



Institute *for*
Birth Healing



INTRO TO:

*Holistic
Treatment of the
Postpartum Body*

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Intro

As a bodyworker, we all understand how much toll pregnancy and birth takes on the body. Growing and carrying a baby inside the body and then birthing creates a lot of changes in the muscles and tissues. No matter which way the baby comes out, it creates challenges to the tissues beyond anything else a person might encounter in their life.

Think about the changes the body needs to go through to support the development and birth of a baby. The abdominal tissues expand to support the baby and create stresses in this area that only occurs during pregnancy. In our moms with shorter waists, the liver and stomach get jammed superiorly as the baby puts pressure on them as they move around. Sometimes the lungs and rib cage get superior and lateral pressures from those wonderful kicks. Then think about the void that gets created once that baby comes out. Lengthened muscles need to find a way to restrengthen and shorten again. Organs need to readjust to find their new homes without the baby in there.

Now think about the changes and pressures put on the body while the baby comes on out.

Only a vaginal birth can create a separation and widening of the pelvic bones in the way that it does. The bladder really gets flattened by the baby's head as it passes by. The pelvic floor muscles need to be able to stretch and lengthen to a degree it will never have to again, unless another pregnancy occurs. All these changes impact a mother's healing.

Understanding the mechanics of birth and how the pelvis needs to move in order to allow a baby's passage can inform us in what needs to happen for more complete healing of these tissues.

In working with the thousands of pregnant and postpartum women in my practice I have found common patterns in almost all the women who have worked with me. These same patterns have informed this body of work which I'll be sharing with you in this course.

When working with the postpartum body we need to be aware of the entire trunk's involvement in growing and birthing a baby. We will discuss the thoracic area, abdominal area, pelvis and pelvic floor muscles in greater detail here.

The Pelvis

The pelvis is a very complex structure. It is a distributive junction between the ground energy coming up through the legs and the weight of the trunk sitting on top. Having a firm foundation in our pelvis gives us a solid ground from which to move. The sacroiliac joint transfers the weight from the legs into the spine. During standing, the symphysis pubis joint takes 30% of our weight bearing forces.

Pelvic mobility

We're not going to get into all the minute patterns of motion that can occur between the sacrum and ilium in the sacroiliac joint. What I have found to be more beneficial is to understand how the bones should move, what it feels like when they don't move, and how to correct for normal mobility.

We will look at the common pattern the pelvis goes through during birth and how to release the different variations. (Common birth patterns are highlighted in pink in this document.) You will also learn how to assess the different bones of the pelvis and how to release patterns of restrictions in these bones.

The pelvic bones go through a multitude of directions of movement during birth, far greater than what is utilized in just normal daily motions.

Every woman brings her own set of issues to her birth from previous injuries and traumas. So you may find other things going on in her pelvis. Making sure the pelvic bones are soft and supple, and can spring easily in the motions they are supposed to, can help restore better function in the pelvis after birth.

It is my opinion that the pelvis cannot be assessed by palpation of structure and with movement alone. For better assessment of the pelvis, we need to be spring testing all the bones of the pelvis to see if they can move easily in the motions they are meant to go.

Trauma in the bone

Bone is actually a spongy structure that is firm but has a slight give to it. When it's been traumatized from impact and/or been fractured, the bone loses that give or sponginess and becomes quite hard. You can learn to palpate the difference in the quality of the bone by compressing the different parts of the bone and comparing side to side.

MOBILITY TESTING OF THE PELVIC BONES

For some of the pelvic bones, we will be using spring testing to assess for mobility of the bones in the joints. This is a much more effective way of assessing the sacroiliac joint. There are three steps to testing.

First, we will LOAD the bone in a direction until end range.

Then, we will PAUSE for a moment to make sure you are at end range.

Finally, we will SPRING the end range position of the joint looking for mobility.

These movements are NOT like CPR where you spring up and down the entire range but instead just do a simple and little end range spring to the bone. You want to assess the LOADING and SPRINGING ability of the bones in these tests. Compare the ability of these movements side to side. They should be even. When there is dysfunction one side can feel like jelly and the other side can feel like peanut butter or even cement!

Not all bones are sprung at end range. Some bones have very little motion to them so they can't be loaded. Just assessing any movement in these bones is enough.

THE ILIUM

The big elephant ear shaped bones on either side move laterally and obliquely posteriorly out to the side to allow the baby's head into the pelvis. In the pushing phase of labor, the ilium move in the opposite direction. However, these motions totally depend on what position a mom gets into for birth.

Sidelying position during birth can limit the ilial motions on the side she is laying on causing the opposite side to move more. A supine position with different people supporting her legs can cause an asymmetrical torsion on the iliums if one person holds her legs at a more aggressive angle than the other. In a squatting position, if she has her legs asymmetrical that can cause more pressure on one side than the other.

We need to allow women to get into whatever position she feels she needs to in order to get the baby out. We just need to know how to rebalance her pelvis to help her not have pain and dysfunction afterwards or during a subsequent pregnancy.

To do this, we cannot work with the ilium alone. We have to rebalance both the ilium and ischium together and make sure the sacrum is mobile to be more effective in our treatments.

ASSESSMENT:

In supine the ASIS is the main indicator of positioning for the ilium. Checking to see if the two ASIS's are aligned is where we need to start. I like to place the palm of my hands on the two

ASIS's and curl my fingers around the top of the ilial bones to get a sense of how the ilium is positioned. Make note if one feels more anterior/posterior, hard/soft, lateral/medial, toward the head/feet.

SPRINGING THE ILIUM:

With your hands in the same position as assessment, apply an oblique force at a 45 degree angle posteriorly to the ilium one at a time, and see if one side moves more freely than the other. When springing the joint it's important to take it to the end range and then apply the force to assess the motion.

