The Pain of Labour – A Feminist Issue
By Andrea Robertson

Pain in labour is universal: it hurts to give birth. Since this is such a common experience it could be seen as comforting, a bond among women, a fundamental truth that confirms our special biological role and affirms the importance of our contribution to society. More often, however, it is seen as a blight, an unnecessary imposition, an affliction we must bear as the price for bearing children. This view, bolstered by the perception that pain is a symptom of disease and illness, has enabled medical men to convince us that pain is dispensable during birth, and is of no value, an evil to be cured with modern treatments and technology.

This view of labour pain as an affliction seems most prevalent among western women. In many cultures, pain in labour is accepted as a necessary, if uncomfortable part of birth, and is not seen as an insurmountable problem. Perhaps the fact that these women are usually cared for by other women, who understand birth and its mysterious benefits for the female psyche, is the central reason why pain is not feared but accepted. The enforced movement of birth from the home setting to a hospital has established birth as a medical event and the ready availability of drugs and technology in hospitals has encouraged its use (Wagner 1994). Women, often unaccompanied by knowledgeable support people, and made vulnerable by their emotional and hormonal state, are ripe for seductive messages conveyed by "experts" that labour pain has no benefit. Most of these "experts" are men who have a different biological view from women as a result of masculine reproductive information. Since men will never give birth, they have no need of innate birthing instincts, and therefore can have no deep sense of intuition and understanding of the birth process. Perhaps this explains why men are often so uncomfortable around women in labour --- they are unable to connect with the process at an instinctive level. Suspicion and fear can be created in such a climate.

Women in labour have a strong need to feel nurtured and protected, to increase the likelihood of a safe outcome for themselves and their newborn. This need to depend on others leaves women open to abuse --- if they trust the wrong people during birth then they may end up in an unsafe environment with unwanted results. Have women been hoodwinked into trusting the wrong people during birth? Have we placed our faith in medical men when we should have had more faith in ourselves and found female companionship for labour and birth?

The relentless increase in birth interventions certainly suggests that this is the case. The continuing push to expand the use of drugs during birth highlights another inconsistency: pregnant women are exhorted to avoid drugs during their pregnancy, yet once labour begins, they are offered various pain killing medications, as if they have no effect on the unborn baby! Women are encouraged to use pharmaceutical pain relief for their own good with little reference to the possible side effects for the baby. Indeed, many women, when they discover that these drugs do cross the placenta, are motivated to try non-invasive forms of pain relief, since harming their baby (even if they see this as remote) is unwelcome. Many women have found that labour pain is bearable if it means better health for the baby.

Since no drugs have been proven safe for the unborn in either pregnancy or labour (Haire 1994), then preventing possible harm to our children will necessitate women once again accepting that pain may be a necessary component of birth. Moreover, pain during birth may offer some positive advantages for the baby, since its presence is an integral part of the process and therefore unlikely to be an addition without some biological benefit. If there is a biological purpose for the pain, then understanding this role may alter attitudes to its action, whilst allowing insights into labour management that enhance rather than block this physiological entity.

So, if there is pain in labour, then what is its purpose, and how can we benefit from it?

All animals are born with innate instincts designed to ensure that the species survives and increases. Two bodies of information revolve around survival skills and reproductive behaviours, and are implanted in the deepest parts of the primitive brain early in fetal life. Each is characterised by systems of automatic responses, utilising various hormones to program the physiologic mechanisms involved. From nature's perspective, both systems must be simple and reliable. Reproductive behaviours therefore, must be inherently effective and designed so all animals (except those with undesirable defects) can manage to produce healthy offspring. Put simply, they must be "foolproof" --- everyone having the potential to reproduce. In addition, to encourage sufficient reproductive activity to not only provide replacement stock, but an excess that will ensure increased numbers, there must be some inbuilt rewards for the participants.

These are important points for women to consider. Pregnancy proceeds without outside "assistance" and birth is similarly straightforward, cleverly designed to be as efficient as possible. Virtually all women have the potential to give birth easily and safely, and no special knowledge or learning is required. The intricate system of hormones, in an exquisite balance, ensures success almost all the time. The very few failures are necessary, to ensure reproductive success amongst strong breeding stock.

In addition, rewards are built in, to encourage further pregnancies. Many of these rewards come in the form of sexual pleasures, as after all, reproduction is all about sex. The natural inclination for people to keep their sexual lives private has also mitigated against childbearing women, and made discussion of the inherent sexuality of birth and lactation difficult. If birth was not so sexual perhaps it would have been easier for women to express their needs and for others to recognise the importance of preserving the natural physiological flow of the process: keeping the sexual nature of birth "out of sight" makes it easy to avoid confronting the issues.

