Holistic Treatment to Facilitating Labor and Postpartum Recovery

Lynn Schulte, PT

Holistic Treatment to Facilitating Labor and Postpartum Recovery for Midwives

OBJECTIVES

1. Understand the 3 main areas of the body that need assessment prior to birth.

2. Understand how to release the lower abdomen fascia to help baby's position in the belly

3. Learn techniques to improve the uterine mobility prior to birth.

4. Understand the motions the pelvic bones go through for birth.

5. Learn how to impact the opening of the pelvic bones during birth.

6. Understand the pelvic floor muscles role in birth and how to effectively release them prior.

7. Understand ways to help the abdominal muscles recover after birth

8. Understand what can help close up the pelvic bones after birth

9. Learn ways to help facilitate healing of the perineum and activate stronger pelvic floor muscle contraction after birth.

TREATMENT RULES

1. RESPECT THE TISSUES AND THE BABY!

2. NEVER CREATE PAIN

3. NEVER FORCE THE TISSUES TO RELEASE

Please honor these rules whenever working with any client!

LAB 1: LOWER ABDOMINAL FASCIAL RELEASE

INTENTION: To make sure lower abdomen has the mobility to allow baby to move into best position for birth

HAND PLACEMENT	Hands on both sides of lower abdomen outside of your hand touching ASIS,finger tips near pubic bone, patients knees bent up, use ulnar border of hand to assess
MOTION	Seeing if hands can sink down into the tissues in groin area
ASSESSMENT	To feel if any restriction in tissue mobility – should be same side to side
TREATMENT	GENTLE release work of sinking into tissues for a release. Take hand to restriction and wait for release to happen.

SPECIAL NOTE: PLEASE CHECK IN WITH BABY BEFORE DOING ANY MOBILIZATION! WHILE DOING THIS YOU CAN SEE IF BABY'S HEAD IS IN THE MIDLINE. HAVING THE CLIENTS KNEES BENT UP MIGHT HELP YOU TO SINK IN DEEPER IF BABY IS NOT TOO BIG AND IN THE WAY.

LAB 2: UTERINE MOBILITY EXTERNAL

Intention: To ensure uterus has mobility side to side

KNEES BENT UP FOR THIS

HAND PLACEMENT	Using a Pinch like hold of your thumb and Fingers about 2 inches apart or sides of hand on both sides of uterus angled down at a 45 degree angle. Make sure sides of fingers or tips of fingers are touching or close to pubic bone
MOTION	Side to side mobility of uterus
ASSESSMENT	To feel if any restriction in organs mobility.
TREATMENT	Take tissues to end range of restriction, hold and wait for release.

LAB 2: UTERINE MOBILITY ON A PREGNANT BELLY

Intention: To ensure uterus has even mobility side to side

KNEES BENT UP FOR THIS

HAND PLACEMENT	Hands on both sides of uterus
MOTION	Side to side mobility of uterus
ASSESSMENT	To feel if any restriction in organ mobility.
TREATMENT	Take tissues GENTLY to end range of restriction, hold and wait for release.

SPECIAL NOTE: WHEN YOU FIND RESTRICTED UTERINE MOBILITY ALWAYS DO THE UTEROSACRAL LIGAMENT RELEASE ON THAT SAME RESTRICTED SIDE. IF THE UTERUS IS RESTRICTED, UTEROSACRAL LIGAMENT USUALLY IS TOO.

LAB 3: UTEROSACRAL LIGAMENT RELEASE

INTENTION: To make sure uterosacral ligament has mobility to allow uterus to be more even and midline for birth

HAND PLACEMENT	One hand on lower lateral side of sacrum near ILA on side you are standing on, other hand on same side uterus
MOTION	GENTLE Compression of two hands together
ASSESSMENT	Comparing mobility of uterus side to side and US lig ability to mobilize
TREATMENT	On restricted side, one hand gently laying on side of uterus, other hand on same side sacrum on lateral edge near ILA. Abdominal hand stays soft, sacral hand compresses into other hand as in approximating the two hands.

