Module 1
The Pain Relief Guide

Family Hubs Camden

Module 1: The Pain Relief Guide

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What are the different types of pain relief available when she is in labour?

No man wants to see his partner in pain.
Worse still, the thought that she is in pain and you can do nothing about it?

This fear is in the top 3 fears that men speak to me about. Before I give you an outline of what will be available to her if she experiences the birthing process as pain I want to say a little about how a woman's experience is shaped by her thinking (not just women by the way, the whole human species).

The word pain is an interesting one, we assume that childbirth is going to be painful; maybe that comes from our reading of the Bible, or from watching reality TV programmes! Now I'm not suggesting for one minute that the birth process isn't painful for some women, but what I want you to think about for moment is how we learned to speak our mother tongue and the influence that that learning process is having on our experience of life.

When we were children we made associations with words as things were shown to us and labelled, and now those referencing experiences lie deep in our unconscious minds. Every time we hear a word spoken, or see it on a page, it triggers an association, or a memory.
So if I'm going to use the word 'pain' for example, immediately the listener makes an association with 'painful experiences'. This happens in a flash and although outside of our awareness it taps into a whole category of experiences that we categorise as 'Pain'.
I've worked with women who experienced the birth process and the tightenings of the large flat muscle of the uterus, in the context of the weight training they have done in the past and put it in the category of a muscle tightening, saying stuff like, 'Oh it feels like, 'just' a muscle tightening'.
Their experience didn't suggest it should be classified as 'pain'.

Birthing process as Pain

So when I talk about ‘tightening’, I’m inviting a woman to go in a different direction in terms of her meaning-making than when I use the word ‘pain’.

My experience suggests that some women, when they get hold of this whole understanding, do not perceive their birth experience as painful. Some women even feel that the experience of birthing was orgasmic! It is important to address all aspects of childbirth with sensitivity and respect. In one instance, a client requested privacy to engage in self-stimulation during the birth process. She found that this helped her achieve a sense of focus, presence, and deep satisfaction during labour. Most women, when free to vocalise their experience while giving birth, sound orgasmic.

All of that was just to say, we frame our experience through language. The way I perceive pain affects the extent to which I experience pain. So in my opinion, it would be a good idea to stop watching One Born Every Minute!

The problem with the shows is that men and women who have never had a birthing experience are now being shown a fairly limited range of referencing experiences, for theirs.

Just for starters, One Born Every Minute shows women who have gone into hospital and have agreed to be filmed giving birth. So if you wouldn’t agree to be filmed giving birth, you’re not like these people. And it’s hard to see how their experience is relevant to yours at all. We’re all far better off allowing ourselves to respond in the moment to what’s happening.

With all that said, I want now to give you some useful information about what will be available for her to use if she experiences the birthing process as Pain.

Given all that we have been discussing so far about the influence of thinking on your partners experience of pregnancy and birth a good place to start when **considering pain relief in ‘labour’ is to consider techniques and practices that enable your partner (and you) to relax more deeply.**

There are lots of resources out there that teach this kind of stuff, ranging from books and audios that teach deep breathing techniques, to six-week courses on hypnobirthing.

Check it out, she will benefit from starting these practices in pregnancy, they will prepare her (and you) for the birth itself.

1. What is pethidine?

Now in most hospitals what's on offer is **pethidine, which is an opiate**.

It's an injection, into the deep muscle in the top of the leg.

There are some side effects; it **slows gastric emptying**, so once she has it the midwife won't want her to eat very much because she'll be worried about stomach contents in the unlikely event that your lover needs a caesarean under general anaesthetic. That's very unlikely, because most caesarean sections, even when they're emergencies, now happen under a spinal anaesthetic, which means the woman's awake anyway.

Slowed gastric emptying can also cause **nausea**, but she can have another injection to offset that.

Pethidine also crosses the placental barrier, so it does **make the baby sleepy**, which can delay getting **breastfeeding** off to a good start in the hour after the birth.

