Pain Is My Friend

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*Most women fear childbirth ~ and rightly so given all the stories they hear when pregnant! But what if there was another way, what if women embraced the pain? The empowerment of acceptance is what **Rhea Dempsey** talks about in this article.*

Pain is my friend, pain is my friend, pain is … ', such a common mantra repeated over and over on the lips of so many of us as we work towards our health, wellbeing and fitness goals, or strive for peak performance, personal best achievements, or whenever we work with the functional physiological pain of our body striving. We know it takes working with physiological pain to pursue these goals. The huff, puff, sweat, strain and challenge of it are expected, supported and culturally celebrated.

But this positive 'pain is my friend, pain is my friend' mantra is not so much repeated on the lips of birthing women. No, birthing women more often repeat over and over an acculturated 'get me the epidural, get me the epidural' mantra. The cultural norm with regard to birthing has moved a long way from celebrating, let alone supporting birthing women to embrace the physiological pain. Instead we demonize labour pain; pity birthing women and 'save' them from the challenge.

For 'Nurture Magazine' readers I'm imagining this cultural norm doesn't quite sit with your values. I'm sure that pregnant Nurture readers are women who I have come to call 'willing' women. Women who still have a yearning for normal physiological birth, who still wish to engage with their bodies and the wild challenge of birthing.

In the present highly medicalised 'labour bypass era', in which birthing women are no longer expected to even feel their bodies', why would 'willing' women still want to engage with the challenge?

Well for one, there's the feed back loop that physiological pain creates for efficient birthing.

Pain as the pathway to your birth-friendly hormones

Oxytocin and endorphins work together for efficient physiological birth and pain is the catalytic agent. High levels of oxytocin drive the contractions; the contractions create functional physiological pain, which causes the release of endorphins.

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Endorphins give some moderation of the pain, but more importantly they swamp the 'thinking brain' to release the labouring woman's birthing instincts. It's a tailored recipe, refined over the ages. Embracing and working with the normal functional pain of labour is a key to unlocking this hormonal formula.

But it's not so simple, because the default settings in the birth culture are entirely stacked against willing women, especially with regard to pain dynamics.

Crisis of Confidence: the challenging edge of achievement

In all peak performance and personal best achievements, including birthing there are vulnerable 'feeling like giving up', 'hitting pain barrier' moments, which during birth I call 'crises of confidence'.

During these crises of confidence the birthing woman's resolve is severely compromised. The combination of the painful reality and the undermining cultural messages about pain in labour leave her wanting out—'give me the epidural'—she wails. What happens now is crucial to the outcome of the labour. Will her yearning for a normal physiological birth collapse or will she be supported to continue on?

To get a greater sense of how this all unfolds there are some other factors to understand.

Pain and Culture: circles of influence

Let's use five concentric circles to help get a sense of the circles of influence that press in on the birthing woman about pain.

These circles of influence will help give an overall picture of the many things that have an impact on labour pain—it's not all about strong contractions.

The outer circle represents the wider cultural circle; it's shaped by the 'spirit of the age', and represents cultural biases, including all those interventionist 'labour-bypass era' inclinations.

Inside this circle is the wider circle of family and friends, with all the attitudes, stories and suggestions they offer about labour pain.

Inside this circle is the circle of birth-place culture, with its practices and procedures regarding pain.

Then there is the circle of known support, which includes whoever women choose to have with them and their take on pain in birthing.

Finally right in the center circle sits the birthing woman with her lived experience of comfort, discomfort and pain zones.

Wider cultural circle

Pregnant women are bombarded by negative messages about pain in labour and these negative undermining messages also creep into their head and psyche, so willing women need to protect themselves from this way of thinking by positively reframing their attitude to labour pain.

But when push comes to shove and a moment of vulnerability hits, what happens? Well if the embedded cultural messages take over then pain-relief thinking trumps. Will the birthing woman be at the mercy of this thinking, or will she have a buffer zone to protect her?

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Wider circle of family and friends

When the birthing woman hits a pain barrier she will be far more likely to overcome it if she has a buffer zone provided by her own wider circle of family and friends. This wider circle of family and friends is made up of 'her people'. Not those she will have with her at the birth, but all her other close family and friends who live within her in the form of stories, comments, suggestions and attitudes. Do they moderate the cultural message and provide a buffer? Or do they amp up the cultural message and reaffirm that she was stupid to ever think she could do it without an epidural?

