Guidelines
Massaging Safely and Effectively

Chapter 2

Chapter Overview

With so much potential benefit in receiving massage therapy while pregnant, why would anyone hesitate to receive regular sessions? Other than financial considerations, and the seemingly inevitable difficulty of finding enough time in the day, the ultimate factor in any pregnancy-related decision is: will this be safe for me and my baby? Women, their partners and their healthcare providers need assurance that massage therapy is beneficial and safe. To deliver that assurance, you must assess what is and is not uniquely appropriate for each individual client. You need to understand when the various positions on a therapy table and chair are safe, or not, and how to make every position comfortable. You need to understand and master various appropriate types of therapeutic massage and bodywork. You need to understand prenatal physiology and functioning, and learn how to adapt your touch accordingly. These adaptations include changes in speed, depth of pressure and pain level, an awareness of precautionary areas, and specific modality variations.

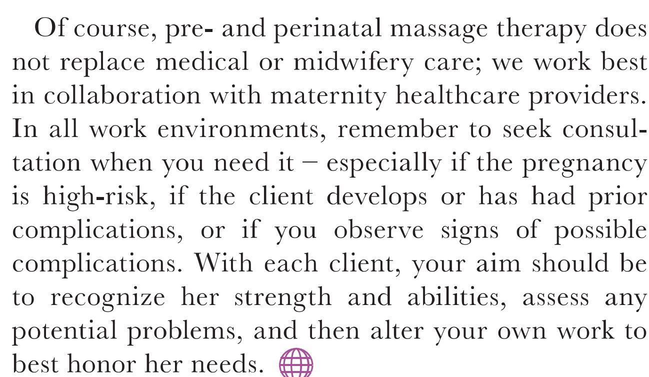
To be safe and effective, you must adapt your existing skills to the needs of typical prenatal clients. This chapter will explore how to adapt. That foundation will then be applied to specific prenatal techniques in Chapter 4; massage for labor and birth in Chapter 5; and massage for the postpartum mother in Chapter 6. You also need to be able to recognize when pregnancy and postpartum are not proceeding normally, which is detailed in Chapter 7.

Is Prenatal Massage Safe?

The short answer is: it depends. Nearly every pregnant person can safely benefit from *some* type of therapeutic massage and bodywork. After all, pregnancy itself is not an illness. Pregnant people are not porcelain dolls; they are far from fragile. In fact, many women feel their most sturdy, energetic and fierce when pregnant. As the mother adapts to pregnancy's demands, some form of massage therapy is likely safe in all trimesters (and beyond!).

These factors will determine whether your work is safe: which week/trimester your client is in; how you position and support your client; what body parts you massage; the speed, depth, intensity and intention of your techniques; and the baby's growth and health. In this chapter, you will learn how to create that safety for most pregnant people.

Your safety and effectiveness also will be determined by your ability to understand each client's particular needs and wants, and to adjust your work accordingly. Sometimes a client will prefer to zone out; other times they will want to actively engage. Remember that she may have other conditions unrelated to the pregnancy – infections or injuries, for example – that you need to consider in determining whether and how to work with her.



Of course, pre- and perinatal massage therapy does not replace medical or midwifery care; we work best in collaboration with maternity healthcare providers. In all work environments, remember to seek consultation when you need it – especially if the pregnancy is high-risk, if the client develops or has had prior complications, or if you observe signs of possible complications. With each client, your aim should be to recognize her strength and abilities, assess any potential problems, and then alter your own work to best honor her needs.

From the treatment room

When I started massaging pregnant women for my doctoral study, almost all of the 400 women I invited said that they had never heard of prenatal massage. They and their families were afraid and did not want to have it done. A few in my region of Turkey eventually joined my study. After my research was over, I returned to my clinic. I learned that a pregnant woman had called everyone in the clinic, trying to reach me! I gave her prenatal massages every week. Another participant, after her prenatal massage, said something similar to "That was almost orgasmic." Of course, there was no sexual contact, but she definitely felt the oxytocin effects of this work.

– **Yeliz Çakır Koçak**, therapist

Reminder

When you follow safety guidelines, some form of massage therapy will be safe for virtually every pregnant client.

Points of view: Is massage safe in the first trimester?