SPECIAL NOTE: WHEN YOU FIND RESTRICTED UTERINE MOBILITY ALWAYS DO THIS TECHNIQUE ON THAT SAME RESTRICTED SIDE.
IF THE UTERUS IS RESTRICTED, UTEROSACRAL LIGAMENT USUALLY IS TOO.

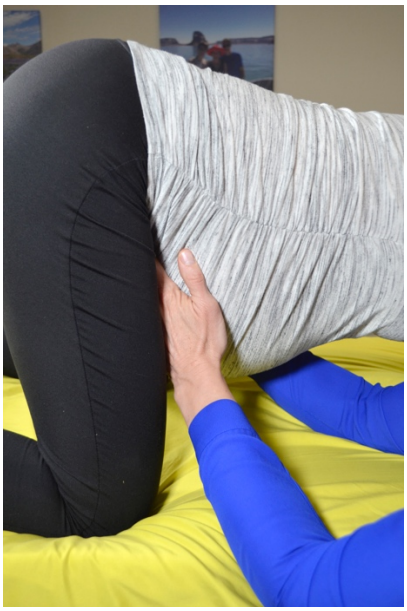
LAB 4: PELVIC DIAPHRAGM RELEASE

INTENTION: To release any restrictions in lower abdomen and pelvic inlet for birth

HAND PLACEMENT	Top hand just superior to pubic bone thumb facing up toward head, bottom hand on lower third of sacrum directly below top hand
MOTION	Force is gentle compression between two hands.
ASSESSMENT	To feel if any restrictions more on one side or other or where tissues take you.
TREATMENT	Allow two hands to gently "compress" together and follow the tissues until release occurs.

SPECIAL NOTE: YOU CAN DO THIS TECHNIQUE FOR HOURS, DO AS LONG AS YOU LIKE. THIS TECHNIQUE IS GREAT TO END A SESSION WITH. ALSO CAN DO THIS AFTER BIRTH TO HELP UTERUS INVOLUTION AND SETTLE IN MIDLINE.

LAB 5: INVERSION WITH ABDOMINAL FASCIAL RELEASE



INTENTION: To work with gravity to assist the release of lower abdomen fascia and uterosacral ligaments make sure there is balance and mobility for baby to get into better position and to move for birth

HAND PLACEMENT	Patient in Inversion position knees and elbows: Your hands on either side of belly near groin area.
MOTION	No motion
ASSESSMENT	To feel if any restrictions to sinking into the tissues more on one side or other
TREATMENT	In this position gently offer compression to the restricted side to work on getting the tissues even.

SPECIAL NOTE: CAN BE DONE IN LABOR BETWEEN CONTRACTIONS TO ASSIST BABY'S HEAD IN REENGAGING IN A MORE OPTIMAL POSITION

LAB 6: ENERGY FLOW IN PELVIS AND LEGS

INTENTION: To see if pelvic energy has the ability to flow down and open for birth

HAND PLACEMENT	1. One hand in front of hip the other on buttock on same side. 2. One hand on pubic bone, other on sacrum
MOTION	Tuning into the energy of the body and 1. see if it's moving down the leg and 2. has an open root chakra flowing out the pelvis.
ASSESSMENT	To see if energy is flowing down the legs and out the pelvis.
TREATMENT	No direct treatment. Left side blockage (feminine) could be about fears of becoming a mother or receiving this baby into her life, Right side blockages (masculine) could be about having baby and still working how to do both? Or issues with men in her life

SPECIAL NOTE: Sometimes when a client starts talking about what is causing the blockage of energy flow the energy may start to flow more. This is a sign they are on the right track and need to focus more on that topic.

LAB 7: IS PELVIS STILL BIRTHING?

INTENTION: TO SEE IF PELVIS IS STILL WANTING TO BIRTH FROM PREVIOUS BIRTH

HAND PLACEMENT	1. On Sacrum 2. Hands on lower part of ischiums
MOTION	Tuning into the energy of the bone to see if 1. Lower part of sacrum lifts back 2. If ischiums splay apart
ASSESSMENT	To see if bones move energetically. If no movement noted the energy is neutral and pelvis is not still trying to open for birth.
TREATMENT	No direct treatment. Need to keep this in mind as you treat the bones and pelvic floor muscles.

