together with the bony pelvis, all of those muscles and fascia and ligaments move together to embrace the child, to welcome the child into the pelvis, that the baby finds their way through the pelvic floor, down past the sacrotuberous ligaments, onto the perineum, and then out into the world. This process can be most smooth, much more smooth than we've expected as professionals. Because there will remain a few difficult births, we tend to focus on that and judge all births based on the few that need our emergency rescue.

Your skills are so important during an emergency birth but let's not interpret all births as being an emergency. I think as you discover the birth anatomy discussed in the body balancing chapter, you'll find out about the anatomy, the muscles, ligaments, the pelvic floor, the curve of carus, and how it all works together, from inlet to mid pelvis, to outlet, to guide and direct the baby into the world, restoring the balance, relieves the tensions and aligns the uterus with the pelvis, which is another way of saying aligns the baby with the pelvis, which is another way of saying easing birth. Birth positions become more effective after body balancing. It seems like so much of our physiological practice before Spinning Babies® is to find the birth position that's comfortable, that brings on labor a little bit stronger.

Patricia Rangel, RN (00:18:19):

I've been a nurse 20 years. I'm a childbirth educator, a doula. I am a lactation counselor. I've been doing this work for, um, it seems like all my life. I come from a line of strong black women. My mother was a nurse. My grandmother was an herbalist and a healer. I feel that birth work is a calling. I really think Spinning Babies® is an asset, not just to the nurses, the practitioners, but to the doulas as well. You're there to support her, but you actually need to know what's going on, why it's going on, the physiology of what's happening, so that you can support her to the utmost.

Gail Tully (00:19:17):

But once we understand body balancing, we have that aha moment to find out that the fascia that might've been tight and holding up the baby is now released and restored. And these restorations can happen in 15 minutes to 2 hours. Very often we'll see that nurses and midwives have 15 or 30 minutes to spare with family outside their usual care. What do I mean by usual care? Because birth positions are usual care and even our body balancing techniques can be interpreted as birth positions. In the book we introduced the jiggle. I've been introduced to the jiggle by Ina May Gaskin and Jenny Blyth, and we've found it through traditional techniques and through ortho-bionomy. Jiggling, that's like a vibration.

When we are birthgiver-centered, we start to see that our jiggling motions are not shaky. We're not trying to shake the baby into position. We're not trying to free marbles that are stuck at the mouth opening of a jar. No, what the jiggle does is it starts to respond to the fascia, which is like a living net made of fibrals that are of moisture, that are in motion and movement, except for when they get restricted from a lot of sitting or similar positions, those fibrals get resistant and stiff. And as we jiggle, we gently introduce our touch to the body. Of course, we've asked for consent and explain what we're about to do. And we begin to juggle.

(00:21:16):

And as we begin to jiggle, the fluid in the fascia in the cells begins to vibrate and in that vibration comes release. First a little, very locally, and then it builds a momentum and becomes looser and looser until the function of the body is restored and the body can then receive the baby and pass the baby by on its way out to birth. So, the jiggle and the fascia starts locally and goes globally further and further through the region of the pelvis, up the back, even to the respiratory diaphragm, and then down to the knees in the other direction around to the abdomen.

This jiggle is now becoming a global experience in the fascia of the body, releasing tensions, allowing for circulation, including circulating hormones. We get released from tensions that might be around an ovary, that might be around a ligament like the round ligament that might be causing pain in the front, or even in the sacred iliac joint that might be sort of locked up. And by introducing the jiggle in key parts of the pelvis, in time, let's say 10 minutes, we start to have a more mobile sacroiliac joint and you know, for the baby to come, we need the sacrum to move out of the way of the baby. So, mobility is key to birth and stability is key to comfort. The balance between stability and mobility is what makes this such a beautiful offering for comfort and ease in birth.