But wait! Perhaps in massage school you were taught to never massage in the first trimester; or maybe your employer forbids it. The typical rationale for waiting to start prenatal massage is that pregnancy loss is more common in the first trimester; we do not want a client to associate **miscarriage** with massage.

Actual accusations of catastrophic results from prenatal massage therapy are rare, but they remain possible (Ernst 2003). Beyond this worst-case scenario, minor injury or just an ineffective massage might occur, especially when a therapist lacks sufficient training. The safety (and effectiveness) of prenatal massage is relative to the therapist's knowledge. The first-trimester prohibition may be a wise legal precaution, especially when the prenatal curricula of many schools are understandably brief and lacking in depth or accuracy (see Chapter 4 for other elements of first-trimester safety).

That said, there is no substantive research that demonstrates that massage is unsafe in the first trimester, when appropriate guidelines are followed. Some erroneous reasons given for the first-trimester contraindication are that it will cause miscarriages or detach the placenta. There is no evidence that either possibility is likely if a therapist works superficially on the abdomen and avoids very specific types of touch on contraindicated points, as discussed later in this chapter. Some teachers claim that first-trimester massage worsens nausea; others say to not massage at all if a client is nauseated. Again, when performed within the informed guidelines given later in this chapter and in Chapter 4, this should not be a concern; in fact, the parasympathetic stimulation of a good massage may calm a queasy stomach. Of course, if the client is vomiting or extremely nauseated, she is not likely to want a massage anyway.

Increase confidence in the safety of your work by gathering thorough client information, maintaining sufficient communications with their maternity healthcare providers, and following this book's sound guidance.

From the treatment room

When I first met Sharon at the upscale day spa where I worked, she returned a blank health form to me. In fact, she gave the receptionist a hard time, feeling that we were prying into her business; after all, she only wanted a massage!

I explained how massage could certainly address many issues, but that if she had any problems, then I would be better able to serve her by knowing. I could ask more questions that might lead her to see her doctor before her next scheduled monthly visit. She was dumbstruck that so much information went into performing a prenatal massage, and I was grateful that I had the knowledge to care for her.

– **Mia Harper**, therapist

Reminder

You may prefer to delay massage until a client enters her second trimester; however, first-trimester massage therapy is safe if performed according to recommendations.

Chapter 2

Safe Positioning

The first practical question most therapists ask when contemplating prenatal massage is how to accommodate that ripe belly. Most of us only work with our non-pregnant clients supine and **prone**, so it is easy for us (and our clients) to feel unsure of any other possibilities. While the pregnant body has unique requirements, the positioning options are abundant. Working in both prone and supine is still fruitful with some clients. But even more advantageous – though initially daunting – is to position your clients on their sides. Safety, comfort and therapeutic effectiveness will determine which positions you use – and when and how (Figure 2.1). We will explore the rationale for all below. Remember that these are not hard and fast rules, particularly regarding their timing. Individual needs change the timing of the recommended positions. But with these guidelines, and a lot of practice, you will be able to efficiently accommodate nearly any pregnant client at any stage of pregnancy.

Prone

Let's face it: many of us are belly sleepers and prefer to not give up that comforting position, even for a massage. And massage therapists are more accustomed to working on a client's back while in prone. But are these reasons enough to use the prone position throughout pregnancy? No. Lying face down may be a safe and comfortable position to rest in (Ricci 2017), but once you apply the pressure needed for an effective massage, it is no longer reliably comfortable or safe for all clients; neither is the three-quarters prone position some of us learned in school. The two potential problems with prone positioning are strain to the uterine ligaments and lower back, and increased pressure inside the uterus, known as **intra-uterine pressure** (Figure 2.2). Let us first consider strain to these posterior structures.

Lying prone on a flat therapy table can strain the structures of the lumbar spine, pelvis and uterus. Prone positioning can create a host of negative effects: it shortens posterior musculature; compresses and anteriorly

First trimester
- Supine, sidelying, semireclining, prone or in a chair, depending on client comfort.
- Adapt for breast tenderness and other comfort and safety concerns, especially if using prone.

Second trimester
- Prone position is not recommended, even with specialized equipment.
- Supine - use pillow under right lower torso, up to week 22. After 22 weeks, only use semireclining and sidelying positions to prevent supine hypotensive syndrome; chair okay.
- Adapt for breast tenderness, SI joint, and other comfort and safety concerns.