SPECIAL NOTE: This will give you an idea postpartum if pelvis is still being affected from birth.

LAB 8: HIP ROTATIONS DURING LABOR

Palpate Ischiums in Neutral

Palpate Ischiums with Internal rotation

SPECIAL NOTE: USE THIS TO GET A BIT MORE OPENING OF THE ISCHIUMS FOR LATE PUSHING PHASE OF LABOR. CAN BE DONE IN ANY POSITION!

LAB 9: PELVIC MOBILIZATIONS TO OPEN PELVIS DURING LABOR

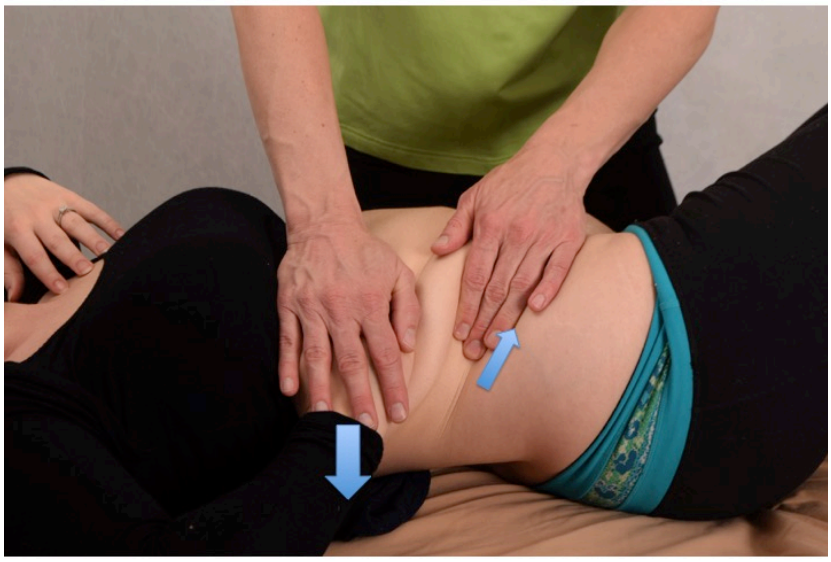
INTENTION: To help facilitate pelvic opening during birth

In early parts of labor compress ISCHIUMS together to open up pelvic inlet to get baby into pelvis

After baby is zero station, Compress ILIUMS at iliac crests to open up pelvic outlet!

SPECIAL NOTE: Use palms of hands to compress bones in either the ischiums or the iliac crests.

LAB 10: OBLIQUE STRETCH AND RELEASE



INTENTION: To release and lengthen oblique muscles so recti muscles can approximate

HAND PLACEMENT	One hand holds ribs down while other hand mobilizes obliques toward midline
MOTION	Pulling oblique muscles toward the midline
ASSESSMENT	Feel for lack of mobility of oblique muscles moving toward the midline
TREATMENT	Massaging oblique muscles toward the midline using broad long strokes from back to front. Release tissue along ribcage and ilium too.

LAB 11: PELVIC FLOOR COMPRESSION

INTENTION: To help the pelvic floor muscles recover after birth

HAND PLACEMENT	Using a warm or cold compress use the palm of your hand to offer compression to perineum as pain allows.
MOTION	Gentle compression superiorly toward the head without creating pain
ASSESSMENT	None
TREATMENT	Direct pressure superiorly to help tissues remain up and inside. Can also add compression with an active pelvic floor muscle contraction when tissues are ready.

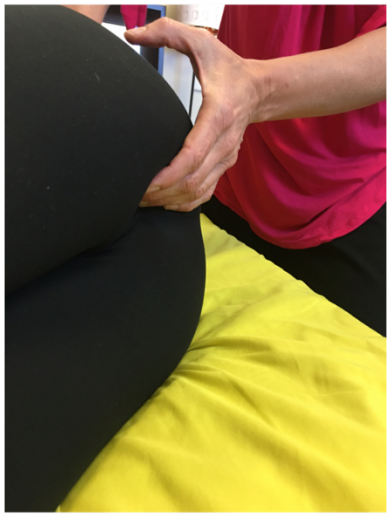
LAB 12: CLOSING THE PELVIS AFTER BIRTH

Intention: To close back up pelvic bones and rebalance ischiums and iliums

HAND PLACEMENT	Index finger and palm/thumb on ischiums, other hand fingers on PSIS, palm on other PSIS.
MOTION	Compression of ischiums and PSIS's to midline
ASSESSMENT	Does one bone feel harder or out of place compared to the others?
TREATMENT	Compress toward midline, balancing all 4 bones until softening occurs.

