



The ABCs of normal labor

Everything you ever wanted to know about Labor Pain, but were afraid to ask!

No labor progresses without labor pains; no labor, no baby! I have long believed that the painful nature of labor was ample proof that God is male -- only a guy would think up such a stupid system. We, as women, would have our babies delivered by FedEx at 10am Saturday morning, after a full night's sleep. The baby would of course be all cleaned up pretty and dressed in a cute outfit, with a sweet little bow in her hair. Personally, I'm going to complain big time about this when I get to Heaven and meet the Big Guy in person.

Ok, now for reality. **Labor hurts.** I know this for a fact, as I've had three unmedicated labors and three spontaneous vaginal births. *Almost changed my mind each time!* Normal labor is best characterized by Winston Churchill's comment about our democratic form of government – not a very good system, just better than all the *other alternatives*. The problem with obstetrical attempts to make labor painless is that *every possible permutation of allopathic interventions has been tried* --drugs or anesthesia. These methods either don't actually work very well and/or they have very serious side-effects.

Unfortunately, drugs given to laboring women usually lead to MORE drugs. As an L&D nurse in the 1970s, every mother-to-be was given narcotics during labor. General anesthesia was the universal way to manage the pain of childbirth. Unfortunately, anesthesia-related complications were the 3rd leading cause of maternal deaths for the preceding decade (1960s). That brings us back to square one – non-drug methods of coping with labor, one contraction at a time. Unmedicated labors are safer and less likely to trigger a cascade of unintended consequences that can lead to failure to progress, fetal distress or operative delivery.

The problem for modern obstetricians is that their hands are tied. The most basic principle of physiological management – **Do not to disturb the natural process** – is the one thing that modern obstetrics can't do, since obstetrical medicine (of necessity) is organized around reducing the legal risk to the doctor and hospital, which means it isn't organized around the mother. So the modern hospital environment presents the modern laboring woman with few options for physiological management *and* a built-in series of small "bumps" that constantly risk derailing the natural process. Once the mother is sitting on the side of the bed in the labor room, the only reliable strategy for pain management in the institutional environment is either repeated injections of narcotics or epidural anesthesia. Both have can have negative effect on the progress of labor, especially if given too early in the process.

Labor is a Subtle System

Labor is a 'subtle' biological system, one that shares the same endogenous hormones and the same delicate mind-body connection as human sexuality.

During labor, exogenous sources of hormones or narcotics (pain shots or anesthetics) has the same propensity to send things in the wrong direction that a 1/16th of an inch bump on a pool table has on the path of a cue ball. When a ball lined up to fall in the corner pocket hits that little bump, it starts to go just

a little off track. For every inch it travels forward, the error is magnified until the original 1/16th of an inch bump has changed the trajectory so much that the ball hits the bumper 10 inches off target. This is one way to think of ‘subtle’ influences on the highly orchestrated and delicate physiology of childbirth..



The Birth Day

Teaching for labor

So what do midwives do to deal with the difficult reality of labor pains? One part of the answer is that we talk about it and teach coping strategies ahead of time. Effective labor support begins long before the first contraction and includes educational preparation of the parents. This may include some form of “breathing technique” but of equal or greater importance is teaching a way to think about the experience of pain, to help demystify the working pain of a progressive labor, to recognize the difference between the pain of injury and the “normal” pain of labor, which is **pain with a purpose**, pain that accomplishes something of great value to the parents. This simple stance invites women to make peace with the idea of labor pain. Fearing and fighting pain always and only makes it more difficult.

It is possible to develop common sense strategies to deal with transient pain. Acceptance is one of them. I once watch a little gaggle of teenage boys deal with transient pain in a remarkably effective way. They were kicking a ball around on the street in front of my house when one of the boys got a minor but painful injury. In unison the rest of the kids chanted a line that must have been the advice of their football coach about how to handle pain. It was: **Don’t sit down, don’t give up -- don’t stop, walk it out**, repeated over and over again, until the kid was OK and able to play ball again.