Third trimester
- Sidelying and semireclining positions only; chair okay.
- Adjust for comfort and safety concerns.

Figure 2.1
Overview of prenatal massage positioning. These positions enable comfort, safety and effectiveness throughout the pregnancy.

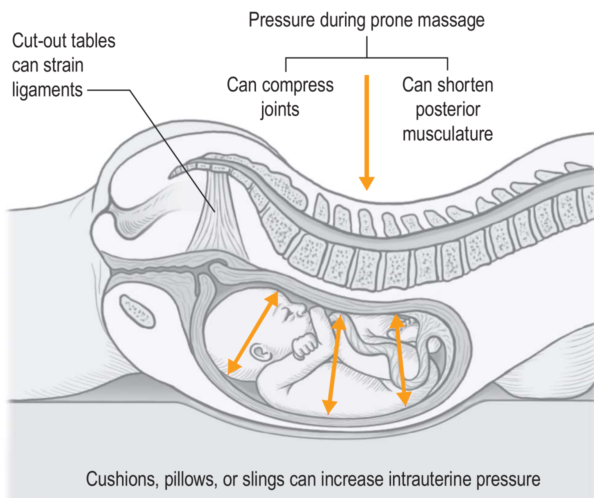


Figure 2.2
Potential effects of the prone position. Notice how both safety and comfort can be compromised with improper positioning.

displaces the lumbar vertebrae and lumbosacral junction; rotates and strains the sacroiliac (SI) joints; and increases strain on the sacrouterine ligaments. Because of these effects, lying face down – particularly in later pregnancy – often aggravates the very causes of back discomfort for many. Although some clients feel comfortable in prone, many feel these strains – not to mention the compression of breast tissue and sinuses – which diminishes the effectiveness of their massage.

Pillows, or specialized equipment marketed for pregnant clients, may mitigate these problems to some extent. However, one-size cut-out tables or prone cushions do not fit all bodies, especially with multiples and various breech fetal positions. Nothing – not pillow props; cushions; pregnancy pillows; tables with cut-out ovals, with or without a sling or net designed to support the belly; or most massage chairs – can alone solve all of the problematic aspects of prone positioning completely. If the client is cushioned sufficiently high to keep pressure off the uterus, then further strain to posterior structures and the taxed sacrouterine ligaments is likely. To prevent that posterior strain, the belly must rest against the table, and that increases intrauterine pressure, especially as you apply sufficient pressure to address the posterior structures. It is the proverbial "catch-22."

Lumbar and pelvic pain is among the top reasons why women come for massage (Osborne 2009). No matter how well intended, even the best effort to maintain pelvic and lumbar alignment while in prone does not relieve strain from all painful structures. The **bodyCushion™** – when used appropriately, as described in Chapter 3 – can be useful for prenatal and postpartum work. When used under a prone client, it supports the pelvis at the anterior superior iliac spine (ASIS), often normalizing the lumbar curve and helping to prevent lumbar and SI joint strain. However, it does not protect the vulnerable sacrouterine ligaments from strain. When this or any similar support lifts the prone pelvis sufficiently to prevent pressing the **gravid** uterus against the therapy table, the (weighty) uterus is left dangling from these ligaments. The fascial attachments of these ligaments on the anterior sacrum, and the associated connective tissue that wraps around the pelvis, are already strained by any anterior pelvic misalignment during daily activities. The area can become even achier during a session, especially for the length of time and with the amount of pressure needed to work effectively on the posterior body. In short: for your client's sake, you must be aware of prone position's significant problems, and be wary of any prone props or tables, however well intentioned, that claim to solve those problems.

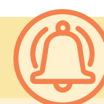
Now let us consider the increase in intrauterine pressure. Because of gravity, the weight of the torso presses the prone client's abdomen into the table, or into any additional supportive device. This increases the amount of pressure already exerted against the inner walls of the uterus by the fetus(es), **amniotic fluid** and placenta(s). The amount of increase depends on the firmness of the table or props and on the client's weight and abdominal size. As you press on her back with any but the lightest touch, your body weight further increases this intrauterine pressure. If you use deeper pressure, especially in the problematic lumbar and pelvic areas – in other words, just posterior of the uterus – that could create even more, albeit unintentional, intrauterine pressure.