The primary need for pain in labour centres around the need for a woman to know that the birth has started so she can retire to a safe place while the process unfolds. The need for a safe place is crucial to the well being of both mother and baby, since both are immobilised and vulnerable during the event and immediately afterwards (Odent, 1994). The typical nesting behaviours of pregnant women demonstrate this instinctive need to prepare a safe place. It is ironic that of all the animal species on earth, human beings must be the only ones who make their nests in one place, then trek elsewhere, to hospital, to give birth. This fundamental shift in birthplace may explain the difficulties experienced particularly by western women during birth. Grantly Dick-Read identified these problems in the 1930's and 40's. He correctly diagnosed that women were frightened and ignorant and that this was impeding their labours. However, he suggested a medical solution of prescribed classes and education rather than tackling the underlying cause of women being moved from their homes into hospitals for the birth of their babies.

The role of oxytocin

Oxytocin is the central hormone in all aspects of reproductive behaviour. In each area of reproduction (sexual intercourse, labour and birth, lactation) it works in the same way and is affected by the same inhibiting factors. A brief summary of some of the actions of oxytocin are listed below:

Oxytocin --- in the sexual cycle:

- Causes uterine contractions.
- Initiates care-taking behaviours in men and women.
- Causes an in-sucking action of the cervix --- aids sperm transport.
- Enhances sperm production and early ovulation.
- Following orgasm, reduces anxiety and depression.
- Increases skin temperature.

During pregnancy and birth:

- Frequent uterine contractions help to maintain pregnancy and stimulate placental blood flow.
- Pressure of the baby on the cervix in labour stimulates contractions.
- Distension of the pelvic floor muscles and opening out of the vagina maintain contractions, and the pushing urge in second stage.
- Stretching of the perineum causes a surge of oxytocin just after the birth --- assists in maintaining uterine tone.

Following birth:

- Stimulation of the nipple or other oxytocin sensitive sites causes milk ejection.
- Release of oxytocin reduces risk of haemorrhage.

- Assists the uterus to return to its pre-pregnant size.
- Increases maternal nurturing behaviours.
- Increased temperature of the breast during breastfeeding is comforting and protective for the baby.

All of these actions of oxytocin are inter-related, and occur across all aspects of reproduction. Therefore those factors that inhibit oxytocin release in one area of reproductive behaviour will have the same effects in other areas. For example, as Michel Odent states "the right place to give birth would be the right place to make love" (Odent, 1982). This interconnection is often overlooked, especially by those who find the notion of birth and breastfeeding as sexual events rather distasteful or even shocking. Our unwillingness the acknowledge the innate sexuality of childbearing has been a major factor in the continued denigration and humiliation of women when they give birth. By refusing to accept the central role of oxytocin, we have excused ourselves from finding ways of ensuring its successful release and unimpeded flow, and in the process, inflicted long and unnecessarily painful labours on women. The resultant "failures" during labour have been attributed to inherent weaknesses in women, when they should have been recognised as a lack of understanding of the action of the basic labour hormones and an unwillingness to provide the necessary conditions for their unimpeded release.

Oxytocin release is triggered in labour by a number of factors:

- Distension of the vagina.
- Clitoral stimulation.
- Pressure on the cervix.
- Distension of the pelvic floor muscles.
- Stretching of the perineum during crowning.
- Nipple stimulation.

Oxytocin release is inhibited by both direct influences:

- Fear and anxiety.
- Anaesthetic injections, which numb oxytocin-sensitive areas.
- Flooding of receptor sites by exogenous doses of oxytocin - which reduces sensitivity to endogenous oxytocin.
- Episiotomy - reduces stretching of the perineum.
- Separation of mother and baby, with resultant loss of skin contact.

and indirect influences:

- Beliefs and attitudes, which may lead to embarrassment.
- Memories e.g. of past sexual abuse - leading to fear and anxiety.

When oxytocin release is inhibited, it results in:

- Failure to achieve orgasm.
- Diminished nurturing feelings and reduced/absent care-taking behaviours.
- Slowing of labour.
- Prolonged second stage.
- Increased likelihood of post-partum haemorrhage.
- Problems with breastfeeding.

Where does the pain come from?

The basic source of the pain in labour is the action taking place in the cervix. The uterus is supplied with sensory nerves that can only register stretching and tearing. Tearing means a uterine rupture --- a very rare yet life threatening event for which a clear signal is necessary. Stretching of the cervix is the primary action during labour and indicates that labour is underway. The varying degree of stretch, and the resultant varying degree of pain provides a feedback mechanism to the woman so she knows how far the labour has advanced.
Since the uterus is surrounded by other structures within the abdomen, there may be sensory nerve messages, sometimes painful, from other sources, such as pressure on a full bladder or nerve compression due to the position of the baby's head. These sources of pain have a different quality and are usually present between the contractions, a clear indicator that something is amiss, and needs attention.