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(00:23:15):

So in our chapter four, B is for Body Balancing, you're introduced to that beautiful jiggle, and then you're taken into some stretch activities. Two of our most favorite and effective stretch activities come from Dr. Carol Phillips, a chiropractor who developed dynamic body balancing, the forward-leaning inversion, and the side lying release. We've done the jiggle. We've relaxed the body, we've awakened the parasympathetics. The nervous system is calm. The person's glowing with the jiggle and relaxed. And now we say, we'd like to introduce forward-leaning inversion. The state of the person is like, whatever you want to do, I'm game. You know, we have to have some care of an inversion of any sort. Is this person strong enough in their shoulders and arms to support their weight when they put their elbows down? Is there a mature attendant who will keep their hand on the shoulder or under their arm in order to prevent a fall? Is the surface correct? Is it the right height? You know, you can use a hospital bed and have the person already resting on their elbows, tucking their chin at the foot of the bed. When you push the button on the bed to lower the foot of the bed lower and their head will go down and their bottom will go up in the forward-leaning version position. The key is to have the uterus hanging from the ligaments. That's what makes forward-leaning version unique from down dog, from Trendelenburg or other inversions. If you had an inversion table, a yoga inversion swing, you'd be able to use those implements just fine.

(00:25:26):

The uterus is not a water balloon floating independently in the body, but it's rather connected to the body through a sheathing of fascia where the sheathings of fascia become thicker, ligaments arise, ligaments are identified. Although they are made up of the same fascia in the front of the uterus, we have the round ligament coming from the approximate place of the fallopian or egg tube and the ovarian ligament. We can imagine this embroidery hoop as being the pelvis and know that this bolt is going to represent the synthesis pubis. The round ligaments come over the front of the pubic bone attaching to the fascia covering the pubic bone, the cardinal ligaments. And they go up into the edges of the lower pelvis, the sacrotuberous ligaments come around the rectum. Now, as we move through gravity, sometimes there's a sudden stop in gravity. This can risk the alignment or the tension of the fascia in the pelvis, particularly the ligaments, but also in the sheathing that is around the inside of the pelvis.

(00:26:49):

Let's imagine someone who is going in a car and as they stop suddenly, maybe they hit a curb, the shoulders are held safe by the seatbelt, but in that movement forward, the uterus is twisting. And because of the sudden shock and often an emotional shock, the fascia stiffens and freezes, so to speak. And now we have a twist in the uterus, a twist in the lower uterine segment is called torsion and it's in the medical literature. And they're looking at a twist of 45 degrees, 45 degree turn in the

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uterine muscle is called torsion. You can imagine that there's probably 44% of a twist for someone and even a 20% twist might reduce some space for the baby to come through. Not only to come through the uterus into the pelvis, but also to settle in an ideal position. Now, the baby is going to be trying to navigate through that twist, to come out through the pelvis. The forward-leaning inversion releases tension in the cervical ligaments that hold the lower uterine segment. By doing forward-leaning inversion, we put the uterus in an inversion, and then it's in coming up that the ligaments can find themselves repositioned.

(00:28:27):

We give an opportunity for any twists or tension in the uterus to come out. We don't know if somebody's got a twisted uterus, but we know that labor is either more painful or taking longer than expected. We've tried some other techniques, perhaps, now we're going to try forward leaning inversion. So, with the safe setup, we let the person's shoulders be lower than their hips so that the uterus can come and hang from the ligaments. Uterosacral ligaments gets a stretch and the stretch goes up to the brain and says, "Oh, I need some length here." And the brain says, "Hey, I can send you some length temporarily. I'll give you some length through the fascial receptors." And then after contraction, we come back up and the ligaments are more often in their proper place. Taking the twist out of the lower uterine segment and letting baby slip down through the pelvis. Forward leaning inversion has helped so many births when it seems like the baby's just not able to fit, but by activating the fascia with a forward leaning inversion and a return to an upright position, the fascia gets hydrated. The body restores its balance in this area of the body and now the baby has a soft cushion to come through the pelvis in the hydrated fascia.