If this wider circle of family and friends doesn't provide a buffer zone it will instead act as an amplifier and multiplier of the acculturated 'pain-relief ' mindset. Now what's going to happen?

This is where the philosophy and practices within the chosen birth-place come to the fore.

Circle of birth-place culture

Presently, apart from in small pockets, the circle of birth-place culture will be made up of midwives and obstetric teams who are strangers to the birthing woman. Relationships within this circle are forged due to institutional circumstance with whoever is on roster at the time. This circle also includes the philosophies, routines, practices, power relationships and workplace regulations, which influence not only who will be working with the birthing woman but also how they work. And generally, regarding pain, the default setting is medical pain relief.

Circle of known support

This circle of known support is made up of the people known to the birthing woman that she chooses to have with her at the birth and usually includes her partner and perhaps other family or friends. It may also include caregivers she is engaging for the birth; an independent midwife, doula, or private obstetrician. (I'm including private obstetricians here, although they do not actually fulfill a pain-support function)

I separate this circle of known support into two distinct types: the Naïve support circle and the facilitating holding circle.

The naïve support circle often becomes, in the moments of a crisis of confidence, when the birthing woman wants all the drugs she can get, the mouthpiece for the dominant negative cultural messages.

The facilitating holding circle however, is specifically designed by a savvy willing woman to support her through pain and distress barriers, in order to back her birth intentions. If the cultural messages about pain in labour have been multiplied by the wider support circle of family and friends and reinforced by the birth place culture, these negative messages are all going to come rushing in, swamping even the willing woman's original intentions and confirming her present distressed 'I can't do it!' self-talk.

If the willing woman's original intentions are to be honoured it will now fall to the circle of known support to hold the line. Is there any buffer zone? Any protective force field within this circle, protecting her from both her own self-doubts and the multiplied, magnified cultural messages.

Buffer or sabotage?

For the birthing woman, whether she's a willing woman at the onset of labour or not, when she hits a pain panic—a crisis of confidence—how many circles can she lean into, how many will hold for her and provide a positive, energetic buffer? Will any amplify a positive message and back her intentions for normal physiological birth? Or will all those negative attitudes come rushing in, multiplying as they crash through circle after circle to eventually crash through the willing woman's now flimsy-seeming intentions?

Hopefully a willing woman is blessed with a wider circle of family and friends who can provide at least the initial much-needed buffer from the negative cultural messages. Then the savvy willing woman can, by her choices, increase that buffer zone and back herself by ensuring she has a birth-place culture and a facilitating holding circle that match her intentions—her choices are so important.

With birth stats for pain relief use in labour running at 75% and 85% for first births, it's clear that most women do not have support for working with pain in labour. And while many willing women expect their personal attitude to give a buffer zone, without a carefully chosen circle of support it's obviously tough to stay with her own intentions. This isn't to say that a woman's own pain attitude isn't important. The birthing woman's attitude to pain provides the portal through which all the positive or negative messages from the circles of influence will flow.

Midwives attitudes to pain

Research into midwives' attitudes to pain in labour identified a 'pain-relief' paradigm and a 'working with pain' paradigm. This research revealed fundamental differences in understanding pain in childbirth—differences that have major consequences for a woman's birthing potential.

Whether it's an independent midwife specifically chosen by the birthing woman, or a midwife who has been assigned through a 'know your midwife' program, or a 'stranger' midwife who is on shift at the time, the midwife counts so much when it comes to pain in labour.

Pain-relief paradigm

This paradigm dominates most hospital birth settings and is informed by medical, obstetric and nursing theory. It is based on pain-relief management developed for pathological pain in nursing, medicine, emergency and surgery situations—you know, the 'assess your pain between one and ten' routine. The bottom line is that pain should be controlled so that you can remain 'comfortable'.

The experts in pain-relief management are anaesthetists, medical caregivers, chemists, nurses and midwives influenced by this pain-relief paradigm. They know about the drugs and the epidurals—the 'when', 'how' and 'how much'.