Considering all that, how safe is the prone position? We do not have enough direct data to supply a confident answer. Here are some considerations, though.

- The only recommendation that the American College of Obstetricians and Gynecologists (ACOG) currently makes regarding positioning is that pregnant women should sleep on their sides after 13 weeks.
- Pregnancy itself enhances the contractibility of the uterine muscles. Increase in intrauterine pressure (due to tight clothing, excessive amniotic fluid and other causes) irritates the uterine muscles (Ricci 2017). These smooth muscles contract when irritated. Because the uterine muscles are already in a hypercontractile state, those contractions may be mistaken for preterm labor or may potentially contribute to preterm labor or miscarriage.
- Avoiding increased intrauterine pressure is of particular relevance with multiples, placental dysfunction, amniotic fluid imbalances and other **high-risk factors** and complications (see Chapter 7).
- Extra caution is also needed if there is heightened concern about fetal blood supply, **uterine competence** and/or a history of miscarriages. People diagnosed with these conditions are often uninformed about how they can be impacted by bodywork. Some of these problems go undetected until someone is specifically screened for them, or until bleeding, cramping or other overt signs of problems have occurred to warrant further diagnosis.
- There is a small amount of recent research that finds little harm for brief periods in the prone position, but also does not offer any conclusive findings about the added pressure that comes with massage (Ray and Trikha 2018; Dennis et al. 2018; Oliveira et al. 2017).

This much is clear: in most uncomplicated, low-risk pregnancies, a mild, temporary increase in intrauterine pressure – such as occurs while resting briefly in prone – is acceptable. During the first 13 weeks, the anterior iliac spines usually protect the uterus from significant increased pressure. Use the prone position in the first trimester if you or your client prefer, but remember that, even in the first trimester, prone can be problematic with the conditions mentioned above, or when the embryo is larger than normal or your client is obese. Because of the fragmented nature of what we do know about prone positioning, and the enormous amount that we do not know, our recommendation is this: to avoid any potential risk of excessive intrauterine pressure, use the sidelying and semireclining positions with all pregnant clients needing posterior work.

Reminder



Prone positioning – especially in second and third trimesters – can increase intrauterine pressure and/or strain posterior ligaments and muscles.

In addition to these safety concerns, there are very compelling comfort reasons to avoid prone positioning. Even in the first trimester, when the abdomen is not significantly larger, prone positioning exerts pressure on enlarged breasts. In fact, first-trimester women often have extremely sensitive breasts. One way to minimize this pain when prone is to use a cushion that has breast recesses carved into the foam foundation. Another alternative is to use a pillow or rolled towels at the clavicles and at the lower ribs so the breasts lie between.

Pregnant people may have more congestion due to a hormonally induced increase in mucus. Those with colds, allergies and other sinus conditions are particularly uncomfortable because their maternity healthcare providers may advise them to discontinue medications that alleviate congestion.

On the emotional side, some clients are uneasy with the idea of "lying on my baby." Similarly, the confines of face cradles and other prone positioning devices can hamper verbal and emotional sharing, important for stress reduction and, for many, a crucial part of a nurturing massage experience. We also lose the ability to gauge the client's experience by observing her facial expressions.

Often the prone position is also the least therapeutically effective position in which to receive a massage session. Stomach sleeping often creates or contributes

to back pain, hip and neck dysfunction and other musculoskeletal misalignments (Pirie and Herman 2003). Do we want to contribute to our clients' problems by using this position when there are beneficial alternatives? And as you will see, working from the sidelying and semireclining positions, rather than from prone, offers more ability to engage and move the most problematic parts of the pregnant client: the posterior body, the hip and the shoulder.

In summary, to ensure the safety and comfort of every pregnant client, and to improve session outcomes, we recommend that you eliminate the prone position after the first 13 weeks – regardless of your or the client's preferences. Even in the first trimester, use caution and make reasonable adaptations.