(00:30:11):

Of course we have contraindications to going upside down, significantly high blood pressure, any chance of a stroke or aneurysm, we would want to avoid going upside down. If the person's just eaten, it's kind of a nuisance to go upside down and risk heartburn, that's not kind. If the person doesn't want to, we respect that. This is a no bully zone. Physiology before force can't be bullied. It's an interaction or relationship between you and the birthgiver. You'll find the contraindications in the book and on our website, please read carefully about the forward leaning inversion so you can get tips that I haven't included in this class or in the book, because we just have limited time. But when you go to the website, you'll find the updated information. I think whether the water has released or not, forward leaning inversion is often appropriate. Whether the baby's high or not, forward-leaning inversion is often appropriate, whether the baby has a malposition or not, forward leaning inversion is often appropriate. It looks a bit alarming to see someone upside down, but many birthgivers reported it as one of their favorite things to do during labor. Try it yourself, try it with a colleague, practice before you try it on another person who is in labor.

(00:31:53):

Let's talk about the queen of all techniques, the sidelying release. Tamra Schatz, and her colleagues at Whittier California decided to work on reducing the cesarean rate. The whole hospital was involved and after about three years, Tamra discovered Spinning Babies[®]. Tamra went to the Spinning Babies[®] website and discovered a whole new world of physiological birth, which she brought back to her hospital. Let's hear about the results.

Tamra Schatz (00:32:29):

Just in the last year I went to her website and using some of her techniques, sidelying release, um, you know, some of the other techniques that I've seen on her website, we've managed decrease our primary cesarean section rate. Last month it was 7.8%. We were in single digits, I think, for the first time in the history of our hospital. So, everybody's dancing and popping champagne at our hospital.

Gail Tully (00:32:56):

Dr. Carol Phillips systemized the sidelying release so that shoulders and hips are stacked. Your job will be to keep the top hip aligned with the bottom hip in a vertical direction so that an architect could put a plumb line from one hip down to the other and it would be a straight line allowing the hip to tip forward when the leg comes over the bed, reduces any kind of effectiveness of sidelying release, and you won't see the good benefits. So, bring that hip back up into alignment after the person's leg is over the edge of the bed. Don't let the leg rest on the edge of the bed, let it hang freely to an aligned hip and it is that weight of their own leg that inspires the brain to send the signal to lengthen the muscles from the leg to the pelvis.

This in turn helps many of the muscles to the pelvis to elongate and relax temporarily but in enough time often for baby to come into position and come down onto the cervix, the sidelying release has benefits before the baby's engaged by helping align the uterus. The sideline release has benefits after the baby's engaged by aligning the pelvic floor and making the pelvic floor more functional to rotate the baby. In an active labor, you may see that sidelying release suddenly releases the baby out into the bed, be ready to catch. Alternatively, if the uterus is quite tired when you first do a sidelying release, the baby's engaged and the uterus is getting tired, then the person may get a one hour break, who doesn't want a break when they've been in a long labor? A lot of people pick an epidural against their own inclinations simply to get that break because labor is much longer and stronger than expected. Why is it longer and stronger than expected?

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Often because the uterus is not lined up with the pelvis, which means the baby's not lined up with the exit. Sidelying release lines everybody up and then our next stage of labor is often initiated. So, if in an inactive labor, sidelying release often brings the labor to pushing with or without a one hour break in between. If there is a break, get the person snuggled in bed for a short little nap and watch the clock because it's usually just one hour. Chapter four on Body Balancing is a long chapter in our book. You can relate it back to our webpage, to our Spinning Babies[®] workshop and to our Spinning Babies[®] parent class.

(00:35:58):

You'll be having fun, seeing the great effects on many, many labors that might make you curious for chapter five. Now, I'd like to talk about chapter five in Changing Birth on Earth. In chapter five, you're going to identify the issues that come up with labor in a new way. You know, so often we look to the cervix to tell us how labor is progressing, how many centimeters dilated is the cervix? Well, once we're at 10, does that mean the baby just drops out and the birth is over? Very often, the issues are not really about cervical dilation. It's simply that the cervical dilation can be measured and so, therefore it is.