Another bedrock strategy of midwifery management is to discuss the possible value of tolerating the noxious sensations of labor. When drugs and anesthesia are presented to women as the preferred response to labor pain, it communicates the idea that the hard work and often painful nature of childbearing has no redeeming value, serves no purpose for mothers or society. This can be viewed as an unconscious form of sexism, which perceives childbearing women as biologically or psychologically unable to cope. In an era of reality TV shows, with women contestants running marathons, climbing mountains, swimming with sharks and eating big, slimy disgusting bugs, it wonders me that women can be convinced to have a scheduled C-section, because childbirth is just ‘too hard’.

In so many other areas of an adult woman’s life -- sports, schooling, professional, political or artistic achievements -- we honor her hard work, respect the determination it takes, we provide effective and sympathetic support for the painful aspects of her efforts and celebrate it as a victory when she succeeds. But for childbirth, we don’t value or respect the hard work of labor or provide the circumstances for its success. In fact, we do just the opposite -- we tell women they are crazy to even try a natural birth and sabotage the mother’s best efforts by asking every 20 minutes if she’s “ready for her epidural yet”.

I once watched a televised Olympic marathon, in which one of the women runners was weaving back and forth and staggering just 20 feet from the finish line. However, she was still on her own two feet and still making some forward progress. The voice of the announcer explained to the viewing audience that were someone to go out to “help” her, it would disqualify her from the event and the entire 25 and 9/10th miles she had already run would be negated. The emotion of pity, which can be a laudable characteristic, would none the less have stolen an incredibly important personal victory from her. As family and birth

attendants, we don't smother the mother in empathy. She has what it takes and with support and encouragement, she can do!

I think of this analogy when nurses or others suggest epidural anesthesia to a laboring woman who is already 8 or 9 centimeters or even completely dilated. The mother is afraid that she won't be able to handle the birth. Yes, she has pain but the deal breaker is the fear. Instead of offering reassurance, encouragement and confidence that she can do it, pointing out that she has already accomplished the lion's share of the work – 23 ½ miles of the 26 mile marathon -- they adopt a 'value-neutral' attitude and just call for the anesthesiologist. This mother will always believe that she didn't have what it took.

I also see a similar phenomenon when doctors want to "help the mother out" by using vacuum extraction to deliver the baby and shorten 2nd stage by 10 or 15 minutes. The mother will be inappropriately grateful to the doctor, believing that without this help she wouldn't have been able to do it or her body just wasn't 'built' to give birth. This attitude is sometimes passed on to her daughters as the idea that women in their family have genetically defective pelvises.

Overview of coping strategies



Practice or warm-up labor – 4 to 48 hours: Most childbearing will experience from 4 to 48 hours of mild to moderate uterine activity, perhaps in tandem with other precursor signs of labor such as a backache or 'back' labor. Even if the mother is planning to give birth in the hospital birth, she should stay at home, supported by the intermittent presence of a professional birth attendant, during this phase of labor. Most midwives ask the mother-to-be to call them whenever they have any signs of impending or early labor. The mother-to-be must be conservative of her biological and psychological resources, as this phase can last for as long as two days before she enters into the early phase of active labor. During this precursor phase, the midwife will be in frequent telephone contact and may even make one or more house calls to evaluate the situation. It's important that the mother continue to eat, drink, void regularly, walk about during the day, rest at night and, as much as possible, and retain a sense of humor.

Doing labor half hour at a time:



An effective piece of advice to the mother and her 'coach' is to "do" labor a half hour at a time. This forestalls the feeling of being overwhelmed. Most people can put up with most things for 30 minutes. So we reassess at the end of every half hour to see if the techniques and coping skills were working for her, and if not, to try something new.

If you can get to 5-6 centimeters, you can make it the rest of the way: A good strategy for managing the experience of pain is to let laboring women know that if they can get to 5 or 6 or so centimeter of dilation, they will have experienced the "it" that labor is. Labor at 7, 8 or 9 centimeters is more of the same, it *isn't* a geometrical progression in which the sensation of 8 or 9 centimeter are twice as painful as they were at 4 or 5 centimeters. If a laboring woman can get to 5 cms, chances are good that she can

get to 10 (complete dilation), if those around her continue to support her physically, socially and psychologically, encouraging her, letting her “complain”, but always returning to the simple statement that says “I know it’s hard, I know it hurts. But you’re already doing it, and I know that you have what it takes. After the baby’s born you’ll be glad you stuck it out. *It’s really worth the pain & hard work*”.