SPECIAL NOTE: THESE BONES NEED COMPRESSION AT EVERY ANGLE OF HIP FLEXION. REMEMBER THE LABOR POSITION BABY CAME OUT AND MIMIC THAT.

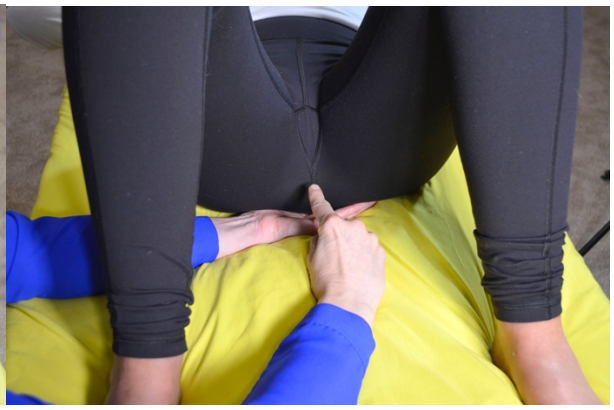
LAB 13: EXTERNAL PELVIC FLOOR MUSCLES RELEASE



INTENTION: To see if pelvic floor muscles have the softness and mobility to open for birth.

HAND PLACEMENT	Mom in side lying, along inside edge of ischium or supine find inside of ischium/rami
MOTION	none
ASSESSMENT	To see if muscles give and have spring to them.
TREATMENT	Direct pressure into tighter muscles until release occurs. Compress boney attachments to facilitate release, ischium medially and coccyx anteriorly.

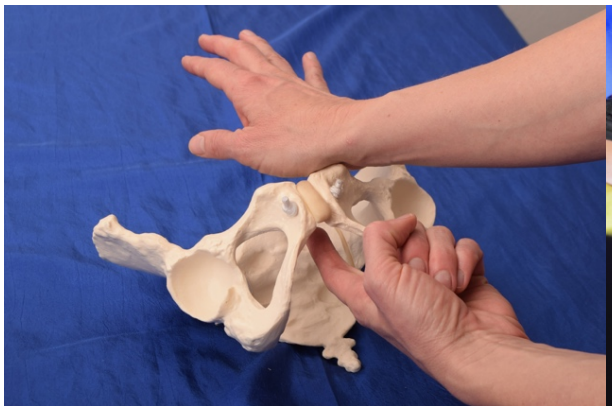
LAB 15: INTERNAL ASSESSMENT OF PELVIC FLOOR MUSCLES DURING PREGNANCY

INTENTION: To make sure pelvic floor muscles have mobility to move for birth

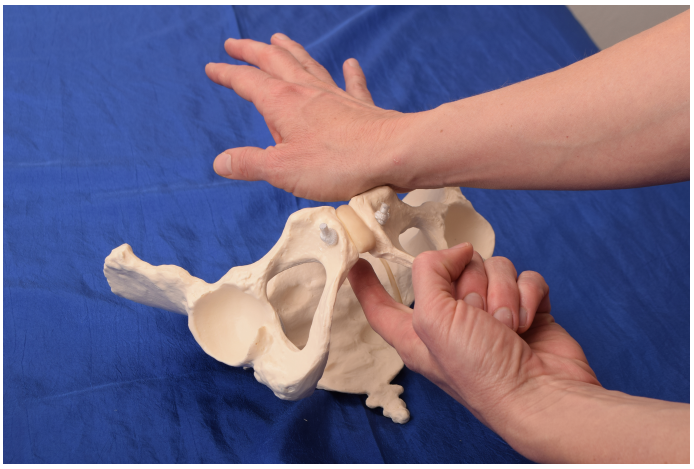
HAND PLACEMENT	Internal finger facing down deep on pelvic floor muscles on one side of rectum. Other hand: A. fingers on coccyx externally and palm on ischium on the same side or B. fingers on far ischium and palm on near side ischium if your hand is long enough.
MOTION	Compression internally of both tightened muscle and externally on coccyx/ischium
ASSESSMENT	Increased tension in pelvic floor muscles on either side of rectum.
TREATMENT	Compress coccyx up toward ceiling and ischium inward as pressure downward on levator ani or coccygeus muscle internally until release is felt.