SPECIAL NOTE ON HYPERMOBILITY!!!

Most women's pelvises will be still lax from pregnancy hormones months to years after birth if they are still breastfeeding. Some women are generally hypermobile in all their joints, which will make everything appear normal on spring testing. You are looking for a difference from side to side. Comparing mobility of both sides should be the same. A mom with general hypermobile joints (you can tell by them extending their elbows or bending their thumb back to their forearm) will be harder to appreciate the differences. It's important to check the mobility **at end range**. ***In spring testing the joints, it's the end range motion of springing that is most important to compare.***

THE ISCHIUM

Best palpated and assessed in prone. The ischium is a curved bone that moves medially in the first part of labor and then gets pushed out laterally as the baby is coming out. It is closely associated with the ilium above and the pubic rami toward the front. Most of the time with birth, one ischium gets more pressure from the baby than the other. It could be just from the baby or the position the mom was in during labor.

I have found that the ischium needs to be addressed in all positions, prone, supine and internally too, to completely treat these bones. The pelvic floor muscles attach on the insides of these bones. If you find the ischiums are not finding their normal position after birth, it could be the pelvic floor muscles need attention internally to help them release more fully.

ISCHIAL ASSESSMENT

We need to assess this bone in three ways.

Position 1. Using either your thumbs or the palms of your hands, palpate the lower buttocks area until you find the ischiums from the top, most superior aspect (toward the ceiling). See if one is more posterior or anterior. Does one feel harder than the other? Using your palm, direct pressure down toward the floor to see if it springs. Be sure to take up the slack with pressure until you get to end range, then apply a little more pressure to assess the spring.

Position 2. Inferior aspect. Now place your thumbs on the bottom most part of the ischium (toward the feet) and compare heights of each side. They should be even. Is one more toward the head or feet? Press directly superior toward the head to see if the bones spring evenly, comparing side to side.

Position 3. Curl your thumbs onto the inside aspect of the ischium. Using the midline of the gluteal crack as your reference point, is one more lateral than the other? Place your palm on the lateral aspect of the ischium and press medially in to the bone seeing if the bone springs toward the midline.

ISCHIAL TREATMENT

Position 1. Find restricted side, and press toward the floor and hold until release is felt.

Position 2. I don't usually treat in this prone position. If one side is more toward the head I do a leg-pull in supine to bring it inferior to correct this.

Position 3. Press medially on restricted side until release is felt. Can also compress the two ischium bones together with fingers to bring to midline.

REBALANCING THE ILIUM AND ISCHIUM IN PRONE:

Use one hand and place your fingers on the ischiums and the other hand on PSIS's. Compress in and feel all four bones. Does one feel harder and not move as easily or flare out more than the others?

Treatment: Compressing either Bilateral PSIS's together, Bilateral Ischiums together, Opposite PSIS and ischium in parallel or in diagonal, or same side PSIS or Ischium toward the midline until even mobility and softness in bone is felt in all four areas.

REBALANCING THE ILIUM AND ISCHIUM IN SUPINE:

Thumb and fingers of one hand under ischium, other hand palm and fingers on PSIS's- Treatment options are the same as above.

THE PUBIS AND PUBIC RAMI

Palpating the pubic bone can be very tender to the touch. Be very careful with your palpation here and use the pads of your fingers or I like to use the thenar eminence or hypothenar eminence of my hand to compare sides. Typically with the birth pattern the left side bone will be harder and less springy than the right side.

Assessment:

Using your palm, contact one side of the pubic bone. Press down toward the floor to see if the bone moves easily. Compare to the other side.

Treatment:

On the harder side: Keep contact with the pubic bone with one hand, while the other hand contacts the same side ischium. Compress both hands together in the direction of the pubic rami until softening occurs in the bones.

Part 2 of the release works with the sacrum. Contact the inferior lateral angle of the sacrum on the same side and compress that anteriorly toward the pubic bone and compress two bones together until softening occurs.

Pubic Rami

This part of the bone angles laterally and connects pubic bone to ischium. Using your thumbs angled in the same direction as the bone, gently press superiorly (toward the head) to compare sides, looking for hardness and springiness. Birth pattern: left side harder than right.

The left adductor muscles can get activated and have increased tone from attaching to the hardened bone of the rami bones. Massaging the adductors to release them isn't enough for complete healing as the tension tends to return. Releasing the boney hardness first can then help the muscles to release more easily and stay that way.

Treatment:

You can try treating this with your thumbs or you can try and use the lateral aspect/ulnar border of hand held vertically on the harder/less mobile side and compress superiorly to release the bone. Then add compression to the adductor tendons laterally, to release held tension in these muscles. Hold until you feel the tissues melt.

THE SACRUM

The sacred bone of our pelvis, the sacrum is the keystone to transferring the weight from the ilial bones up into the spine.

The sacrum can move around several different axes: vertical, horizontal, and oblique ones in both directions. We don't need to get too technical here with what is really happening. When you spring the sacrum in different points you see what moves and what doesn't move, and you treat the immobility.

General Sacral Assessment:

You can assess the sacrum in both supine and prone. Prone can be easier for those newer to working with the pelvis, and supine can be more challenging until your palpation sense and skills improve.

Sacral Base - Prone:

Assessment:

Find sacral base and compare levelness. Is one side more superior (toward the head)? Standing on the side of mom facing her feet, with lower palm of hand on one side of the sacral base, press inferiorly (toward the feet) and see if it springs and moves easily. Take to end range first then spring. Compare to other side.

Treatment:

On side that is restricted, add pressure toward the feet (same as during the assessment) and hold at end range until you feel a release, then reassess the motion.