There are other clues right in front of you, there's clues all around the labor and I developed listening to these clues when I was a doula, because I wasn't checking cervixes. I needed to hear how labor was progressing without the measurement process. As a home birth midwife, I didn't do many vaginal exams. I had many clues to how labor was progressing by listening to the respirations and sounds, watching behavior, feeling body tensions move lower and lower through the pelvis. Listening to different pitch of the sounds that the birthgiver made. There were lots of signs to labor progress. Now we know about the purple line from late dilation into full dilation that 60 to 80% of women have in the cleft of their buttocks. That's another way of seeing how labor is progressing, is the sacrum bulging out? The sacrum in the back of the pelvis bulges out a centimeter and we feel that rise of the bone as if the baby's head is pushing that part of the pelvis outward.

(00:38:14):

How can a baby with a 15 inch head come through with a diameter of 13 centimeter pelvis without molding? It is because the sacrum bulges outward, the mobile sacrum is key to vaginal birth. There won't be a vaginal birth without a mobile sacrum. So, these are issues you're going to learn about in chapter five. We're going to ask a new question, not how far dilated is the cervix, but where's baby? Such a simple question. isn't it? I used to ask the question is the baby posterior or anterior?

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Well, that implies a judgment that one is better than the other and judgements raise fear. So now, I'm frightening birth givers and providers alike when there's a posterior baby detected. The other consequences: nobody's taking action that's necessary in the birth anatomy, just because the baby's anterior or no one's identified a posterior presentation yet. Maybe there isn't back labor, maybe there is a coupling of the contractions. And so people are waiting and waiting for something to happen.

(00:39:38):

Spinning Babies[®] is the active part of patience. We are tuned to the rhythm of the birth, the labor pattern, and we are keeping an eye out for indicators that there might be an invitation to act. We're interacting with the birthgiver, observing, suggesting, and offering our help in these interactions that we talked about in chapter four, Body Balancing. Identifying issues allows us to address potential labor dystocias before the birthgiver's exhausted, before there's fetal distress. Waiting until there's fetal distress before we do an emergency cesarean means that we have been missing the signs of distress for many hours before the heart rate is starting to falter. Chapter five empowers you to see these issues long before anybody else is even noticing them.

(00:40:48):

And the only reason that this success can be this universal is because we are teaching ways to identify the issues. We are not waiting until the last minute to try sidelying release. Because in that case, our window of opportunity is quite narrow and many birthgivers will not have access to that last minute. So, a surprise technique that brings the baby to the gurney as two midwives in Liverpool told me as they were waiting for the operating room to be cleaned, they went ahead and did sidelying release and then they called into the operating room and said, cancel the OR, we've got a baby in the gurney. But there are occasions where that's not enough time, especially for someone who's had either a series of accidents, maybe a lot of sports injuries, a person who might have a hard time moving around due to a high BMI or stiffness or illness. When our metabolism is off, like severe diabetes or severe high blood pressure, premature labor.

(00:42:01):

I don't expect these techniques to be as wondrous as they are for a healthy person at 40 weeks, for instance. Of course, we teach daily activities for body balancing throughout the pregnancy so that we don't have to resort to emergency measures. But what I want you to do with chapter five is to identify the issues that you will be coming across from the time a person enters your care so that you can warmly and cooperatively introduce them to their own birth anatomy, through physiological stretches and jiggles to help align their baby, their uterus, their pelvis together.

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And then after chapter five, we're going to go into chapter six, repositioning ourselves around the topic of birth positions. Now we're going to be looking at chapter six, Repositioning. Repositioning our birth positions, repositioning our attitudes towards birth positioning. The pelvis is designed for upright birth. We can imitate some of the advantages of upright birth if the person's laying in bed, but let's not fool ourselves and think that it's equal. Now, in repositioning, we take the information we got in identifying issues about the inlet, the mid pelvis and the outlet, moving the femurs in this ball and socket and moving the spine for the sacral promontory and tailbone.