Supine and Semireclining

The other presumed massage position, of course, is lying face up. For prenatal massage, the safety of the supine position is determined mostly by maternal and fetal circulation. The inferior vena cava is the body's major vessel returning blood to the heart from the lower body through the iliac veins. It runs up the right side of the vertebral bodies along the posterior abdominal wall. The inferior vena cava is unaffected by supine positioning in the first trimester: the uterus has not grown beyond the pelvic cavity, and it is not very wide or heavy. Once past 13 or so weeks, when an expectant person lies on her back the weighty uterus and its contents rest against the common and internal iliac veins and the inferior vena cava. Extended compression of these vessels will result in low maternal blood pressure and decreased maternal and fetal circulation, called **supine hypotensive syndrome** (Figure 2.3). Some women report uneasiness, dizziness, weakness, nausea, shortness of breath or other discomforts when lying flat on their back, although others seem entirely content. However, with or without notable negative maternal effects, decreased fetal circulation can occur, particularly if the placenta is embedded posteriorly, its most likely location (Ricci 2017).

Some authorities advise pregnant women to never lie supine, even when resting or sleeping (Stone et al. 2017; Heazell et al. 2018; Callahan and Caughey 2007), primarily when there is increased concern about fetal oxygenation because of complications. Others caution pregnant women only to avoid supine exercising for long periods (ACOG 2015). From these parameters, it appears safe throughout pregnancy for most of our clients to lie on their backs briefly: say, for up to five minutes. Of course, if she becomes uncomfortable, or if her maternity healthcare provider places greater restrictions on supine positioning, you should adjust accordingly.

There are some options for longer supine work: in the early second trimester of a single-gestation pregnancy, you can use a pillow support under the right side of the lower torso, thus shifting uterine weight toward the left and reducing compression of the vessels. After 22 weeks, the rapidly expanding uterus will compress a sizeable section of the vena cava, even with the pillow under the right pelvis. Instead, you need to utilize what is ultimately the optimal position for face-up prenatal work: semireclining, which we will discuss below.

Comfort is another reason to avoid prolonged supine positioning. More than a few minutes on her back can aggravate the expectant client's SI joints and cause back pain. This is more likely if the back is poorly supported, if she is on an inadequately padded table, or if she is in the last trimester. These conditions can create an immediate,

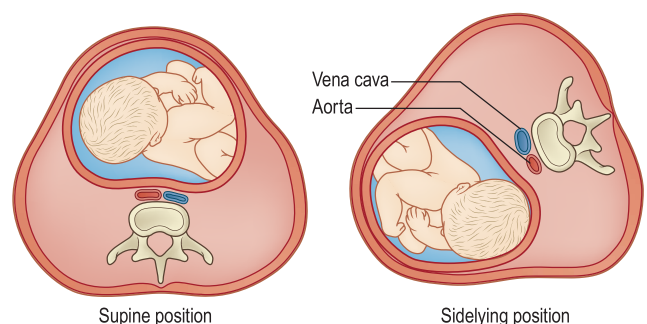


Figure 2.3
Supine hypotensive syndrome. In supine position (left), the enlarged uterus compresses the inferior vena cava. In sidelying position (right), torso vessels are free of the weight of the uterus.

painful, locking sensation in the upper buttock and iliac crest, usually on one side, particularly if one SI joint is hypomobile and the other is hypermobile (Riczo 2020; Noble 2003). Consider a minimum of 3 inches (7.6 cm) of triple-density foam padding for massage therapy tables used prenatally.

No matter how briefly you place the client in supine position, be aware of supporting and reducing lumbar lordosis, when needed. You can best accomplish this with sufficiently high knee bolsters to help mechanically relax the lumbar area against the table. To help relieve lower-extremity edema, place another pillow under her calves and feet level with the knees.

The solution to nearly all of the potential problems of supine prenatal work is to use the semireclining position (also called semirecumbent), either in addition to or instead of supine. Chapter 3 offers detailed instructions for creating this and all recommended positioning adaptations, but the basics are simple: you support the client's torso, assuring an angle of 45 to 75 degrees from her hip to her head. With a few modifications to your own body position as well, what you normally do in supine can be performed in semireclining, without any of the difficulties.

If a client has multiples or is overweight, you should switch to a semireclining position after the first trimester, and not use the pillow under the right pelvis at all. Other clients will be fine using a combination of supine in first trimester, then the pillow under the right pelvis for part of the second trimester, and then semireclining for the remainder. But remember that some clients will prefer the semireclining position throughout their pregnancy, particularly those who are obese or short of breath, or have heartburn. (As discussed in Chapter 6, semireclining can be valuable in postpartum as well.)