LAB 16: ASSESSING AND TREATING BLADDER INTERNALLY




HAND PLACEMENT	Internal finger facing up on urethra, outer hand on L side lower abdomen just above pubic bone.
MOTION	Use index finger to assess length of urethra on both sides, then find side of bladder and sidewall of vagina and compare position of bladder. Then place finger along urethra so tip is on bladder wall and do local listening to see what the bladder energetically wants to do.
ASSESSMENT	Usually find bladder off to left so less space between bladder and vagina on left side.
TREATMENT	Place finger on left side of bladder and gently encourage tissue to the midline. Once bladder is back in midline, place finger on internal sphincter at bladder neck and unwind sphincter until tissues stop. Very fine, minute motions here.

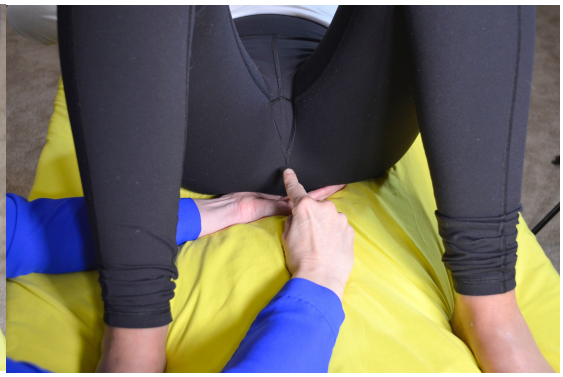
LAB 17: MOBILIZING THE CERVIX



Intention: To make sure cervix is midline and has freedom of movement in all directions

HAND PLACEMENT	Finger finds cervix
MOTION	Determine position in vaginal vault
ASSESSMENT	To see if you can sweep your finger around entire cervix and it has mobility in all directions.
TREATMENT	Work on bladder first, then if cervix is not midline use internal finger to press cervix to midline while outside hand works to bring uterus to midline. Direction of outside hand is determined from external uterine mobility. If uterus is diagonally restricted or pulled over to one side will determine your outside hand motion.

LAB 18: INTERNAL PELVIC FLOOR MUSCLES - LEVATOR ANI RELEASE

Intention: To release pelvic floor muscles to help bring ischiums back to midline

HAND PLACEMENT	Internal finger facing down on levator ani muscles. Other hand fingers and palm cupping both ischiums. OR Fingers on tailbone and palm on same side ischium.
MOTION	Ischiums are brought together as pressure is placed on tight pelvic floor muscles internally.
ASSESSMENT	Increased tension in pelvic floor muscles and ischiums feel splayed
TREATMENT	Compress pelvic bones together as you add pressure on the tight pelvic floor muscles. Hold until release is felt and ischiums feel more in midline.

SPECIAL NOTE: After both levator ani's are released, use this technique again on both sides to help bring ischiums back to midline, with outside hand on both ischiums if you can reach them.

LAB 19: INTERNAL COCCYGEUS MUSCLE RELEASE

Intention: To release pelvic floor muscles to help bring ischiums back

HAND PLACEMENT	Outside hand on tailbone mobilizing anteriorly while Internal finger feels for the motion. Once find it the muscle lateral to it is the coccygeus. Outside hand fingers on coccyx and palm on ischiums.
MOTION	Ischiums are brought medially and tailbone anteriorly as pressure is placed on tight coccygeus muscle internally.
ASSESSMENT	Increased tension in coccygeus muscle
TREATMENT	Compress ischiums medially, tailbone anteriorly as you add pressure to the tight coccygeus muscles hold until release occurs.

LAB 20: PERINEAL BODY AND SCAR TISSUE RELEASE

Intention: To release any tone and scar tissue from the perineal body area.