Pethidine also **changes the baby's heartbeat**. In some units, once she has had a dose of pethidine they want to continuously monitor the baby's heartbeat for a while to keep an eye on that sleepy trace. If your partner has pethidine, and the baby's born within an hour to an hour and a half, the baby might need an antidote to pethidine, called Narcan, if the baby is slow to breathe.

What do I think about pethidine?

Having watched women in the early stages of labour. I would say that it works effectively for some and not for others.

It can lead to a woman having short-term memory loss as well. So she can feel as though she's not really 'there' for the birth.

I've seen it work with women that have been in the latent phase for a long time and haven't got any rest. They have some pethidine, go to sleep and wake up in active labour.

But I've rarely seen it work well in the active phase of the birthing process.

2. What is gas and air?

Gas and air, or **Entonox, is a mixture of nitrous oxide and oxygen** that she can breathe in through a regulator, off the wall or a cylinder.

She can take gas and air throughout the whole of the birthing process – some midwives say she shouldn't take it early on, but really there isn't any cumulative effect.

It doesn't cross the placental barrier.

Sometimes women say the mouthpiece tastes of plastic and makes them feel sick, but it's the tubing that's doing that, not the gas and air itself. My feeling is that women can take as much as they want of it, and for as long as they want. There are no real side effects to it. Getting into a rhythm of using it, particularly in conjunction with TENS (more about this later), can be very effective.

Being mobile, using TENS and gas and air, is a really effective combination when it comes to creating an environment where the woman can dip down into herself.

3. What about an epidural?

At the moment, 35% of women giving birth in England chose to have an epidural.

It's good to know what you think as a couple about the various things that are available.

Often a woman will say, **don't let me have an epidural even if I ask for one.**

That doesn't work if women make that decision prior to the experience. Then, as the husband or the partner, you're in the situation of 'What do I do?' because she's begging for one.

What I normally suggest is that you set up some kind of **code word** and you agree that you will only accept it on the second occasion. The first time she asks you can say 'I hear what you're saying. I'm going to wait now like we decided, and if you ask for it again then I'm taking it that you're making that decision.'

That way you're not taking any responsibility for the decision, you're just being the guardian of the coding system.

What does having an epidural actually involve?

An epidural involves **a needle being inserted into the epidural space in the spine**.

Your partner will have to sit still, lean forward and curve her spine so that the anaesthetist has access. The needle comes out and a small plastic catheter goes in, which is taped up your partners back. A small amount of the analgesia or pain relief is dribbled in.

In the majority of cases it works perfectly and will **stop all sensation from the waist down**. Sometimes she may get more pain relief on one side of the body than the other. It stays in until after the baby's born; it will usually come out within forty minutes of the baby being born.

Anaesthetists are highly trained, specialist registrars. They're very, very good. But there are occasional side effects to an epidural.

In one in a hundred cases, the covering around the spinal column can get punctured by the needle, causing what they call a **dural tap**. This causes leaking of cerebrospinal fluid, which can lead to a really painful headache. It can be treated with something called a blood patch. Some of her own blood is injected into the epidural space and it causes a clot over the hole that seals it up.

Anaesthetists will also say that there's a slight chance of your partner being **paralysed** from the waist down, but they only tell you because we live in a risk management culture. The chances of it happening are ridiculously low.

She will lose sensation in her legs with an epidural, and she will lose any feeling of wanting to push when the baby is ready to come. Now the pelvic floor, when there isn't an epidural, makes a kind of undulating movement. It's the same kind of movement that your gut makes to move food along.

Now in theory the **undulation** helps the passage of the baby's head down the birth canal and out. With an epidural in place that undulation is gone, because the pelvic floor is floppy. Which may well be why there are higher rates of assisted birth with epidurals.

So it comes down to pros and cons:

- the pros are that for most women it's **100% pain relief**,
- the cons are that there's an increased **risk of forceps or ventouse** (the vacuum suction) being needed to get the baby out.

What does having an epidural actually involve?

Is it ever too late to ask for an epidural?

Some midwives will say it's too late for an epidural. The answer to that is this: ask them 'Will my baby be here in half an hour? Can you tell me my baby will be here within half an hour?' The midwife will say 'There's no way I could possibly tell you that', and you can say 'Thank you. I want to speak to an anaesthetist then'. It's as simple as that.