Reminder

When the client is supine, use a pillow under the right lower abdomen (weeks 13 to 22), or prop her in a semireclining position, to prevent supine hypotensive syndrome.

Sidelying

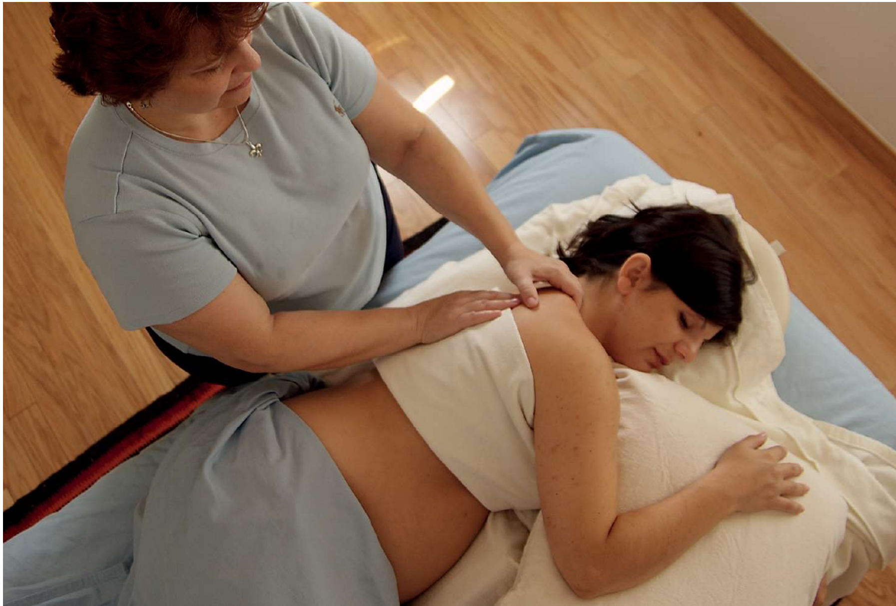
The position that offers the greatest combination of safety and comfort, for nearly all clients, and throughout the pregnancy, is the sidelying or **lateral recumbent** position (Figure 2.4). When sufficiently supported by pillows, bolsters and/or positioning systems, most clients find great relief and are happy in this position (see Chapter 3). Properly aligned sidelying position minimizes musculoskeletal and uterine ligament strain. It avoids pressure on the uterus, sinuses and breasts, and enables emotionally helpful conversation. This position offers the psychological comfort that comes from being in (or similar to) the fetal position. Nestled comfortably on her side, the client may feel more able to talk about her excitement, and her concerns, without the obstruction of a face cradle (as when prone) or the confrontational effect of talking face to face (as when supine or semireclining).

Physicians and midwives recommend the sidelying position for sleeping and resting. In sidelying, the vena cava is not compressed, and with proper abdominal support, the strain on uterine ligaments is reduced (see Figure 2.3). In many high-risk pregnancies, or when complications occur, women are told to sleep only in the left sidelying position, which allows for maximum maternal cardiac functioning and fetal oxygenation (Ricci 2017).

Unfortunately, this requirement is often exaggerated to an overly cautious and ultimately uncomfortable conclusion: that all pregnant people should lie exclusively on their left sides. Not only is it perfectly safe for most to lie on either side, but sleeping on both sides may even improve sleep and digestion (Silver et al. 2019). Unless their physician or midwife requires otherwise, feel confident to position your clients on whichever side they prefer or that offers you best access to problematic areas; or divide your session time between left and right sidelying positions. (Also, note that clients who sleep mostly on their left side often need the left side worked more extensively.)

Reminder

Sidelying is the safest (and usually most comfortable) position for prenatal massage therapy when the client is properly supported.



- Improves access to pectoral and pelvic girdle for therapist
- Avoids increased uterine pressure and supine hypotension
- Decreases edema
- Maximizes maternal cardiac function and fetal oxygenation
- Avoids sinus congestion, breast compression
- Psychologically comforts and soothes
- Faclitates sharing

Figure 2.4
Advantages of the sidelying position. When properly supported, the sidelying position benefits mother, fetus and therapist.

