

Pain in childbirth

Sheila Kitzinger

Sheila Kitzinger describes pain and its control throughout the various stages of childbirth. She stresses the value of antenatal preparation as well as the need for a supportive environment during the labour stages. All concerned – the prospective parents, doctors, midwives and any other personnel in a maternity unit should be educated to be able to provide such an environment.

Normal labour pains

The pain of normal labour is distinctive. Characteristically it occurs rhythmically, accompanying uterine contractions as they each reach a peak and then fade, in what is often described by women as a wave-like pattern. There are always rest periods in between contractions when a woman who is not tense with anxiety can relax completely. It is this rhythmic character, perhaps more than anything else, which can contribute to the experience of contractions in childbirth as satisfying. Yet there is something else, intimately bound up with human values and with the meaning of childbirth, which profoundly modifies the affective characteristics of pain. Women who have had education for childbirth often say that they experienced pain which was different from ordinary pain, and may describe it as 'positive' or 'functional' pain, 'pain with a purpose' or 'creative' pain.¹ It seems that there is a significant qualitative difference between pain as a side-effect of a task which is willingly undertaken, comprehended and perceived as essentially a strenuous, joyful activity which is voluntarily engaged in, and pain which is part of a process involving injury and the psychological stress which we might call 'destructive anguish'.

Pain is never merely a sensation. It always involves a mental *percept*, an idea of its meaning and purpose, its part in a larger whole. It is well known that very strong emotional states can alter the experience of pain; when facing a real or imagined threat the whole organism responds to become alert to cope with the danger or to escape from it. Pain felt as a by-product of competitive sports or athletic activity or during passionate love-making may go unnoticed, be noticed but considered as of minor significance, or even be experienced as part of the pleasurable activity.

Labour pain can have negative or positive meaning, depending on whether the child is wanted, the interaction of the labouring woman with those

attending her, her sense of ease or dis-ease in the environment provided for birth, her relationship with the father of her child and her attitude to her body throughout the reproductive process.

Body fantasies

For each woman, too, the meaning of pregnancy and birth is associated with body fantasies which define the stimuli she receives from her uterus. These in their turn are based on cultural values in the larger society. Jamaican peasant women welcome backache in labour because they interpret it as indicating that a gate in the lower spine through which the baby must pass to be born is swinging open. In an emotionally unsupportive hospital environment they may become distressed at the first signs of the expulsive reflex, however, since they believe that the baby can 'come up out of the belly' and choke them, and the involuntary catch in the breath which commonly heralds the second stage is often taken to be a sign that this has occurred. Such fantasies of injury contribute to the experience of pain and can turn it into anguish.

Emotional preparation

In our own society, labour pain can be part of a pattern which has significance in terms of what women know is happening to their bodies in childbirth and in their personal lives and marriage relationships.² An important part of education for childbirth is emotional preparation of the expectant mother so that she finds meaning for the experiences through which she is passing, one that is not imposed from outside but which she discovers for herself in companionship with other women and couples in the antenatal class.³ This is quite different from classes designed only to teach exercises or to give information. Under these circumstances, given choice about whether or not to experience the pain of normal labour, a proportion of women choose to feel it. The opportunity to decide for themselves whether to have drugs for pain relief may in itself be an important element in reducing the degree of pain perception.

A study by Stevens and Heide⁴ at the University of Wisconsin demonstrates that the techniques taught in certain (but by no means all) classes in preparation for childbirth produce effective psychoanalgesia. Using ice-water to test perception and

endurance of pain, they tested subjects who had been taught methods used in childbirth education classes, using as controls those who had had no such training and another group who were offered distraction during the tests. They found that those who had been taught the techniques had only about half the pain of the controls and endured it 2.5 times longer, that the prepared childbirth strategies improved with practice, that they were effective for pain lasting longer than most contractions in labour, and that they were more effective than distraction techniques. They conclude that 'psychoanalgesic strategies may adequately substitute for chemical analgesics in normal vaginal delivery'.

Techniques used for control of pain

The techniques taught to expectant mothers include a range of skills related to different phases of labour. One of the most important of these techniques is systematic *relaxation*. This includes both general, complete relaxation and differential relaxation in which some muscles are contracted while others are consciously released. At its best relaxation is based on a foundation of pleasurable body awareness and a sense of the body as an effectively functioning whole. Instead of tensing up to fight or flee from pain, the woman adjusts to meet it, actively releasing tension, especially in those parts of the body which she customarily contracts in response to stress. This entails an increased awareness of her personal habitual responses to stressful stimuli, both physical and emotional, and also an awareness of *residual tension* and the skill to let this go too.

She is also taught to become aware of her own *breathing* and again, of how this varies in response to stress. She learns how to control and regulate her breathing so that she maintains a steady rhythm and can adapt it to meet contractions of different intensity and length. One effective way of doing this is for couples to work together, as with learning relaxation, using firm touch to give signals where the main sense of breathing activity is experienced with each breathing 'level'. One method is by applying pressure from the palms of the hands to different areas of the back; this avoids forceful sucking in of breath or 'pumping' the abdominal wall or rib cage in and out as if fighting for air.