What the midwife is really saying is that by the time she gets the anaesthetist and the epidural is put in and all the rest of it, the baby's going to be here. But she cannot know that for sure.

Siting an epidural is a slightly more difficult procedure if a woman's cervix is fully dilated and she's started bearing down. We talked about the **first stage of labour**, which is what happens while her cervix is dilating, and the **second stage** is from when she's fully dilated to when the baby's born.

How long that takes depends on who you talk to. When a woman is responding to her body intuitively, and her cervix is fully open, the baby's head pushes on the rectum. So she has a feeling of wanting to open her bowels. A woman left to herself will, at the end of a tightening, just bear down until the tightening passes and the urge subsides again; she'll work like this until the baby's ready to come out.

But what you see in hospitals, on the telly, is women being told to put their chin on their chest, hold their breath and push. It's not helpful. It's called the **Valsava Manoeuvre** and it's never appropriate, in my opinion, because if the mother holds her breath it deprives the baby of oxygen. The only way the baby's receiving oxygen is through the mother. When a woman's left to herself the second stage takes longer than if she's directed to push, but that shouldn't be a problem.

In some units they still put an arbitrary time limit on how long the second stage can be. From full dilation to when the baby's born, they might say two hours at most. Some places say an hour! My contention is that when a woman is left to herself, it might take two hours, it might take three hours, but the implications for the baby are not the same as if she were breathholding.

4. The use of warm water in the birthing process

I have seen many, many women who found that, when they **got into a warm bath, the intensity of the birth process seemed to ease.**

I've also been privileged to watch as women have given birth to their babies in the water.

There's no doubt it's a useful tool and some women absolutely love it. In hospital there might only be one or two pool rooms, and there's always a chance there'll be people in there already when you go in, so it's good to have thought about other possibilities too. Some hospitals have large baths that women can use during the birth process, especially earlier on.

One reason your partner might think about a **home birth** is that it's one way of guaranteeing that she will have access to water, whether a bath, shower or a birth pool that you've bought or hired in advance (there are lots of options).

Does the idea of a water birth at home freak you out?

If so, find out a little more about it, and listen to what your partner says about it. Bathing in warm water can act as a guide in the early stages of the birthing process; if your partner gets into a bath or pool and the tightenings slow or stop, you'll know she's still in the latent phase and she can continue trying to rest.

Being in a birthing pool also enables a woman to be free from too much unnecessary touching by the midwife. It offers a sense of privacy that will cause her ancient hormonal response to grow.

In the context of risk, **water birth is safe** and most midwives will have experience of it, particularly those attending a home birth.

There are no side effects from using water, and your partner can get in and out as she wants to in order to be comfortable.

5. What about T.E.N.S machines?

They’re great, but don’t let her get in the birth pool with it on!

TENS stands for Transcutaneous Electrical Nerve Stimulation. These are **electrical pain relief machines**, with four pads that go on the woman’s back. Sometimes the midwives lend them out, and sometimes you have to hire or buy your own.

It’s best to get the machine at 35 weeks and practise putting the pads on and turning it up as high as she can bear it, so that when the birthing process starts you can whack the pads on and she can dial it right up. I’ve seen women get all the way to eight or nine centimetres with just a TENS machine when they’ve practised ahead of time.

But if you get it and only put it on when the birthing process has started you might as well not bother with it. There are a few theories about how it works. One is the gate theory, which suggests that it **interrupts the sending of pain messages**. Another suggestion is that it causes the **brain to release endorphins**, natural painkillers. A third theory is that it’s **just a distraction**.

I don’t care how it works as long as it does!

There are no side-effects for mother or baby.

That pretty much covers what will be available to your partner regarding pain relief when she is giving birth, if want more information or to talk about the subject more, just drop me an email: mark@birthing4blokes.com.

Being truly present when she is giving birth is the very best thing you can do to support her.

If she is experiencing pain you will find maintaining this kind of presence a challenge, my six module video program: The Birthing4Blokes Online Course covers this aspect of your role fully.
Knowing what is available to relief her pain will prepare you to fully support any choices she makes.