Side of Sacrum - Prone: (SACRAL ROTATION)

Palpation:

Find PSIS's with your thumbs and drop medially onto the lateral sides of the sacrum near the base. Are your thumbs the same depth on each side? Walk your thumbs down on either side of the lateral aspect of the sacrum seeing if the thumbs are level. If one side is higher then the sacrum is rotated.

Assessment:

Place the ulnar border of your hand on one side of the lateral aspect of the sacrum, place your other hand on top of this hand and press directly toward the floor. Take up the slack then spring the joint. Switch to the other side of the sacrum and repeat comparing the motion from side to side. Make sure you are on the sacrum but not in the midline. Your hand should be on the lateral border of the sacrum. If you are on the gluteal crack you are in the midline. Your hand should be between the PSIS and the gluteal crack. You also want your knuckle of the mobilizing hand to be at the level of the PSIS to ensure your pressure on the sacrum is getting rotation and not flexion or extension of the sacrum.

Treatment:

Just as in the assessment, add pressure directed toward the floor at end range on the side that is higher and less mobile, hold until release occurs.

Inferior Lateral Angle (ILA) - Prone:

Assessment:

Find ILA of sacrum on either side and compare to see if they are level or not. Place palm of hand on ILA with fingers pointed down toward the feet and press anteriorly, toward the floor, assessing the motion. Load, pause and spring the bone. Compare motion side to side.

Treatment:

If restricted, add pressure anteriorly to the higher and more restricted ILA, toward the floor, until release is felt.

SUPINE ASSESSMENT OF SACRUM:

Assessing Sacrum and Sacral Position in Supine

Slide your hand, between clients legs, under the sacrum and feel the position of the sacrum and how the sacrum feels in your hand. Is the lower part hard, sticking more into your hand, is the coccyx feel hard? How does the sacrum lie in comparison to the pubic bone? Is it midline or off to one side? If off to one side, then pelvic shear may be in order.

Sacral Base:

Palpation:

We want to make sure the base is level and not tilted either superiorly or in an anterior/posterior direction. Slide hand between legs to place it under the sacrum with fingers finding sacral base on the inside of PSIS on one side. Slide other hand in from the side and other fingers find the sacral base on that side. Compare levelness of the base.

Assessment:

Bring both sets of fingers over to one side of the base in the sacral sulcus and apply pressure upward toward the ceiling. Assess mobility of the sacrum in the SIJ. Move fingers over to the other side and press toward ceiling assessing mobility on this side. Was there a difference in the ease of motion of the sacrum? Typically, with the birth pattern, the right side will be higher and have less mobility.

Treatment:

On restricted side, bring all your fingers to this side of the sacral base and apply pressure toward the ceiling and pull the sacrum inferiorly toward the toes at the same time.

Pelvic Shear:

Assessment:

Take your hand and slide it under the sacrum from the side and find the lateral edge of the lower part of the sacrum. Use your other hand and place it on the lateral side of the pubic bone. Pull the sacrum toward you and push the pubic bone away. See if you feel a spring at the end range of this motion. Now switch sides and compare mobility of the shearing in the opposite direction.

Birth pattern is for the sacrum to be toward the right and have less mobility moving toward the left and pubic bone toward the right.

Treatment:

Find the restricted mobility side and stand on the side that the pubic bone doesn't want to move toward as easily. Take the bones to the end range by pulling the sacrum toward you and pushing the pubic bone away and hold until you feel a release, then reassess. Sacrum usually goes to the right and has restricted mobility moving to the left in the common birth pattern.

THE SACROILIAC JOINT

In treating the sacroiliac joint not only do we need to assess the mobility of the sacrum and ilium, but there are two other areas that need to be assessed to ensure proper treatment of the SIJ.

One area that affects the mobility of the SIJ is the anterior lower abdominal tissues that sit directly on top of the SIJ's. On the right side we have the ileocecal valve, where the small and large intestines meet, and on the left side we have the sigmoid colon. Ensuring proper mobility to these two areas can help with getting proper mobility into the joint.

When doing the sacral rotation springing test in prone, if you find one side is more restricted than the other, and it remains restricted after treating it, you need to assess the lower abdominal tissues. Release the abdominal tissues on the opposite side of the restricted sacrum. Ex: left side sacrum doesn't spring as easily as right side, it may or may not be more posterior with palpation, you would treat the right side ileocecal valve (opposite side would be the sigmoid colon) by releasing it, then reassess sacral mobility.

The second area that may be affecting SIJ mobility are the pelvic floor muscles. If there is tightness in the pelvic floor muscles on either side it can cause the sacrum to not be able to move properly in the joint. I always assess pelvic floor muscles when there is SIJ dysfunction.

The Abdominal Tissues

Carrying a baby takes its toll on the abdominal tissues. They get stretched to the brink as the baby grows. After the baby comes out, it can leave this area in complete dysfunction with weakness and restrictions. Being able to release these restricted areas, and make sure the belly muscles are functioning properly after birth, will help moms recover more completely.

During pregnancy, the breathing strategies of a mom changes. The diaphragm becomes restricted by the baby's presence, so mom becomes an upper chest breather. After birth, we need to help make sure mom is breathing more efficiently and safely for her belly tissues to heal.

BREATHING

Without them realizing you are doing so, observe your mom's breath. Do the ribs expand in every direction including laterally? Does the belly rise significantly with her breathing? Does her breath reach all the way down into her pelvis, or does it stop in her belly?

There are 3 ways to bring air into our lungs.

1. Accessory Neck Muscles:

The tiny accessory neck muscles could become primary breathers when the baby takes up all the room in the belly and moms use this strategy for breathing. You will notice overdeveloped scalene muscles in moms who are excessively using this strategy. The shoulders will rise as moms inhale.