This is subsequently linked with pain to form a practical *rehearsal* for handling the pain which is a frequent but by no means inevitable side-effect of many contractions in strong labour. The partner pinches some flesh on the upper inside thigh, gradually increasing pressure, holding it for some 15 - 20 seconds, and then releasing the pressure, while the woman 'breathes over' the contraction, adjusting her breathing to become higher and quicker as the crest of the contraction is reached, and then returning to slower, fuller breathing as it fades away. This practising for pain avoids the

besetting sin of many antenatal classes: the undervaluing of pain, amounting to what some women see as 'evasiveness' or 'dishonesty' so that the reality of the intense experience of labour comes as an overwhelming shock. Such practice cannot exactly duplicate labour pain, of course, and this should always be pointed out, but it is a good deal more realistic than merely discussing contractions in terms of charts and diagrams or verbal stimuli alone.

A further element in preparation, of which breathing also forms a part, is *attention focusing*. This is really the opposite to those distraction techniques which are sometimes used in an endeavour to reduce the perception of pain. It involves concentration on what is happening, one's response to it as a task, and visualisation of what is being achieved by the work of the uterus during contractions. The focus may be on the fantasy of the contractions as a shape, colour, sound, or even curve of increasing and decreasing heat, a shape provided by actual objects (furniture, architectural details, flowers, a painting) in the room, or a combination of these factors. Following on their original study Stevens and Heide found that such attention-focusing is very important in achieving psychoanalgesia.⁵

Mobility and frequent change of posture is important for many woman, and the assumption that the right place to labour is in bed is rarely made in primitive and peasant societies. The pain of labour is augmented, and additional pain may be produced, by lying in a supine position for long periods and being immobilised by intravenous drips, fetal monitors and other equipment. Flynn and Kelly⁶, reporting on the use of telemetry which allowed labouring women to walk about while being continuously monitored, said that their subjects did not want to get back into bed when testing had finished because contractions were much more comfortable when they were upright and moving.

Another strategy is to provide a *counter-stimulus* by massage, pressure, or stroking. The area to which the stimulus is applied may be anatomically far removed from the area where pain is felt. Pressure on a point at the centre of the balls of the feet can be useful, for example, or firm holding of the shoulders, and there may be much to be gained from study of both acupuncture and the system of Chinese pressure points in relation to labour pain.

Communication and knowledge

The purpose of all the techniques which the woman and her partner learn is not only to reduce or remove pain, but to enable her to achieve psychophysical co-ordination so that the uterus is allowed to function effectively and dilatation and descent to progress, unimpeded by maladaptive behaviour in response to stress.

They are further enhanced by acquiring *knowledge* and understanding of what labour involves, the terminology used by obstetricians and midwives, and by information about what happens in hospitals, including a tour of the delivery suite and an opportunity to meet staff and become familiar with any equipment which may be used. The facilitating environment for birth also provides *continuity of care*. This is lacking in many maternity hospitals today, but used to be the norm when one midwife attended a woman in pregnancy, delivered her at home and cared for mother and baby in the puerperium.⁷

The environment in which birth takes place can either contribute to or reduce the perception of pain. French exponents of psychoprophylaxis emphasise the importance of 'verbal asepsis' on the part of members of staff who should be careful not to imply that labour is necessarily painful, that it is going to get still worse, or that the woman will be unable to cope with the experience without drugs for pain relief. One vital element in the relationships between staff and patients is the staff's own attitudes to pain, and frequently their own feelings of helplessness to offer women anything other than pharmacological control of pain. It is intolerable to have to stand by and watch someone in apparent pain when one has the means to obliterate it. The new approach to labour pain entails the obstetrician being aware of his or her own responses to pain, finding out how much or little the labouring woman wishes to be done to modify the sensations she is experiencing, and also to learn the ways of giving psychological support to allow her to draw on her own resources, and offering support to whatever labour companion she chooses – usually her husband – so that he, too, can coach her through contractions when she wishes.

Supportive environment

The woman who has learned techniques for coping with labour is dependant on a facilitating and emotionally supportive environment at the time of birth. If she is to understand what is happening to her and is to know at what phase of labour she is, she needs attendants who will keep her fully informed of progress and any difficulties. To be in touch with reality she needs to share that reality with all those who attend her, and is able to use the information and skills she has much more effectively if she is given guidance and encouragement from midwives who understand what she is doing, and why. In a study of British maternity hospitals I discovered that this is one factor which is almost everywhere missing.⁸

These are all essential elements in the eradication of environmental stress. Stress can interfere with the physiological processes of labour and delivery in many animal mothers, and controlled studies in mice demonstrated that stress created by putting the mice in a goldfish bowl scented with cat urine, resulted in delay in going into labour, longer labours and in the delivery of more dead pups.^{9,10} It is difficult to believe that the nervous system of women is any less sensitive than that of mice. In an environment which is not supportive the labouring woman feels that she has to remain permanently vigilant and on guard.

It is because the environment of birth and the personalities of people assisting with it so deeply affect the mother's subjective experience that preparation of the pregnant woman, or even of couples together, is never enough for the optimal experience of birth; education of expectant parents must be accompanied by education of doctors, midwives and everybody else in the maternity hospital, from consultant to porters and tea-ladies, to provide an environment which is worthy of the act of bringing a new life into the world. Pain then becomes part of a pattern which has meaning and for many women can be relatively unimportant compared with the life-enhancing and deeply satisfying experience of giving birth.

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