Points of view: Positioning

Positioning a pregnant client is one of the most confusing, and contentious, aspects of prenatal massage therapy. So it is important to clarify both the places of overlap and the places of disagreement. With little to no direct research on positioning for prenatal massage therapy, other evidence – anatomy, physiology, and nursing and obstetrical best practices – can provide some objective guidance.

All maternity massage instructors agree on one aspect of prone positioning: after the first trimester, a woman should not lie prone directly on a massage table without some type of accommodating equipment. The area where differing opinions arise is regarding whether any supports sufficiently reduce the problems of second-and third-trimester prone positioning: increased intrauterine pressure and strain to the posterior structures. Some claim that specially contoured cushions will prevent these problems while the client is in prone. Such cushions may be effective for those massage therapists and other providers, such as chiropractors and physical therapists, who do very brief prone treatments (Stillerman 2008) or whose pressure is superficial. Unfortunately, there is no published evidence to confirm or negate this safety concern for the length of most massage therapy sessions or with deeper pressure.

Recommendations for supine positioning have more variance. Some instructors advise to never use supine without modifications to prevent supine hypotensive syndrome, even in the first trimester. Given the small weight of the fetus (1 ounce/0.03 kg) and the size of the gravid uterus (4 inches/10 cm high and barely wider than the pubic bone) at the end of the first trimester, significant compression of the vena cava is highly unlikely before 14 to 20 weeks, except when there are multiples.

Among instructors who advise use of supports under the right side, as described above, there are small variances in placement and timing. Some suggest a wedge or blanket all the way from the shoulder to the

iliac crest. Because the inferior vena cava bifurcates deep in the abdomen, into the common and then internal and external iliac veins (which then descend into the pelvis), having the support underneath both the abdomen and the right hip seems more accurate. There is also disagreement as to when to move the client from this modified supine position to semireclining: at 14 weeks (Stager 2010), 18 to 20 weeks (Stillerman 2008), or as late as the last couple of months (Yates 2010). In a singleton pregnancy with average fetal growth, the uterus reaches maternal umbilicus level at 20 to 22 weeks, and is wide enough to press on the iliac veins and the inferior vena cava. Thus, positioning her in semireclining has the desired effect: directing uterine weight more toward the pelvic floor. But in semireclining, using additional supports under the right side is a redundancy, and makes stability in this semi-recumbent position more tenuous.

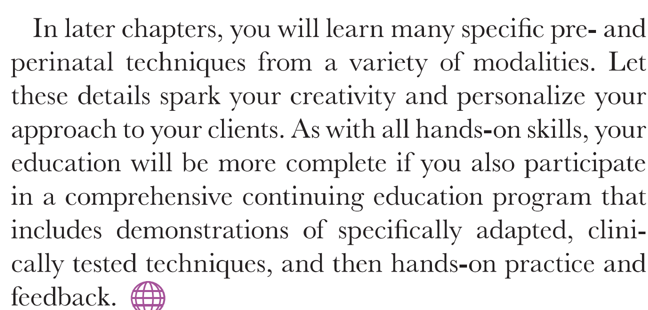
In summary – and until more direct research on the issue is available – we wholeheartedly recommend the sidelying position for prenatal massage therapy, regardless of possible inconvenience to, or the preference of, the massage therapist. It offers the most advantages and avoids some potential discomforts and risks, especially of prone positioning (see Figures 2.2–2.4). Another safe option, although generally not as comfortable for the expectant client, is seated massage therapy on either a household chair or a stool. Note that most massage chairs are a safe alternative only when the pregnant client rests her back against the pad normally used for chest support, for the same reasons as described in the prone positioning discussion above (and see Chapter 3).

Effective Modalities for Prenatal and Perinatal Massage

Most basic massage therapy training programs teach at least one therapeutic method that is readily adaptable for maternity care. Simple Swedish massage routines and introductory deep tissue or neuromuscular techniques can reduce stress, help relieve achy joints and muscles, and help the client feel nurtured. In other words, you already have some techniques that will help pregnant clients. Chances are, in whatever modalities you currently practice – from myofascial release to Reiki, from Shiatsu to Swedish – you have much to offer a pregnant client.