2. Belly Breathing:

Commonly taught in yoga classes, breathing into the belly is a great calming mechanism but in pregnant women it can create excessive strain on the abdominal muscles. Also as baby takes up space in the abdomen, it becomes harder to do this. For moms with diastasis recti we really want to discourage this breathing strategy. It puts too much strain on the linea alba and prevents DR from healing.

3. Rib expansion breathing:

Ideally, with inhalation the ribs expand fully in all directions, front to back and out to the sides. The ribs lift up and outwardly as the lungs fill with air. The belly should just go along for the ride without excessive rising. The air should be able to travel all the way down to the pelvic floor.

The diaphragm and pelvic floor muscles create a canister. They are two domes that work together. As we inhale, both domes descend down and relax. When we exhale, they contract

and lift upward. The pelvic floor muscles should work reflexively with this breath, but after birth they need help relearning how to reactivate. Getting the core muscles activating with the breath is the first step in helping a mom heal her body after birth.

As a mom exhales, there should be a slight concavity happening in the lower transverse abdominis. You can have a mom pretend she is blowing out 100 candles slowly as that can help contract this lower inner muscle, but be careful she doesn't activate her outer core muscles (obliques) before her inner core muscles (transverse.)

There are two parts to our core muscles: the inner muscles which act more as holding muscles, and the outer core muscles which are our mover muscles. A lot of time after birth, the outer core muscles get activated more before restrengthening the inner core muscles. When the outer core muscles are overworking without strong inner core muscles, moms may be pushing her abdominal and pelvic contents downward with abdominal contractions. If this strategy is not changed, it could lead to possible bladder leakage and/or pelvic organ prolapse.

INNER CORE MUSCLES

The inner core muscles are comprised of the transverse abdominis in the front/sides, pelvic floor muscles down below, the multifidi muscles in the back, and the diaphragm up above. It's super important to make sure this inner core activates prior to any outer core muscles firing.

One of the biggest things that impact our cores ability to work effectively is our alignment. Rib thrusting and slumped sitting puts strain on the diaphragm thus diminishing the effectiveness. A tucked or posteriorly rotated pelvis impacts the pelvic floor muscles ability to contract fully. Being in proper alignment with ribs stacked on top of the pelvis, pelvis over the heels in a neutral position, is ideal for inner core activation.

To activate the inner core muscles, we want to work with the breath. Allow an inhalation with ribs expanding outward, and on the exhalation pull the pelvic floor muscles up and in and make sure the lower abdomen pulls in as well. You should note a slight concavity to the lower belly as the transverse abdominus muscles contracts. This is not a huge massive contraction. It's a slight, gentle one and super important. I will assess this internally after I've done some release work and make sure the pelvic floor muscles and lower transverse are working together. I will have them work on contracting and holding for 5 seconds at one time while they are exhaling so they aren't holding their breath. I also assess the pelvic floor muscles ability to do quick flick contractions.

Sometimes you need to have mom back off on her efforts and only do a 25-50% contraction to just use the inner core and not the outer core muscles. With a pregnant belly it's much easier to activate the TA and it's about hugging the baby back up against the spine. There are videos of pregnant bellies sucking their babies into their spines with a complete transverse contraction,

squeezing all the way around the belly, not just belly button to spine, and the baby bump just disappearing.

OUTER CORE MUSCLES

After a mom has reached her 5-second holding ability of the inner core muscles with the breath, I will have her do some outer core activations or end range pulses. Making sure the inner core is firing first, I then ask mom to contract the outer muscles in a way that compresses the abdomen in the middle from all directions. It's not just front to back but cinching the entire waist in to make it smaller. You want to make sure the pelvic floor muscles are countering any increased pressures from the abdomen and that the outer contractions are not just pushing downwardly. There should still be a lift up and in as the abdominals contract. Watching the umbilicus is a great way to see what is happening. Any downward movement is overactivation of the oblique muscles. Seeing a pulling back of the umbilicus with a slight lift is ideal.

ABDOMINAL RESTRICTIONS

You want to assess the lower abdominal tissues after birth to make sure they have full mobility. After birth, **the left side lower abdominal tissues typically gets more restricted than the right.** By sinking your fingertips and outer ulnar side of your hands into the lower abdomen near the iliums, assess to see if there is even mobility toward the midline. If not, take the restricted side to its end range and hold until a release is felt.

UTERUS MOBILITY

The uterus needs to have good mobility side to side as it sits just superior to the pubic bone. To assess, have your mom bend her knees up with feet flat on the table. You can use your thumb and index finger or your two hands. Start 2 inches apart about an inch above the pubic bone and sink your fingers/hands down deep into the abdomen. Assess the mobility of the uterus as you move it side to side. If restricted, take to end range and follow the tissues, holding until a release occurs.

DIASTASIS RECTI

During pregnancy, the growing uterus puts strain on the rectus abdominis muscles causing them to separate. The linea alba then stretches thin. Healing diastasis recti requires that the linea alba shrinks back up to a shallow position. There are many contributing factors that create diastasis recti. Katy Bowman wrote a great book, [Diastasis Recti](#), that goes into greater detail about the forces that contribute to DR. I highly recommend you read this to better understand how to help moms heal from this issue. She talks about the pressure systems in the trunk and how we need to keep them even to avoid straining the linea alba. Also mentioned is how

tightness in the shoulders and hips contribute to DR. In reality, our core really is our whole body. We need to address all the links in the chain to make sure true healing can occur.

We also need to understand how abdominal tissue restrictions can cause a DR to not be able to heal and how to release them so it can. When the oblique muscles, which insert into the rectus sheath, are tight they will prevent the recti muscles from being able to come back together again. Manually releasing these tissues can help facilitate healing.