Endorphins

The biological necessity for pain in labour is mediated by the body's ability to produce endorphins in times of acute physical stress. This phenomenon is well known amongst athletes and those who take regular aerobic exercise. The beneficial effects and protective nature of endorphins are helpful for enhancing performance and as they are similar to opiates in their chemical structure and action, they have the ability to cause addiction in those who regularly experience endorphin release.

Endorphins offer a number of benefits for pregnant and labouring women:

- They are natural pain killers, produced in response to the heavy work of pregnancy and the stress of uterine contractions.
- Withdrawal behaviours are encouraged, useful for self awareness and protection.
- They create a sense of well-being and promote positive feelings.
- They may be an important link in mother-baby attachment --- creating a positive emotional climate for the first meeting with the baby.
- The feelings of achievement and satisfaction with birth increase self-esteem and confidence.
- The amnesic effect of endorphins enables women to forget the worst aspects of labour providing an incentive to reproduce again.
- They offer a natural reward for the effort involved in giving birth.

From the baby's perspective, endorphins may also be important, ensuring that the mother is feeling positive and nurturing when they first meet. The hormones produced in the baby's body in response to labour (nor-adrenalins) are important for all babies' immediate survival, ensuring that they are able to maintain body heat and breathe successfully, due to adequate surfactant production. In addition, the baby's pupils dilate and they exhibit quiet alert behaviour - both very important in attracting and holding the mother's undivided attention (Lagercrantz & Slotkin 1986).

Endorphins are nature's natural pain-killers, with numerous side benefits for mothers and babies. They are only released in response to the work and effort of labour, and specifically when pain is present. Therefore, women need first the labour and then the pain of contractions to ensure they have the endorphins they need. Without these factors, endorphins will not be produced, and the woman will not only suffer during labour, but may be in a less than optimal state to greet her new baby. The process of bonding, often thought to be a nice "extra" in a good birth, is actually critical for reproductive success and is guaranteed by a number of hormonal interactions. Having expended considerable effort in both growing and successfully birthing a baby, nature's imperative is to ensure baby's survival through "capturing" the mother's commitment to its continued nurture. It is time to recognise that problems with breastfeeding and the breakdown of

bonding and nurturing behaviours in new mothers may be the result of inappropriate birth practices and insensitivity to the unique and intricate balance of pregnancy and labour hormones. Can we really afford to ignore the power and necessity of oxytocin and endorphins to the well being of women and children?

The effects of adrenalin

When the natural flow of labour is disturbed, the body takes instinctive evasive action to ensure survival and protection of the parturient woman and her baby. The mechanism involved uses adrenalin as the medium - the "flight or fight" hormone with which we are all familiar. Producing adrenalin is an automatic response in any frightening or threatening situation, and women giving birth are especially vulnerable. In addition to the well-recognised signs and symptoms of adrenalin production in the body (raised blood pressure, cold clammy skin, increased heart rate, rapid breathing, dilated pupils, restlessness, etc.) a woman in labour, confronted by this situation, and her baby, need extra protection, to prevent reproductive loss. By nature's reckoning, if the circumstances are dangerous for the mother then they are no place for a helpless newborn, and biological action is needed to avoid imminent birth. The release of adrenalin may be initiated by any number of overt or covert stressors: loud noises, strangers, unfamiliar or hostile birth environments, interruptions and distractions, lack of privacy and invasive procedures. Subconscious fears may also trigger adrenalin release, as may acute embarrassment. Whenever adrenalin begins to flow, a number of clinical signs will appear:

- Panic behaviours.
- Raised blood pressure.
- Slowing of contractions due to the effect of adrenalin on oxytocin production.
- Increased pain caused by reduced flow of oxygenated blood to the uterine muscle.
- A pause in dilatation as the circular uterine muscle fibres contract and counteract the action of the other muscle layers.

These normal and expected reactions and symptoms are often misdiagnosed as:

- "Failure to progress".
- "Inco-ordinate uterine action".
- "Dystocia".
- "Inefficient myometrial action".

when a more accurate diagnosis would read:

- "a natural response in a threatening situation".
- "perfect hormonal interplay in the circumstances".
- "normal reaction to hostile surroundings".

The failure to label this condition correctly is a prime example of the medical model being applied to a normal bodily process. The labelling of this condition as a "failure" of the woman has given medicine the excuse to take over labour and orchestrate women's labours to meet criteria arbitrarily set by people with little insight into normal bodily functions. Control over women's bodies is thus achieved and maintained, and as an additional insult, women are tricked into believing that a managed, predictable labour is not only desirable, but safer for themselves and their babies. The epitome of this approach is the "active management of labour" - a calculated assault on a woman's natural hormonal function carried out with mechanical precision and a total lack of regard for nature's grand plan for reproductive success.