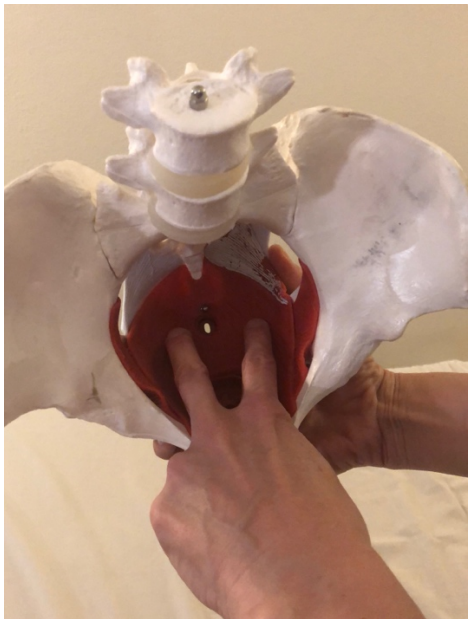
HAND PLACEMENT	Index finger on perineal body and thumb on skin externally. Other hand fingers on tailbone and palm on ischiums or fingers and palm on bilateral ischiums.
MOTION	Use a downward pressure on tissues to feel for restricted tight scar tissues.
ASSESSMENT	To feel if any restriction/tone in perineal body tissue moving as laterally side to side as you can.
TREATMENT	Compress tightened and restricted tissues between index pad and thumb on outside of tissues and hold until release occurs.

LAB 21: ANAL SPHINCTER MUSCLE RELEASE

Intention: To release tone in anal sphincter muscle

HAND PLACEMENT	Index finger on perineal body and thumb on outside of anal sphincter. Other hand fingers on tailbone.
MOTION	Use a pinching pressure to check top half of anal sphincter muscles, then take thumb nailbed and press around the clock of the anus on the lower portion feeling for any knots or restrictions in the sphincter muscle.
ASSESSMENT	To feel if any restriction/tone in perineal body tissue and in anal sphincter muscles.
TREATMENT	Find knots in anal sphincter and compress between perineal body and anus to release upper half of sphincter and just press into knots in lower half with your fingernail until release is felt. Fingers of other hand on coccyx compressing anteriorly for release.

LAB 22: KINESTETIC AWARENESS OF PELVIC FLOOR FOR BIRTH



INTENTION: To prepare moms/birthing persons to recognize and release pelvic floor as baby's head applies pressures to pelvic floor

HAND PLACEMENT	Internal fingers on most posterior and inferior part of the pelvic floor
MOTION	Pressing posteriorly and inferiorly
ASSESSMENT	None – to get mom used to sensation of pressure
TREATMENT	Instruct in exhale with TA contraction while practicing releasing and relaxing pelvic floor muscles

Institute for Birth Healing

Back Pain Disorders and Birth

Low back pain

Reported in 50-80% of pregnant women
Pelvic Ring dysfunction including sacroiliac, pubic symphysis, pelvic girdle relaxation, pelvic insufficiency - range from .8%-50%
Positions For Stage 1: Squatting, standing, walking, heel sitting while leaning forward, leaning, sitting on a ball, hands and knees
Positions For Stage 2: Squatting, sitting, sidelying, kneeling and hands and knees
Birthing bed, squat bar, tub, birthing chairs are good too.
Often limited to lithotomy, semi-reclining and side lying

Herniated Disc

Avoid increasing intradiskal pressure by flexion of the trunk and flexion while seated, ie, McRobert maneuver
Positions that maintain the torn edges of the annulus posteriorly mean better healing, use extension or back bending.
Breath holding and Valsalva maneuver should be avoided causes increased pressure
Use open glotting pushing or physiologic pushing
Suitable Positions: sidelying, semi-reclining with adequate lumbar support, hands and knees (if hip flexion is not restricted by nerve root impingement)
Use squatting between partners knees and come into extension with exhalation
Kneeling onto a chair come into extension with exhalation
Avoid semi-reclining with knees to chest, and squatting and lithotomy as it can increase nerve root tension.