There is no single method or sequence that is *the* ideal prenatal or postpartum session. To limit yourself in that way would deprive your clients of the extensive benefits of the many **somatic practices** available to the professional massage therapist. Assess the methods you know to determine which can best help your pregnant clients. During the childbearing year, you will likely need to significantly modify some of those techniques and eliminate others. Use the guidelines and precautions here to carefully evaluate the physiological, structural and psychological impact of every technique from any method you contemplate using. Box 2.4 later lists critical guidelines for making technique choices and modifications.

In later chapters, you will learn many specific pre- and perinatal techniques from a variety of modalities. Let these details spark your creativity and personalize your approach to your clients. As with all hands-on skills, your education will be more complete if you also participate in a comprehensive continuing education program that includes demonstrations of specifically adapted, clinically tested techniques, and then hands-on practice and feedback.



Moderating Pressure, Speed and Pain

If *whether* and *how* are our first concerns when working with pregnant clients, usually the next is finding the appropriate level of pressure, speed and pain. To some therapists, pregnant clients seem so vulnerable, yet certain methods seem to require deep work to be effective. As mentioned, prenatal clients are far from fragile, but their preferences do vary widely. Determine each client's needs, and recognize that they can be very different in different parts of her body and on different days. Furthermore, cultivating your palpatory sensitivity will make you even more effective; the more aware you are of her tissues, the more you will be able to modify your work to her needs (Chaitow 2017).

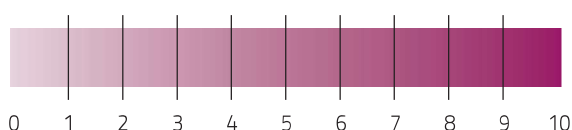
Certain techniques in certain areas, such as abdominal effleurage, need to be superficial, reaching only into the

skin and superficial fascia. Others, such as deep tissue and trigger point work, need therapeutic depth, but no deeper than what the client experiences as pleasure at the borderline of pain. And in certain parts of the body, especially the medial leg and abdomen, deep work may be dangerous (as detailed below). Just as with non-pregnant clients, you will be able to work as deep as clients want and need in most areas, while still calming them, if you work more slowly, especially when entering and exiting from the tissue.

Always learn the client's pressure preferences, perception of pain, tension level, and needs in a given body area. Her general health, injuries or other safety considerations (discussed later in this chapter) may dictate lighter pressures than those used with non-pregnant clients. Explore with her what qualities of your touch and what techniques best help her to relax, to experience less pain and to expand her enjoyment of her childbearing experience.

Provide her with a reliable means to communicate her experience of your pressure; generic responses like "that feels fine" do not really tell you anything. One option is a number scale (Box 2.1).

Box 2.1
Number scale method for labeling pressure and pain



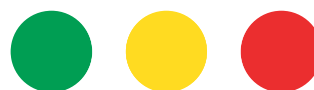
Pressure/pain level	Client's sensation
0	Pressure only
1–5	Pressure perceived as pleasurable
5.5–7	Increasing pressure is beginning to change from purely pleasurable into mild discomfort; however, that discomfort still feels good
7.5–10	More pain than pleasure, becoming intolerable at 10

Alternatively, try imagery rather than numbers. Pregnant people often relate better to right-brain metaphors than left-brain linear concepts, as pregnancy expands right-brain functioning (Naperstek 2007). You could introduce a color scheme for pleasure and pain feedback that follows the common correlation of a traffic light (Box 2.2). Soliciting your client's feedback can deepen her own engagement with, and control over, your work together.

Regardless of modality, remember that a client's pain level is greatly influenced by the depth and speed of your pressure. Gradually adding your body weight to your working tool makes the client more receptive; their tissues yield rather than guard, and invite greater depth. Instead of forcing or "fixing" your client's tight areas, think of facilitating or encouraging your client towards a position of greater ease. That shift will usually enable you to work more easily and with greater depth, and often makes your client more engaged. As you develop their awareness, their sessions will likely feel more pleasurable and informative. An actively participating client also means that your work will be often less effortful for you, physically and emotionally.

Mechanical considerations, such as table height, positioning and your own body use, also contribute to a client's pain perception. Chapter 3 will give you many tips

Box 2.2
Color method for labeling pressure and pain



Color	Client's sensation	Therapist's response
Green	Completely pleasurable	Keep on going
Yellow	Pleasure tinged with mild discomfort but still feels good	Proceed with caution
Red	More pain than pleasure	Decrease pressure