When the true role of adrenalin in labour is understood, that is to prevent an untimely birth, remedies that will reduce its necessity and enhance productive labour become apparent. The following suggestions are in no particular order and will need to be tried in light of the individual circumstances:

- Identify the source of fear or disturbance and remove it.
- Use basic panic control measures.
- Provide privacy.
- Avoid unnecessary procedures.
- Change the environment.
- Dim lights, provide warmth and quiet.
- Reduce attendants, beginning with unnecessary staff.
- Provide continuity of empathetic caregivers.
- Remove anyone who is showing signs of anxiety.
- Allow time for adrenalin to decrease and endorphins and oxytocin and endorphins to reappear - at least an hour in the new conditions.
- Whisper, avoid eye contact and conversation.

In considering these options, the following important points should be noted:

- If the mother and baby show no signs of medical problems there is no need to take medical action.
- Avoid using negative language and labels as they colour perceptions and behaviours.
- Oxytocin drips and pain killing drugs should only be used as a last resort, when everything else has been tried and given time to work.

Women and their care givers are beginning to recognise that labour is often unnecessarily painful. The solution, in traditional fashion, has been to apply the medical model to the problem and medical science has come up with the epidural anaesthetic as the most "acceptable" way forward. The energetic promotion of this largely untested technology has again focused women on the pain of labour and interpreted it as an evil, avoidable entity that has no benefit for them or their babies.

Perhaps it is time to view the necessity of epidurals from a different perspective - that of the failure of hospitals to supply women with safe and protective environments for birth. Instead of labelling the women as "failures" when their body takes fright at the conditions provided, hospital staff, and particularly midwives, could recognise the inherent dangers for women giving birth in their institutions and take action to reduce the source of the fear. Epidurals would then only be offered when all else was tried and in clear acknowledgement of the hospital's failure to provide safe birth environments, or on the basis of clear medical need. Midwives, with their understanding of the normal labour process, and their interest in protecting women and physiological birth, are well placed to highlight the real situation being played out daily in our hospitals, and to take remedial action.

A feminist issue

Improvements and change will come when women take charge of their bodies and acknowledge the special role of their hormones during labour. We need to:

- Demand safe havens for birth - such as birth centres and home births.
- Resist unnecessary interventions during birth.
- Exercise our legal rights to the preservation of our bodily integrity - no unsolicited touching and no treatment without consent.
- Demand information that is balanced, unbiased and understandable.
- We need to come to terms with the pain of labour. It is not to be feared, but rather welcomed for its intrinsic benefits and rewards: pain is a necessary part of normal labour and is important for maternal physical and emotional well-being. It is also good for babies!

- Midwives need to reclaim their skills in sitting and waiting in anticipation of normal birth. They also need to take action - especially when they witness ritual abuse of women in labour wards. How can we remain silent when our sisters are being treated in this way?
- There needs to be better training for midwives, based on practical experience of birth in settings that enhance normal physiology - the home would be the ideal place to start. Textbooks need to include information on hormones and their actions during birth - my book Empowering Women is the only book I've come across where the action and importance of hormones is explained. Medical style midwifery texts seems to have dismissed these topics as "irrelevant".
- Women will be better served when midwives stop being nurses and practise woman centred midwifery. Abandoning the medical model is difficult, especially following years of indoctrination during nursing training, yet embracing the social model of birth is central to its success.

Pregnant women need information, based on research. We need to tell them:

- Trust your body - it works well.
- Forget "the breathing" and other learned behaviours - they are stunting your self-discovery and disempowering you at a time when you most need to tap into your own innate capabilities.
- Get yourself good labour support - it's been shown to shorten labour and decrease your need for pain killing drugs.
- Avoid induction or augmentation in an effort to control your body during labour and birth, unless there is a proven medical need.
- Think carefully about where you give birth - nesting behaviour has a purpose!

The health system, although a monolithic structure, is being forced into some timely changes, due to the rising cost of technology and increasingly vociferous complaints from users. Birth, being a wellness condition, requires special consideration and health care provisions: safe havens such as birth centres, support and promotion of home birth, and increased midwifery care.
The harsh reality is that we women have allowed our bodies to be taken over by the medical men peddling ideas that pain in labour is unnecessary and safely avoidable. We have condoned this takeover because we have been kept ignorant about the nature and purpose of our labour pain, and we have been swayed by arguments that seem persuasive, but are not based on fact. The time has come to reclaim our pain --- we and our babies need it to survive!

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