(00:44:07):

The pelvis changes shape according to how we position our legs and our spine. For instance, how we move our spine can affect where the sacral promontory is in relation to the inlet and where our tailbone is in relation to the outlet. How we move our legs to push pressures in this ball and socket can affect how the pelvis moves at the top and the bottom, and even out to the side. We can move this leg out in a lunge and get room to the side. We can move the leg in internal rotation and get room at the bottom. We can do external rotation for flaring at the top, but to make room at the top, we're interested in bringing the sacral promontory out of the way, making a much larger diameter in the inlet. Sometimes freeing the head from pushing against the sacral promontory or later the shoulder.

(00:45:24):

But when it comes time for the baby to be pushed out, this tailbone is often brought into the path of the baby by pulling the knees apart. Pulling the knees apart, actually, doesn't bring the bottom out at all. It brings the bottom into the path of the baby. Now we're laying on our sacrum, pushing that into the path of the baby, and we're pulling our legs apart, putting those great, uh, tuberosities in the path of the baby and narrowing the pelvic arch. We have lots of literature on the disadvantage of a narrow pelvic arch, and yet that's the birth position. We put so many birth givers into in practices today, where indeed, if we put knees together and toes coining together, but heels apart, we'd open that outlet. And if we are arch lower back, we can bring the tailbone out and we can make a quite large outlet.

(00:46:31):

Indeed. Once you do body balancing throughout labor, and then we ask where's baby, and as we follow baby's path through the pelvis, we're opening each level of the pelvis. So that baby has less bony protrusions to navigate and can just slip through the mucus membranes, right through the bony tunnel, rotating through the pelvic floor and coming out in an anterior position. Or if the baby

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can't rotate, then we've softened the way so that upright birth positions and moving the pelvis in advantageous ways can help the posterior baby or the asynclitic baby find room. Now there might be great pushing, purple pushing, with an asynclitic or posterior baby, but we can learn to make room so that we really know, is this pelvis going to accommodate this baby?

Susan Baker (00:47:37):

About five years ago, I was thinking of either changing careers or looking at it in a different area of nursing. And, um, I had heard about Spinning Babies[®]. I took the class with Lorenza [Holt] and from that day on, it just changed. I mean, I had been doing labor delivery for 20 years and my biggest hangup was to push with someone for three hours and then they had a C-section. And so the tools that I learned with Spinning Babies[®] provided everything I needed to know and everyone at work will say there's many, many, many C-sections that we've prevented from occurring. Um, the patients feel loved. They feel like we give them so much more attention by being at the bedside more, um, which that wasn't an issue for me. It was more not knowing how to get them into a position where, um, you know, they pushed for so many hours and, and then we couldn't facilitate the vaginal delivery. So it's caused me to have a whole new outlook and I've had a lot of success and patients couldn't be happier.

Gail Tully (00:48:51):

You too, like Susan Baker, will find that going to the operating room for an emergency cesarean is far less frequent than you found it before Spinning Babies[®]. I'm not just saying this because I am a lover of Spinning Babies[®]. I'm saying this because you've told me, the nurses and midwives of the world, have validated this again and again. Too often, people are told their babies are too big or their pelvis is too small. When indeed the practices of the day have pushed the tailbone into the way of the baby and close the tuberosities on the baby's head. And now they're told your pelvis is too small for your baby, we have to go to cesarean section. What's too small is our repertory. We need to open up the outlet of the pelvis and let the baby through. We need to identify when the baby is at the top of the pelvis, even though the cervix is fully dilated, so that we can open the inlet and let the baby through, and then change positions when we see baby's head. This is where all nurses and midwives can have a lot of confidence choosing the right birth positions, matching the birth position to the baby's whereabouts, that's what the right birth position is. Yes, there's personal choice. There's positions that suit, there's positions that challenge, there's positions that work with gravity or work against gravity. The position that is appropriate is the position that makes room where baby is passing through. Especially a baby is waiting for anybody to notice that this big sacral promontory is in front of their head, or this tailbone is pushed in front of them. And what happens when you turn to chart, you turn around and you see the person giving birth has rolled to their side, pulled their knees together up to

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their belly and are now breathing through their contraction. And you echo the voice that you heard when you came into the unit and say, "Dearie, pull your knees apart, hold your breath and curl over your baby."