Spinal Stenosis

A narrowing of some part of the spinal canal or lateral foramen
Risk of nerve root impingement
Aim to open up the foramen by positioning in spinal flexion and lateral flexion to the opposite side of the stenotic changes. Use pillows under the waist to open up the up side of the foramen with knees bent and hips in flexion
Try squatting to flex the spine, but excessive hip flexion may cause nerve root pain via a traction force on the spine.
Try quadruped, flexed over a ball, beach bag chair, or stack of pillows

Spondylolisthesis

An anterior slippage of a vertebral body relative to a vertebral body below. They are graded by x-ray 1-4. Some are asymptomatic till pregnancy when increased strain on the lumbar spine from the abdomen. The lumbar spine takes on an extended posture by the excessive lordosis so that contributes to the symptoms.
No birthing position exaggerates extension except standing, but if a disk herniation accompanies the spondylolithesis then that is the limiting factor.

Sacroiliac Dysfunction

Pain with supine, transitional movements, ambulation, avoid asymmetrical postures, avoid the lithotomy position,
Recommended positions: Any position where the lower extremities are symmetrically supported such as semi-reclining with pillows under both knees
Hands and knees or upright kneeling if weight bearing is comfortable.
Avoid walking during stage 1.
Avoid Semi reclining with the lower extremities unsupported

Coccydynia

Subluxation, dislocation, fracture, or ligamental strain may occur so allow free movement of the coccyx
Avoid sitting and semi-reclining
Try: sidelying, squatting, hands and knees or upright kneeling or standing

Symphysis Pubis Dysfunction

Laxity of the symphysis pubis joint
Keep separation of the legs to a minimum
Avoid lithotomy positions if possible, squatting
Hands and knees is probably the safest position
Sidelying is ok as long as top leg isn't too abducted
Discourage moms from placing feet on attendant's hips because of the excessive force hip abduction and strain on the pubis

Institute for Birth Healing

SYMPHYSIS PUBIS DYSFUNCTION - SPD

Symptoms:

- Pain
- Difficulty or inability to walk
- Difficulty w/ movements such as rolling in bed, getting in/out of car
- Suprapubic pain, sacroiliac or lumbar pain
- Radiating pain to the buttock, groin or leg
- Difficulty waking w/ long/normal strides
- Difficulty in abducting legs
- ***Anxiety over cause of pain!***

Signs:

- Pain on palpation of symphysis
- Pain on unilateral weight bearing
- Waddling gait
- Tight hip adductors
- Unable to get up only an examination table
- Getting in/out of bath

Lifestyle Restrictions:

Difficulty in:

- Getting in and out of a car
- Turning over in bed
- Climbing the stairs
- Shopping and household activities
- Sexual intercourse
- May experience loss of self-esteem and depression

Immediate Advice:

- Stand with even weight on both feet
- Sit w/o crossing the legs. Sit evenly on both buttocks with knees APART
- Use a pillow in the small of the back when seated.
- Turnover in bed with knees always APART
- Try to keep knees APART when doing activities such as getting in/out of a car
- Try to use the shower instead of the bath
- Brace your lower abdominal and pelvic muscles whenever you need to bend or lift.

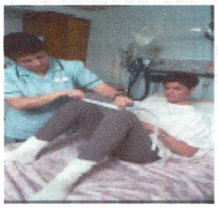
GUIDELINES FOR CARE IN LABOR AND DELIVERY

During Labor and Delivery:

- All member of the team must be aware of the implications of SPD
- The distance a women is able to abduct her hips w/o causing pain (pain-free threshold) should be measured by placing a tape measure between her knees and recording the distance in the notes prior to labor
- Keep separation of the legs to the minimum
- Perform vaginal examinations in the most comfortable position for the woman
- Be aware of the masking effect of epidural and spinal anesthesia in relation to excessive abduction of the hips.
- Enable mother to adopt a position of optimum comfort in all stage of labor. Lying on the left or right side or kneeling upright should be considered for delivery.
- Actively discourage women from placing their feet on attendant's hips because of the excessive forced hip abduction and strain on the pubis.
- Consider the most comfortable position for the mother for suturing
- If lithotomy is required, it should be for the shortest time possible: i.e. for assisted deliveries, suturing or manual removal.
- In severe cases an elective caesarean may be necessary