MEASURING DIASTASIS RECTI

While having some measure for documentation is important, as professionals we are learning that the distance and depth of the linea alba is no longer the gold standard nor as important of a measure. What is most important for healing DR is if the linea alba can generate tension when loaded. Helping our moms learn to engage their core correctly to ensure closure of the system is the goal. While knowing initial measurements and being able to see changes can be helpful and motivating, let's help our moms not get stuck on the distance and measures but focus more on the function.

To have something to document here are 4 things to assess for DR.

Have your mom lay on her back, doesn't matter if knees are up or straight. For the first two assessments, place your fingers directly in the umbilicus so your fingers are together and perpendicular to the recti muscles.

1. First, how many fingers can fit in between the two recti muscles- *when the muscles first engage!* The more the mom lifts her head the more the muscles should come together. You want to see where the muscles are hanging out. You may be able to appreciate this at rest if her recti muscles have good tone to them; most of the time you need some sort of engagement.
2. The second thing you are looking at is how deep do your fingers go down before hitting connective tissues. Anything before your first knuckle is shallow, past first knuckle is medium, and to the second knuckle is deep.
3. Third, you want to assess the length of the DR. With her recti muscles engaged, start at the top of the muscles and walk your fingers down the length of the linea alba and see where it dives deep. Continue walking your fingers down until it becomes shallow again. This will tell you how long the DR is.
4. For the final assessment you place your fingers in the opposite direction so your finger pads face your body as you place your hands side by side and in the centerline of the recti muscles. You want to make sure the recti muscles approximate as she lifts her head. Do they come together in the midline with activation? You want both recti muscles to pinch your fingers on

either side in the midline. If you aren't feeling pressure on both sides of your finger the recti muscles need help finding their way back to midline. (See Oblique stretch and Recti release.)

Normal recti muscles have 1 to 2-finger width separation with very shallow depth in between. The most important thing to assess is if the recti muscles come together and approximate with activation, and if the linea alba creates tension when the muscles contract. You want both to occur.

OBLIQUE STRETCH AND RELEASE

Have your mom lay on her back knees bent up. Assess to see if her lower rib cage is in contact with the floor. If not, place some pillows or blankets under her head and shoulders until the lower ribs touch the floor. Securing her L lower rib cage to the ground with one hand, bend her knees over to the right side, only as far as her ribs stay in contact with the floor. While she is in this position, take your other hand and reach as far behind her L side trunk as you can and encourage the tissues to stretch forward to the midline. Work along the rib and ilial borders moving the tissues forward. Also work on the front along the ribcage and lower in the abdomen encouraging tissues to move toward the midline. Repeat on the other side.

There is something magical about this release work. In releasing the oblique muscles it can instantaneously change the quality of the linea alba tissues. It will become less deep and have more strength and thickness to it. Also releasing the Quadratus lumborum on the back side just superior to the ilial bone is really helpful in healing DR.

RECTI RELEASE

It's important to make sure the muscles have the ability to come together in the midline. Sometimes lateral abdominal fascia can get restricted and need release work. Using both hands side by side, start by pinching and lifting up the two rectus bellies in the midline. Keeping the tissues pulled up, move the muscles and tissues side to side. See if it is more restricted on one side than the other.

When you move the lifted tissues to one side, see if you feel the inner tissues pull down and away from your fingers. It can be subtle but it's important to make sure those inner tissues get released. Hold the restricted side at end range without letting the tissues pull down and away from your fingers until you feel a release. Reassess both sides again and then have your mom lift her head up and see if the recti muscles can pinch your fingers on both sides.

Please follow the exercises in the book by Katy Bowman for further healing of DR and learn [Julie Wiebe's Piston Science](#)* as another great tool for core activation.

PSOAS RELEASE

Rib thrusting is a huge contributor to DR. When the lower ribs jut forward in front of the pelvis this is rib thrusting. I like to think of our ribcage as an open barrel from below and we want the ribs to dump down into the pelvis and not in front of it. When we are thrusting our ribs forward they are dumping in front of the pelvis. This puts excessive strain on the abdominal tissues and linea alba.

This tends to be a habit for people as we were told to stand up straight. Instead of just moving our shoulder back we learned to lift our ribcage to tilt ourselves backwards so we'd look like we are standing up straight. Also with tightness in the shoulders, which is so commonplace when caring for and carrying around an infant, the inability to move our shoulders independently from our chest is diminished. So moving our ribcage is the only way to get our shoulders back. Stretching our shoulders out while keeping our ribs down can help this situation.

However our psoas muscle is also a big contributor to rib thrusting. The psoas muscle attaches into the lower parts of the ribs and when it gets tight it pulls the back part of your ribs down, tilting the ribcage forward. If a mom has an inability to stop rib thrusting, she needs her psoas muscle released.

The psoas muscles attach on the lateral side of all the lumbar vertebrae with some fibers attaching into the lower ribs. The muscles insert on the inner thigh just below the groin. Since it is such a deep muscle the only way to contact it is through the abdomen.

By palpating the back muscles on either side of the lumbar spine you can sense if there is more tension deep within underneath the more superficial lumbar paraspinal muscles. That tension could be the psoas muscles. If you find the paraspinal muscles tight, release the psoas muscles and see what happens to those paraspinal muscles.

Psoas Muscle Release Technique

Many practitioners have learned to approach a psoas release by going deep into the belly and releasing it from the front. I have found a much more gentle and noninvasive way of approaching the psoas muscle from behind. Since the psoas muscles are so connected into our nervous system, and are responsible for our activation response, a less direct approach can be more soothing to the body.

Have your mom lay supine, and you stand on the side that is tighter. Compress in on the lateral sides of the paraspinals from behind with one hand while the other hand compresses into the inner thigh muscles where the psoas muscle inserts into the lesser trochanter. Compress both ends of the muscle together and hold this until you feel the muscles release. Reassess the tone near the paraspinal muscles to see if there is a change.