(00:51:15):

And this might be exactly what reduces the room for the baby, adds strain on the perinium, strain on the baby. Oh my goodness, we really have some fun with our repositioning chapters to show you ways that you can make room for the baby so that you too can notice that with physiology, human birth is much easier than we see today, where all the disruptions of hormones and our, even our bony anatomy are introduced by well-meaning and well-educated providers. It's not to put blame on anybody. We do what we've been taught. The information has been there. We're just connecting the dots and bringing it to you. When you're done repositioning, let's talk about talking to the parents. Our chapter T is for Teaching parents in the birth room.

(00:52:20):

Let's take a look at chapter T, it's chapter seven, T is for Teaching in the Birth Room. How are we talking to parents? How are we bringing this knowledge forward? Really the excitement of learning a new techniques sends many, many people into teaching these techniques. And yet when they come back for their second Spinning Babies[®] workshop, they find that something wasn't quite lined up with the birth position or the technique. Some people would say, oh, well, sidelying release doesn't really work for me. I don't really see good results sometimes then I know something's off because sidelying release is amazing. So yes, it's not going to work for every single birth, but we're expecting to see amazing results. I'm not even going to say good results. I'm going to say amazing results overall in your practice.

(00:53:20):

So in order to teach, you need some integration, integration with your own being, integration with the material, and then some legal guidance because I, you know, I'm not a fruit tree out in the wild. I'm actually a owner of a company that has a brand and brands have licensing agreements and to get a licensing agreement, there's quite an intense business relationship. And there's a growing and a developing of a, of a hive mind, if you will. Um, cause I like these, you know, when we come together as Spinning Babies[®] Approved Trainers and Spinning Babies[®] Certified Parent Educators and our body workers are Spinning Babies[®] Aware Practitioners, we've made a real commitment to

honor the brand, to use words that reflect physiology first and to understand how two companies, an independent contractor and the Spinning Babies® brand can work together. So, I invite you to take that seriously.

(00:54:28):

I would like our conversations together to be about being together. That's the two topics in teaching. We talk about your integration with the material and we talk about the proper use with the brand. And that way we can grow a movement that holds the paradigm. It's not enough just to learn technique and teach a technique and that won't change birth on earth. What changes birth on earth is that we join together in a paradigm that we take that risk of vulnerability and that time of developing a relationship to move into the future. As a group, that's really upholding physiology first. We use physiology according to the needs of the birth. If we have a birth that, let's say there's high blood pressure in pregnancy that can't be controlled and we have to have the birth early, then the techniques aren't gonna necessarily work very well. Right? They'll add some comfort and some reassurance that they're done regularly throughout an early induction, but because the uterus doesn't have oxytocin receptors, we're not going to see as dramatic a result as we do in a healthy system. And indeed we need to address the needs of the, of the parent and baby. When there is something out of the ordinary, let's have compassion, let's have appropriate use of the cesarean, of the interventions, and let's add physiology where we can, restoring that mother-baby bond with skin-to-skin contact and not separating and do the best we can with what we have dealt with us.

(00:56:30):

So, as we finish the teaching chapter, we set our intentions for physiology first to be parent-centered, to have informed consent, and to pace with the person that we are helping so that they are guiding and leading their own birth, even as they look to you for guidance. It's a dance together, a give and a take and a moving forward and a retreating back, and a listening and a speaking, working together with birthing parents is such a beautiful opportunity. So unique in human experience. I hope to support your joy of teaching. Now we're going to go to our healing chapter.