This paradigm is based on the belief that the importance of women being comfortable and pain free, outweighs any of the disadvantages, risks and unintended consequences of pharmacological pain relief. Besides these caregivers are used to picking up the pieces medically when it all goes pear-shaped.

This is the default setting regarding pain in labour. Any distress on hitting a crisis of confidence, instead of being normalised and supported, will become entry points for pain-relief options. These options are supposedly offered in the spirit of 'informed choice', but in reality, in the absence of any other meaningful support for boosting pain tolerance, they actually work as 'nudge' choices and are almost impossible to opt out of.

'Working with pain' paradigm

In contrast to the medically influenced pain-relief practices, a 'working with pain' philosophy comes out of a 'keeping birth normal' midwifery understanding. This midwifery philosophy is underpinned by two core beliefs. Firstly, that normal physiological birth takes normal physiological pain and that, with the right encouragement, women can work with that pain. Secondly, that functional pain plays an important role in the physiology of normal birth because, as mentioned previously, functional pain is a stimulator of endorphins, which are part of the hormonal cascade that promotes normal physiological birth and enhances bonding behaviours.

'Working with pain' in labour, just like working with functional pain in other endeavours, requires practical skills and summons intense human support. Experts in these forms of support are personal trainers, coaches, sports psychologists, team mates, yoga teachers, massage therapists, and so on—and, when it comes to birthing, the experts are midwives who are influenced by this paradigm, doulas and maybe mothers, sisters or best friends who have already climbed this mountain.

When birthing women are well supported by midwives who embody this 'working with pain' philosophy, they will be encouraged through pain barriers, supported through any vulnerability or crisis moments and guided into a deeper rhythm of engagement with their body and birthing power.

Now there is a need, obviously, to be able to discern the difference between normal (physiological) and abnormal (pathological) pain states in labour. As a general rule though, birthing women can trust the pain in all its intensity and give expression to it—singing out their birth song and rocking out their birth dance.

The impact of the midwife

Willing women will need to know if the midwife is a facilitating midwife for normal physiological birth, or a midwife more attuned to nursing techno-medical practices.

Does it matter? You betcha.

Let's imagine a typical situation. A birthing woman hits a crisis of confidence; she's distressed and feels she can't go on. 'I can't do it', she wails. 'Help me, help me, get me something', imploring her support team to get her an epidural now! Regardless of her intentions before the birth, now she wants out.

If she is birthing in a setting dominated by pain-relief practices, any emotional distress will be interpreted by the midwife as 'unnecessary suffering'. Then, being a caring midwife within this pain-relief paradigm, the midwife will feel that her best duty of care at this crisis moment is to 'save' the birthing woman from that suffering. The way she can do that is by offering the birthing woman the 'pain-relief menu'. Then the birthing woman, in her distress, and in the absence of any other buffer, will gratefully accept the drug smorgasbord on offer.

On the other hand, if the woman is birthing in a care setting based on the 'working with pain' model, the midwife will respond differently. Far from seeing 'suffering', the midwife will see 'potency'. In fact, she has been waiting to see these moments of vulnerability because she knows that they are signs of progress, signs that the hormones and contractions are intensifying. The midwife celebrates this intensity jump-up, soothing, encouraging and boosting the birthing woman's pain tolerance, guiding her into a deeper engagement with her labour.

It's not rocket science; it's very easy to see the different probable outcomes in these scenarios. Same woman, same pain vulnerabilities but different possibilities based on the midwifery support she receives. Willing women need to be savvy about these pain dynamics; they can't leave it to chance. They must strengthen their facilitating holding circle to ensure they are surrounded by the expertise they need at these crisis of confidence moments.

Willing women of course need to look to their own attitudes to pain in labour, they also need to develop resources for boosting their pain tolerance thresholds, however I hope my explanation will alert them to the cultural and structural issues that also play out when pain dynamics get going and help them to make savvy choices in support of their birthing intentions.

Rhea is an Independent Birth Educator/Birth Attendant/ Trainer/Counsellor. She has 36 years experience working in the birth field and is now an Author. Her book - Birth with Confidence: savvy choices for normal birth, is available through her website or good book stores. www.birthingwisdom.com.au