More Info on Laboring with SPD:

4. Labour

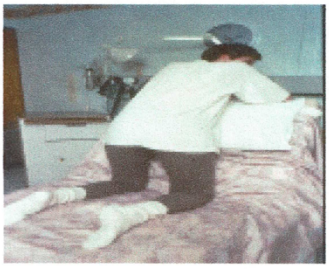


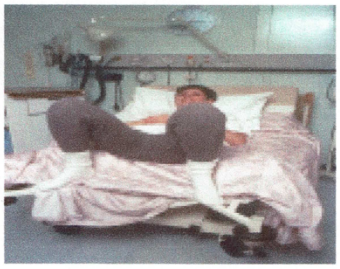
1 Just before your 'due' date, your 'birthing partner' should measure how far you can part you knees without pain when you lie with your knees bent. This is known as your 'pain free gap'. Tell your midwife on the labour suite if movement is restricted and painful. She and your 'birthing partner' can then try to ensure that your knees are not parted beyond their pain free range.

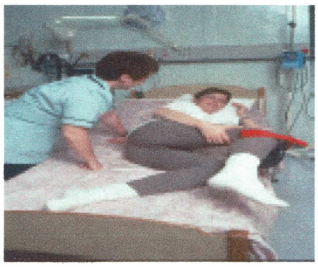
2 Epidural. Your 'birthing partner' should ensure that your legs do not fall into a position outside your 'pain free gap', holding them together if necessary! It is the position of the legs and back while the epidural is effective that is vital. The back should be supported and not sagging or slumped. One Obstetrician has recommended tying a cloth belt around the knees to keep them within their pain-free range.

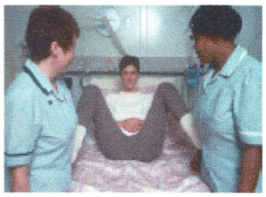
3 Birthing pool. This depends on the policy of your labour unit. In general, if pain is mild and you are reasonably mobile it may be possible to use the pool. If the pain is more severe, the it is probably not advisable to use the pool. Discuss your options with your labour team/midwife.

4 Delivery positions. Lying on your side with someone supporting your upper leg is the best position to put the least strain on your pelvis and back. You should, however, use whatever position feels most comfortable. Kneeling upright over some pillows or beanbags lets your body work with gravity and allows the baby to descent through the birth canal. There is slightly less strain on the Symphysis than there would be if you were lying on your back.









5 Squatting, which could stress the Symphysis Pubis, is not advisable. The lithotomy position, with legs in stirrups, or on midwives hips, is possibly a cause of postnatal pelvic pain.

SCHULTE INTRAVAGINAL PROTOCOL

- Assessment of Pelvic Floor Muscles and Tissues
- Correct Bladder Position
- Give Cervix some attention
- Free up Cervical Mobility 360 degrees
- Get Uterus back in midline if able
- Release pelvic floor muscles
    - Levator Ani and Coccygeus
    - Bring Ischiums back together
- Scar Tissue and Perineal body
- Release Anal Sphincter Muscle
- Work on Core Engagement- Pelvic floor muscles contraction on exhale with transverse abdominus pulling back up and in.

Next Steps:

1. Join our Private FB Group: https://www.facebook.com/groups/InstituteforBirthHealing/

Join our mailing list to be kept up to date with latest news from Institute for Birth Healing. Sign up for the 6 Key Assessments for a Stronger Pelvic Floor and you'll be added.
https://instituteforbirthhealing.com/professionals/

2. Check out our other in person and online courses:

   https://instituteforbirthhealing.com/professional-courses/

   - Holistic Treatment of the Pregnant Body
   - Holistic Treatment of the Postpartum Body
   - Advance Treatment of the Postpartum Body
   - Confidence in your Core, Pelvic Floor and More- Online
   - Facilitating a Smoother Birth and Faster Recovery -Online

3. Become Certified as a Birth Healing Specialist- Learn more here:
   https://instituteforbirthhealing.com/certification/

I'm so grateful to you for being a part of this course. Thank you for sharing and spreading this work with moms and professionals.