(00:57:26):

As we turn to our healing chapter, chapter eight, H is for Healing of the art of the birth. I think the art of birth is to remove obstacles in front of the ease of birth. And like Rumi said about love. It's not about finding love, it's about removing obstacles so that you can be loved. The healing chapter addresses the stresses of life and the stresses of birth practice, our practice with birthing parents. It helps us to restore ourselves and to integrate our beings with our work, with our passion that we have for physiological birth.

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(00:58:21):

As we show up to the birth, we need to be present with the birth in order to be modeling and receiving the modeling of the parent. We allow for vulnerability, we allow for observation, we allow for that birthgiver to be the goddess within, rather than us being the authority outside of that person. The physiology leads in the birthgiver and within our own beings. We have responsibilities in our practice. The person is coming to us, expecting us to fulfill those responsibilities, but we're also being tuned in. So, I hope that you find some exploration in our healing chapter and that it's open for discussion in your life and maybe we have a chance to discuss it in the future together.

(00:59:28):

The Process chapter, chapter nine, is where we put the previous chapters into an application for malposition, labor dystocia, for simple pain relief by using these simple protocols in the chapters that came before. It is in chapter nine, is where we take the birth chapters together and we seek a protocol. Now, individuals are served by fluid activities and responses and not a rigid protocol. I get that, I'm a home birth midwife. Believe me, I am all about the individualization of birth to that birthgiver, the family, and the baby, right? The baby carries half the story, too. So, I offered this protocol chapter because I want to support you in the beginning of your efforts. Once you integrate the understanding of body balancing, you're identifying issues, and you've got the birth position sorted out, you're going to easily move outside the protocols and individualized each person's needs with good matching of body balancing and birth positions for that individual.

(01:00:54):

I trust you. I believe you. I trust you. I know that will happen for you, but there is an initial beginning time in your development, in your exploration of this paradigm, where it's good to follow a protocol and you might be busy and you might be tired at the end of your shift and you reach for the book and you page through it, and you say, now, what am I going to do about this asynclitic head? What am I going to do about this posterior baby? So, we put the protocols in the book to help you feel more confident in your explorations. It is appropriate for the nature of the book, which is introducing you to the paradigm, to help you integrate it into your birth practice. Let's hear it from nurse Stephanie.

Stephanie, RN (01:01:51):

Yeah. I listened to what the patient's feeling. If she's feeling more of the pain in her back, um, also what stage are we at? Does she have an epidural? Is she earlier on, is she an antenatal patient? Um, is it something that I can do, you know, forward leaning inversion, you know, or is it something where I can do the sidelying release if she has an epidural? You know, safety is always my first concern as well, but, um, a lot of our patients are epiduralized because I work night shift. So, I have more experience with Spinning Babies[®] with patients that are epiduralized.

So, a lot of times they're feeling the pain in their back or that pressure, that classic direct LP pressure in their bladder. So then, you know, I know that maybe sidelying release is going to probably be the most beneficial. If I know that the baby's really high, I think Walcher's is probably my favorite position out of all of them, actually. I feel like I've seen so much progress with that when a multep came in, fourth baby, and she had beautiful vaginal deliveries before. And for some reason, this baby's tracing was not great. And the doctor was really not wanting to do a C-section on a multep. And I said, can you just give us some time, give us all some time. She goes, I'll do whatever you want, just please, if you can avoid a C-section. I said, okay, so we did, we actually did Walcher's with the bed broken down. [Gail] So, the full Watcher's to get the high baby to come into the pelvis. [Stephanie] And she did deliver. That was Thanksgiving a year ago. I'll never forget that.

