

Knitting Midwives for Drugless Childbirth?

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by Michel Odent, MD

I cannot forget the time when a woman could give birth in a small, dimly lit room with nobody around but an experienced and silent midwife, sitting in a corner and knitting. The situation was obviously conducive to easy births.(1)

The Physiological Effects of Repetitive Tasks

It is fruitful to reinterpret such a scene in the scientific context of the twenty-first century. At the April 2004 British Psychological Society conference, Dr. Emily Holmes, from Cambridge University, presented her studies on the effects of repetitive tasks, such as knitting, in stressful situations. In one study, volunteers were recruited to watch video footage of real car crashes showing dead bodies and a lot of blood. Some participants were given a repetitive task, such as tapping out a complex five-key sequence of numbers on a keypad, to do while they watched. Those who were given such a task experienced fewer flashbacks during the following days than the others. The author concludes from Dr. Holmes' studies that repetitive tasks are an extremely effective means of reducing tension. Dr. Holmes emphasized that her research was consistent with the actions of notorious French *tricoteuses* of the French Revolution, such as Madame Defarges, who knitted while watching people being guillotined, apparently never experiencing post-traumatic stress disorder. She also referred to the use of worry beads in many cultures, such as Greece, as a way to cope with stressful situations.

We might translate such findings into physiological language and conclude that when midwives spend hours and hours knitting, their own levels of adrenaline are kept as low as possible. Since high levels of adrenaline are extremely contagious, the progress of labor is to a great extent dependent on the adrenaline levels of those around the laboring woman.



Primary Objective

Such considerations are of paramount importance at a time when we must learn to think long-term and to think in terms of civilization. The aim of any futuristic birth strategy should be that as many women as possible give birth vaginally, thanks to an undisturbed flow of love hormones. The future of our civilizations is at stake.

The essential first step is to improve our understanding of birth physiology and to rediscover the basic needs of women in labor. These basic needs are shared by all mammals. All mammals need to feel secure when giving birth: They postpone the delivery if there is a predator around. All mammals need privacy: They have strategies for avoiding observation during the period surrounding birth. After thousands of years of culturally controlled childbirth, decades of industrialized childbirth and a proliferation of "methods" of "natural" childbirth (as if the words "method" and "natural" were compatible), these basic needs have been forgotten.

The primary objective should be to reduce the need for drugs, since all drugs used during labor are pharmacological substitutes for the hormones a woman is

supposed to release when giving birth. All of them block the release of the natural hormones and don't have the same behavioral effects. For example, intravenous oxytocin is effective at stimulating uterine contractions (peripheral and mechanical effect), but it does not reach the brain receptors and has no behavioral effects. All drugs used during labor have serious side effects. Anyone exploring our data bank, which focuses on the long-term consequences of what happens during the "primal period," will be convinced of the importance of avoiding drugs during labor.(2)

If the basic needs of laboring women and the specific role of the midwife were better interpreted, a shift towards drugless

childbirth would not be an unattainable ideal. Drugs would be mostly used in the particular case of a c-section—a safe operation in a well-equipped and well-organized maternity unit.

There are serious reasons why elective caesareans should be avoided as far as possible. When a non-labor caesarean has been scheduled, there is no guarantee that the baby, particularly its lungs, are perfectly mature. Maternal and fetal hormones associated with the progress of labour contribute to the maturation of the lungs. The increased risks of respiratory problems with c-sections are well documented.

In general, a non-labor caesarean implies that the fetus has not participated in the initiation of labor. It also implies that the fetus has not been given the opportunity to put into action its system of stress hormones. Breastfeeding difficulties are more probable than after an in-labor caesarean. Furthermore, the chances for a successful vaginal birth after caesarean seem to be higher in the case of an in-labor caesarean.

On the other hand, there are also serious reasons to avoid emergency c-sections that involve a race between the surgeon and

progress of fetal distress. All statistics confirm the dangers of such a situation.

Futuristic Strategies

We must prepare for a binary strategy, with two basic scenarios.(3) Either the birth process is straightforward by the vaginal route. In spite of several generations of medicalized birth, this will become more common on the day when the importance of privacy and the reason for authentic midwifery are rediscovered.

Or the birth process does not appear as straightforward. This should lead to an in-labor, non-emergency caesarean. The critical task is to decide early enough during the first stage of labor when a caesarean is indicated. We need non-pharmacological tests adapted to twenty-first century strategies. The "birthing pool test" is a good example of a tool adapted to futuristic scenarios.(3) It is based on a simple fact. When a woman in hard labor enters the birthing pool and is immersed in water at body temperature, spectacular progress in dilation should occur within an hour or two. If already well-advanced dilation remains stable in spite of water immersion,


privacy (no camera!) and dim light, one can conclude that there is probably a major obstacle. There is no reason to procrastinate. It is wiser to perform an in-labor, non-emergency caesarean right away.

Such a simple binary strategy, which is based on an improved understanding of birth physiology and which takes into account the safety of the modern caesarean, is compatible with both drugless practices and low rates of surgical intervention. It is not unattainable; I had adopted such a strategy at the Pithiviers state hospital in France. Decreased needs for drugs and lower rates of caesareans should be the result of rediscovering the basic needs of women in labor, rather than a primary objective.

Such a rediscovery implies a resurgence of authentic midwifery. Authentic midwives are effective at transmitting tricks, the effects of which reduce adrenaline levels. Fathers who were spending hours boiling water while the midwife was knitting were not at risk of male postnatal depression. We can dream of the day when any Midwifery Today conference includes a knitting workshop.

Such considerations should not lead to simplistic conclusions. We do not suggest that all midwives should be experts in the "throwing method," the "continental way," or the "two-handed, two-color knitting." Our objectives are to underscore that the main preoccupations of authentic midwives are easily explained in the language of physiologists. They are based on the antagonism adrenaline—oxytocin. In other words, they are based on the fact that stress hormones inhibit the release and the action of the hormone necessary to induce and maintain effective uterine contractions during labor and delivery. The most important aspect of the art of midwifery is, therefore, to protect the mother-to-be against anything that might increase her level of adrenaline. This is what countless birth attendants have done intuitively, without referring to the physiological perspective. However, at a time when the authentic midwife needs to be rediscovered, it is useful to reconcile intuitive knowledge and scientific perspectives.

A good understanding of the physiological processes leads the midwife to make sure that nobody is under the effect of adrenaline in the environment of a laboring woman. It also leads her to be aware of her own levels of adrenaline. That is why knitting needles might become the symbols of a renewed, simple and cheap technology.

 Michel Odent has been instrumental in the history of childbirth and health research. He developed the maternity unit at Pithiviers Hospital in France in the 1960s and 1970s and is known as the obstetrician who introduced birthing pools and home-like birthing rooms. He later founded the Primal Health Research Center in England, which focuses on the long-term consequences of experiences during the primal period (from conception until the first birthday). Odent is author of 11 books published in 21 languages. He is also a contributing editor to *Midwifery Today* magazine.

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