You can also access both psoas muscles at the same time and we'll learn this in the course.

Two stretches to help release the psoas muscle.



Listening To The Body

Listening to the body's energy can guide you to where you really need to be working in the body. Sometimes the problem area can't be felt through direct palpation or mobility testing, and the energy can inform you as to what the body really wants to do. The body is more intelligent than we are and learning to allow the body to guide us in our treatment can help us have more successful treatment sessions.

There is general listening through the head that will guide you to a specific place in the body, and then local listening that will allow you to be more specific as to the problematic structure.

Your relaxed hand passively receives information from the tissues. It will get attracted in the direction of abnormal tissue tensions which may be muscular, fascial, or visceral in origin.

GENERAL LISTENING

General listening is done in standing. Standing behind your patient, you place one hand gently on the top of the head and the other hand gently on the upper back. You see which direction the head gets pulled down into the body. This gives you a general idea of the location of the problem area. You can guess as to where the head is pulling down to by inhibiting different structures in the body and seeing if the head releases its pull. When it does you know you have identified a problematic area.

LOCAL LISTENING

Local listening is done with the client in supine. Your relaxed hand starts just above the pubic bone in the midline. Gently place your hand on the body and see if there is a pulling of your hand down into the body, one way or the other. You don't wait long to see if the hand moves, as it should happen within seconds of putting your hand on the body. If it does get pulled in it happens immediately, if it doesn't then move on.

As your hand gets attracted to an area, you can inhibit structures with your other hand and see if it influences the release of the pull. Pointing to and saying either out loud or in your mind what you are inhibiting, wait to see if that releases the attraction in your other hand. If it does, then the body is letting you know you are right. If it doesn't, then keep on guessing.

Local listening can also be applied to the bones and joints of the body. Take an ankle sprain for example. By placing your hands on the foot and ankle, you are asking the tissues to show you how it got injured. Allow the part of the body in your hands to move as it wants to. You are

tuning in to the energy of the tissues, allowing them to show you what they want to do. If the energy of the injury is still in the tissues, the tissues will move. If the tissues don't move, there isn't an issue there and they are neutral. This is what we want.

When you do this for the birthing pelvis, you stand behind and slightly to the side of your client and place one hand on the sacrum. I have my opposite hand on their upper chest just as a counter force. You are listening to the sacrum to see if the tailbone lifts backwards. If it does move, then the pelvis is still birthing. If it doesn't move, the bone is neutral and that is what we want.

You can do the same for the ischiums. Place one hand on each ischium and listen to see if the bones want to splay apart, or if they stay neutral. Splaying ischiums are a sign the pelvis still wants to birth.

Listening to the energy of the tissues really allows you to feel what the body wants to do.

ENERGY FLOW IN THE BODY

I also place my hands on the shoulders of my clients and feel what the energy of the body is doing on each side. I'm looking to see if the energy is flowing down both sides of the body, down the legs and into the ground. Sometimes the energy will be flowing up on one or both sides. If it's flowing up on both sides, this can indicate the client is not well grounded in her body. She may be more spiritually focused. This is just general information I use to get an overall sense of what is going on in my client's body.

The other thing I check out is the energy flow down both legs. I'll bring one hand to the front of the hip/groin area and the other on the back on the same side and see if I can feel energy flowing down and back up the leg. I compare both sides and see if there is a blockage of energy at the pelvis.

We need to remember the body is very intelligent and knows more than we do. It wants to heal. By listening to see what it wants to do, we can follow the energy and see what needs to happen to release the pattern from the body. When we do, we become just as smart!

Thoracic Area

During pregnancy, depending on the baby's location in the belly, he/she might exert increased pressures on either the liver on the right side of the upper abdomen or the stomach on the left. The baby's movements can repeatedly jam these organs superiorly into the chest cavity, usually one side more than the other.

Also to make more room for the baby, the mom may become a rib thruster, tilting her ribs upward by extending her upper back. The jamming superiorly of the organs and the tilting of the ribs can cause restrictions in the diaphragm post birth. The lungs and rib cage can get stuck in inspiration. It can look like the whole chest cavity is stuck in inspiration. This can make it challenging for a mom to be able to take a deep breath during pregnancy and also after birth. She may also complain about mid-back pains with these restrictions.

The shorter the mom's trunk, the more jamming the organs will receive. Long waisted women tend to have less liver/stomach/diaphragm issues post birth.

ASSESSMENT

By placing your hands on the lower rib cage, you can listen to the energy of the liver and stomach and see if either side is moving superiorly. If one side is moving superiorly, that side organ is more jammed and stuck in that movement. Also with your hands on the lower aspect of the ribs, you can sense whether the ribs still feel flared up and out to the side.

CHEST and LUNGS

Moving your hands up onto the chest wall, you can assess whether the rib cage and lungs are stuck in inspiration. You will feel like the tissues are in full expansion and can't find relaxation into exhalation. By gently compressing the upper chest, you can assess the mobility of the lungs and ribcage and see if there is good springiness to the tissues.

THORACIC SPINE

By placing one hand under the chest area, you can assess the mobility of the thoracic spine by mobilizing each segment superiorly and seeing if there is good mobility to the vertebra. A lot of times, one or more of these vertebrae will be stuck with decreased mobility.

RIBS

You also want to mobilize the ribs on each side and check for good mobility to each one. Lack of mobility in the thoracic spine and ribs can be the cause of mid-back or bra line pain moms frequently complain about post-birth.

DIAPHRAGM

Diaphragm restrictions can be felt along the inferior border of the rib cage anteriorly and posteriorly on the lower ribs and at L1. Tightness in the diaphragm feels like increased tone in this area. There also may be less mobility to the lower ribs and the L1 vertebrae.