Gail Tully (01:03:30):

Now I told you at the beginning of this course that I had a little gift for you at the end of the course, and that's our mini spin book. It's downloadable, print it up, bring it with you, slip it into your birth bag, or keep it in your locker. The mini spin book gives you pages where you can write down your experiences, which with each of these chapters, you can make your favorite protocols mix and match for your setting, your families, and your favorites. So, be sure to download the mini spin book, and then look for me online in November and December of 2020, we're going to have question and answers. I'm excited to hear about your first experiences changing birth on earth, that you write down in your mini spin book and maybe you can get together with me and other readers for a free follow-up online. We'll get you the registration link, it's free. I just want to see your faces, meet you personally, hear about some of your experiences, try to answer any questions that you might have and in the future when we can all be together again, I hope you come to a Changing Birth on Earth event, where we gather for advanced skills for birth and opportunities to talk and storytell together so that you can integrate your paradigm of Spinning Babies[®] in your life and work.

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(01:05:21):

I'm very serious about changing birth on earth and I need your help to do it. My goal is that 30% of birthworkers will be using physiology first positions, stretches, and jiggles at the bedside, in the birthing room, in the birthing pool, wherever the person is giving birth. 30% of physiology before force will be enough to meet a tipping point. I'm hoping that 51% of all birthworkers come and visit us at the website, read this book, take a workshop, or have some sort of interaction with Spinning Babies[®]. And if 51% of all birth workers visit Spinning Babies[®] in some form or another, then I think 70% will recognize the name. I call this the 70-51-30 goal, 70% have heard our name, 51% have come and experienced something from Spinning Babies[®] and 30% have integrated with Spinning Babies[®] into their practice.

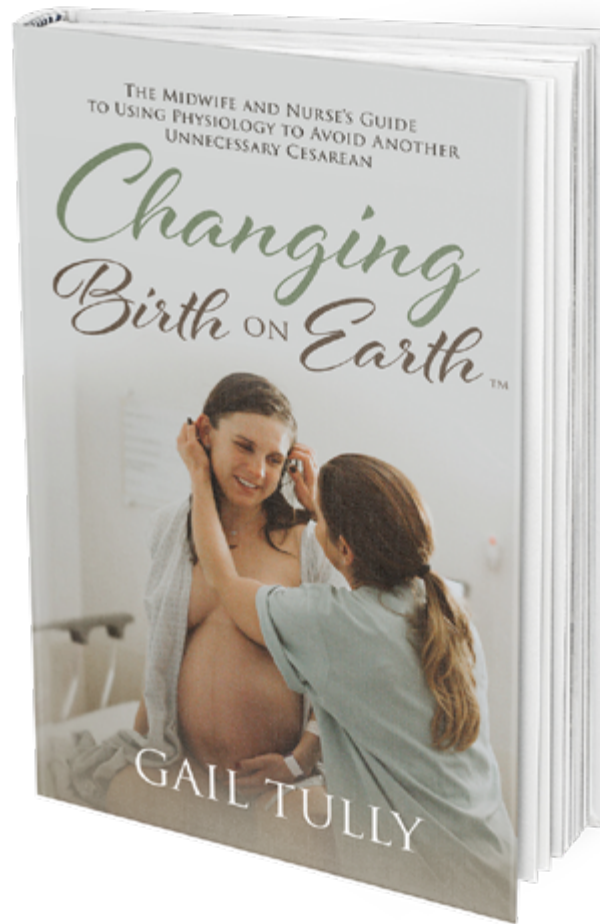
(01:06:39):

Let's make room for baby so that birth can be easier on the baby and the birthgiver and that ultimate optimal baby position back to the heart can be attained for most families where the relationship with the future begins in love and reassurance in vagal nerve connection between two bodies where heart cells begin to beat in unison together. Yes, I'm about ready to say world peace will result. As we heal birth, we have less trauma, but more compassion. I hope to empower you to move through your birth work feeling your own physiology and then joining up with me and other Spinning Babies[®] community members so that we can support you to do the work that you love to do. Let's keep our passion alive and we'll see each other in person and online. I'll be available online from time to time so that we can chat together. Thank you so very much for changing birth on earth.

~The End~

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