And interesting aside is that the safe use of epidural anesthesia requires that women be 4 or more before getting an epidural. When the mother-to-be is less than 4 centimeters, the rate of CS is doubled. So even with epidural, a significant part of labor must be successfully coped with before anesthesia becomes a relatively safe option. So if you can get to 4, you probably can get to 5 and if you get to 5, there is every good reason to believe that you can labor without anesthetics.

I can't do it! I just can't go on!

Hitting the wall – just around the corner from the finish line: Another aspect of this type of pre-labor education and preparation is to know that “hitting the wall” is a very normal experience, one that often indicates that the labor woman is just about to break thru to the pushing phase (for first time mom) or about to have the baby (for second or subsequent birth). This provides some psychological comfort in that experience, replacing fear and overwhelm with the encouraging knowledge that the labor is coming to an end and baby is about to be born.

Active Support -- Managing Labor, one contraction at a time

Physiological management of labor is far more than just abstaining from the use of interventions. The ideal is to support labor in such a way that one never need to use interventions and to manage any variations or deviation from normal progress early on, that the situation is corrected within the system of physiologic process. As for the coping skills listed above that will be required, they have been initially taught and talked about long before the first really long and strong contraction.

Early or latent labor: Mothers laboring at home need to get up and move about freely in a place that is familiar and affords psychological privacy. Both movement and psychological privacy are important. If you’ve ever hit your thumb with a hammer you’ll be familiar with the need shake your hand while moving rapidly around the room and yelling “OWWW!”. Contemplate for a moment what it would be like if you were forced to hold REAL STILL and NOT MOVE! Horrible thought. So freely moving about is a good start.

Distraction - self-directed, self-calming, attention but self calming, self-contained, interactive, one on one breath work with identified labor support person (husband, relative or doula) and self-directed pushing.

Variety of Loc, Activity, Posture

Variety of activity, variety of position, variety of location

Hydration and food --“grazing”

Total midwife presence for a first time mother usually spans 10-15 hours at the family’s home.

Intrapartum care for active labor & birth: The primary midwife or a qualified assistant comes to the mother's home from the time labor is well-established (usually about 4 centimeters cervical dilation, earlier if needed) until mother and your baby are in stable condition after the birth (approximately 2 to 4 hours).

But at the center of physiologically-based coping strategies, patient education, pre-labor practice sessions, real-time coaching by husbands and other family members, etc, there is a deeper layer of one on one labor support by the midwife herself. The first line of pain management lies in the mother's own coping capacity. The initial responsibility for coping is managed by the mother and her family or other labor support person. However, that system sometimes just doesn't work out as planned, perhaps because the mother's supporters don't have the needed background to meet the challenges of a particular labor. When that occurs, the midwife herself usually steps into the gap.

What that looks like is hard to describe because it is based on an intense personal interaction between the midwife and the mother. Usually this starts when the midwife looks into the mother's eyes, commanding her full and focused attention during the 60 or so seconds of each uterine contraction. This is accompanied by a light stroking of the mother on some little patch of exposed skin or bilateral stroke that begins simultaneously at the base of her neck and going down over her shoulders and arms, down to her hands and then starts all over again. While this description enumerates a series of simple physical acts, the real impact of it is the strong emotional bond that lies at the bottom of this activity.



Giving Birth with Grace & Gravity



The Equalizing Hand Grip ...



Coping is an Activity!



Breath Work - Stopping Time!

Intimacy Skills

Managing Time - the 24 hr Day/Nite

UG 5' x 60" X 60min = 12m on & 48 mins

Longer, stronger & closer together



Important Nutrients

Upright Postures / Table Manners



Interactive Labor Support



Painful Not Fair!

Not how its suppose to be!

WHY ME!

Right Use of Gravity

Pushing – early & Later

Making Epidurals Work for you



Don't raise the labor, U raise the baby



It's worth it