TREATMENT

I start with the organs first, as they dictate whether the spine and ribs can function normally. The body will protect the restricted organs by pulling on their attachments to the boney structures.

LIVER

The liver sits along the lower edge of the R ribcage inferiorly and ascends to the 5th intercostal space on the right and ends at the midclavicular line on the left at the level of the 5th or 6th intercostal spaces. It may extend below the xiphoid process depending on the costal angle. The liver sits posteriorly at the superior aspect at the level of T8 or T9 and inferiorly at the level of T12 to T11 on the right.

Mobility of Liver:

Along the frontal plane, the lateral side of the liver gets pushed down from the excursion of the diaphragm. During pregnancy, the liver can get jammed superiorly. With its close connection to the diaphragm it can restrict both the diaphragm and liver mobility.

STOMACH

The stomach lies opposite the liver on the left side of the lower rib cage area. It varies in its location depending on if it's full or not. The top part, or cardia, lies at the level of T11 posteriorly and the 7th costal cartilage anteriorly. The lesser curvature of the stomach goes from this cartilage to the lateral aspect of L1 around the level of T10 to T11. The lower aspect of the stomach varies from L1 to L3. In standing, the stomach goes more inferiorly than when lying down.

However, all of this gets shifted superiorly during pregnancy and location depends on babies positioning in the body. We want to keep these locators in mind as we work on our postpartum clients.

Balancing the Liver and Stomach

The baby's position in the belly determines which organ gets more pressure superiorly from its movements. One organ may be more stuck superiorly than the other. You can assess this with your local listening to the energy of the organs.

Once you release whichever organ needed it, it's important to make sure the liver and stomach are balanced in the abdomen again post treatment. They are intimately connected and share sliding surfaces on each other.

DIAPHRAGM

This dome-like muscle sits directly under the ribs in the front. With your client's knees bent up, you need to assess if the tissues along the lower ribs can compress up and inside the ribcage. If there is resistance to moving up inside the ribcage, the diaphragm is restricted. Gently work in the restricted area until a release is felt.

Also, the diaphragm can be released with a more general approach that works the diaphragm as a whole. Your hands cradle the diaphragm with one hand on top near the xiphoid process and lower costal cartilage and your bottom hand mirrors it underneath the body around the thoraco-lumbar junction with the spinous processes of T12-L2 in the palm. Your relaxed hands will slightly engage the tissues, listen, and then follow the tissues until a release is felt. This release can free up the fascia of the respiratory diaphragm and all the surrounding structures.

The Tissues of the Pelvic Floor

ANATOMY

The labia tissue creates two folds on either side, the majora are the usually larger outer folds and the minora folds are on the inside. They offer protective closure to the opening of the vagina. Separating the folds we enter into the introitus. Thinking of the vaginal opening as a clock, at 6:00 (the bottom of the opening in supine) lays the perineal body. This is a hub of tissue that creates a separation between the opening of the vagina from above to the anal sphincter below. Three different muscles connect under this perineal body and lots of trauma can occur in this space from birth.

The Superficial Muscles create what is called the Urogenital Diaphragm or perineum. They form a triangle with the symphysis pubis and two ischial tuberosities as their attachment points. Running from the symphysis pubis down laterally to the ischial tuberosities are the ischiocavernosus muscles, one on each side. Then the transverse perineal muscles connect the two ischial tuberosities running directly across to form the lower part of the triangle. The third muscle that wraps around the opening of the vagina is the bulbospongiosus. It has connections at the pubic bone and perineal body. Another muscle that connects into the perineal body is the anal sphincter muscle.

The deeper muscles of the pelvic floor connect from the tailbone in the back to the pubic bone and along the pubic rami in the front. Named from back to front, the deeper muscles include the coccygeus muscles (directly off the coccyx), the iliococcygeus muscles, pubococcygeus, and finally the puborectalis muscles.

EVALUATION OF THE PELVIC FLOOR TISSUES

EXTERNAL VISUALIZATION

While observing the outside of the perineum, ask your client to do a pelvic floor contraction or kegel. You are looking to see how the tissues move with a contraction.

Ideally you want to see the clitoral hood descend, or nod, with the contraction and the anal sphincter tighten and draw up and in, as in a wink. A good contraction will tighten and lift the tissues up and in equally on both sides. Sometimes with dysfunction one side will move more than the other.

External observation is just a starting point to give you an idea of what the client can do. What you feel internally is really the most important and doesn't always correlate to what you found externally.

INTERNAL ASSESSMENT

Using your thumb and middle finger to separate the labia visually check out the introitus, looking for any major bulges of tissue that might indicate prolapse. After checking visually, the perineal body is the first place to connect with by just placing your finger on its structure and seeing how the client reacts to your touch. With this touch, you can assess the quality of the tissues of the perineal body. You can appreciate any scar tissue in this area if the tissues are rough. Also, you can see how thick the tissues are in this area and with a gentle pressure downward can see if there is flexibility in the tissues. Scar tissue is very common along the perineal body and transverse perineal muscles. After birth, it is very common to find the perineal body twice its normal size from the trauma. After treatment, you can reassess and see if the perineal body has decreased in thickness and/or has greater mobility. Learning to appreciate the difference between normal and abnormal size of the perineal body will come with experience and time.

PELVIC FLOOR MUSCLE CONTRACTION

After assessing the perineal body, check to see how the pelvic floor muscles contract in the four quadrants. Slide your finger deeper in and off to one side of the rectum and have them contract. In the lower two quadrants (4-5:00 and 7-8:00), assess the deeper levator ani muscles function, comparing left and right sides. In the upper quadrants, you are assessing the superficial urogenital diaphragm muscles feeling for the contraction of the bulbospongiosus and the ischiocavernosus muscles. You should feel a pulling down feeling as these muscles contract. Again, you are comparing left side contraction to the right side.

PALPATION FOR TONE/TENDERNESS OF PELVIC FLOOR MUSCLES

Using the whole length of your finger, go around the vaginal walls and press into the tissues in all the hour hand spots and assess for mobility, the springiness of them, and if the pressure produces any tenderness for your client. Make a mental note of what structures you are on when the tenderness is elicited. Compare tone of muscles from side to side.

BLADDER ASSESSMENT

The bladder is the most important structure internally. When the bladder is not happy, the rest of the tissues in this area are not happy. Working with releasing the bladder FIRST will help make it easier to release other tissues in the vaginal vault.

URETHRA

Turning your index finger so the pad faces up, find the urethra at 12:00. Assess the urethra for the quality of its tissues. Soft and supple is ideal but after birth the urethra can get compressed

against the pubic bone and feel traumatized. Sometimes the bladder and urethra can feel rubbery, swollen, or hard.

When a mom had a catheter in during the delivery, that can also cause damage to the tissues. How the urethra feels and where it needs release work requires being extremely sensitive to the structure and developing a keen awareness of normal versus abnormal tissue.

Moms may complain about burning with urination, pain in the urethra after intercourse, or just a general discomfort in this area. These are your signs to be diligent in your evaluation of the urethral tissues.

If she complains of urethral burning after intercourse, assessing the mobility of the levator ani is important to ensure the penis has ample room in the introitus for thrusting. Tightness in the levators will compress the penis anterior into the urethra. Focus on releasing the levator ani muscles.

You can start by assessing the tissues at the urethral opening. There is a sphincter in the distal aspect of the urethra. Place your finger lightly on this structure and just listen. See if you feel any movement in the tissues. What does it want to do? Just follow it until you get a release. Sometimes the urethra may need compression to release the birth trauma from the tissues. Listen and feel what the tissues need for release and offer it that.

Next, assess the length of the urethra. Run your finger along the outside length on one side and compare to the other side how far in you reach until you hit the bladder. **If the bladder is in the common birth pattern, you may find the left side of the urethra is shorter than the right.** Also assess if there is the same distance from side to side from urethra to vaginal wall. It may have gotten squished to one side as the baby came out.

Then, assess the bladder's position in the vagina. Move your finger over to the far left side of the bladder tissue and feel how much space is between the bladder and the vaginal wall on the left. Then do the same on the right. **If the bladder is in the common pattern, you will find less space on the left-hand side.**

LISTENING TO THE BLADDER TISSUES

Place your finger midline on the urethra so your finger pad is on the bladder. Listen to the tissues. What does the bladder want to do? **The common birth pattern will pull your finger to the left.** Be open to whatever the tissues want to do though.

TREATING THE BLADDER

To treat the bladder, your internal finger is on the bladder and your outside hand is on the left lower abdomen just superior to the pubic bone on the left. With your inside finger on the lateral edge of the bladder on the left, gently encourage the bladder body to move to the midline while your outer hand is encouraging the tissues of the abdomen to move to the midline as well.

Continue to work with the tissues until you feel a release. Reassess with local listening to see if the energy of the tissues has shifted, and compare left and right sides to see if the bladder is sitting midline. You may also notice a shift in the quality of the tissues.

Sometimes the bladder on the left hand side needs some lifting up. If the tissues are still sagging down, use your finger pad internally and the palm of your other hand just above the pubic bone and offer superior pressure as you let the tissues unwind.

Even though the bladder may not feel that out of position or abnormal in its feeling, I've been surprised by how treating it can still impact the qualities of the tissues in a good way. When in doubt, always offer the bladder some lovin'!

Internal Urethral Sphincter

After the bladder is back in midline, it's important to then treat the internal sphincter at the junction of the bladder and urethra. Gently place your finger pad on this junction and follow the tissues until all unwinding is complete. The longer the bladder has been off, the more unwinding and release work there needs to be done. With urinary incontinence, this sphincter needs special attention. Make sure there isn't any tightness or restriction on either side of this area and that the sphincter is fully released. Use extremely gentle pressure and lots of micromovements to get releases here.

Cervix Position

Once the bladder is in its happy space, you'll want to check to see the location of the cervix in the vaginal space. A lot of times after birth, the cervix can either be impinging upon the bladder's space or shifted off to the left or right side or way in the back.

Ideally, you want to find the cervix midline and at a good reach up at the end of your fingertip into the vagina. You'll want to see if you can sweep your finger all around the cervix, (if you have a long enough finger). When it's positioned well, you should be able to go all around it. If it's off to one side or back too far, you might have a hard time getting all the way around it.

You also want to assess the mobility of the cervix, mobilizing it in all directions around the clock. If you find a restricted spot, gently encourage its release.

If you find the cervix off to the right-hand side, the body of the uterus can be either off to the left-hand side or off to the right-hand side. Remember which side was restricted when you mobilized the uterus externally and go there to help facilitate the uterus' return to the midline.

Mobilizing the Cervix and uterus

If the cervix is off to the right, (internally) place your fingertip on the far right side and your direction of gentle force will be to the left. Your outside hand will be just above the pubic bone. Use your thumb and index finger of the outside hand to sink down into the tissues of the abdomen until you reach the uterus. Assess the mobility side to side of the uterus and see if

there is a restriction on one side. Keep your external hand on that restricted side and encourage the uterus to find midline again, at the same time encouraging the cervix to move to the center. Follow the tissues until a release occurs. Reassess cervix position after release to see if it is more midline.

Thank you for taking the time to read this document prior to the course. This will help you have a sense of the material we will be covering together.

Lynn Schulte, PT

**Affiliate Disclosure: If you purchase from Julie Wiebe, PT through my link, I will be compensated.*