Working with pain in labour
An overview of evidence

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This overview presents the case for developing a ‘working with pain’ approach to the care and support of women during labour. It sets out the rationale for this approach before comparing it with widely held beliefs and practices in the UK. Evidence to support a working with pain approach is presented.

‘Working with pain’ - beliefs and practices
The ‘working with pain’ approach to the care and support of women during labour was developed as part of a masters degree.¹ As a result of an extensive literature search on pain, drawing on multi-disciplinary discourses and undertaking semi-structured interviews with midwives, it was found that attitudes to pain in labour could be separated into two paradigms, that of ‘working with pain’ and that of ‘pain relief’.

The ‘working with pain’ paradigm includes the belief that there are long-term benefits to promoting normal birth in terms of women’s experiences and lives, and that pain plays an important role in the physiology of this process.

At the beginning of labour, pain allows a woman to realise that she is about to give birth: to find a place of safety and gather people around her who will support her. As labour continues, the pain triggers a cascade of neurohormones that control the process; the pain changes and shows that labour is progressing as it should. The pain of labour marks the enormous change that is occurring in a woman’s life — her transition to motherhood; the complex interplay of hormones and chemical changes helps her prepare to welcome her baby. Her joy at becoming a mother can be heightened by the contrast with the pain of labour, together with a sense of achievement and triumph at the completion of a huge and challenging task.

When labour is progressing normally — that is when contractions are normal and the baby is well positioned — it seems that, with support and encouragement, women are able to cope with the pain they experience.¹ ¹ This is due to the production of the body’s natural pain-relieving opiates, endorphins.² ³ ⁴ Where midwives and birth supporters are using the working with pain approach, they try to create an environment which encourages the production of endorphins and to avoid creating the circumstances that inhibit their production. In contrast, if a woman experiencing normal labour is offered pharmacological pain relief, she will find it irresistible, as labour involves both pain and uncertainty, which can be emotionally demanding and exhausting. The use of pharmacological pain relief not only affects a woman’s perception of labour, it increases the use of other medical interventions, reducing the chances of having a normal birth.⁵

In some circumstances, the pain can be described as ‘abnormal pain’ according to the working with pain approach, for example where the baby is poorly positioned or labour has been accelerated with drugs. Women experiencing abnormal pain are likely to have a genuine need for pharmacological pain relief.

In contrast, the ‘pain relief’ paradigm is characterised by the belief that no women need suffer the pain of labour and it is a kindness to alleviate it by a variety of pharmacological methods of pain relief. Women are offered a ‘pain relief menu’ including the pros and cons of each method to enable them to make an ‘informed choice’. Women may also receive the implied message that it is not possible to get through labour without resorting to pain relief. Many health professionals also promote the use of pain relief because they feel disturbed by the noise and behaviour of women labouring naturally.

Mainstream beliefs and practice
Historically, the childbirth culture might be viewed as being consistent with a...
‘working with pain’ approach. Women were supported by other women when they gave birth. This began to change in the mid 19th century with the advent of obstetric anaesthesia and the notion of ‘saving women from pain’. The dominant cultural approach to labour in high income countries is now the ‘pain relief paradigm’ in which using some form of pharmacological pain relief in labour is the norm. The pain relief approach is supported by NICE clinical guidelines for the NHS which state that women should be supported in making informed choices about pain relief.

A recent survey of 26,000 women’s experiences of maternity care in the NHS in England identified that 34.1% of women in labour had an opiate injection and 29.4% had an epidural, with wide variations in the use of different methods of pain relief across trusts. Only a few did not use any pain relief in labour (6.6%), with varying rates between NHS trusts of 0% to 21%.

In two linked studies, Green et al found evidence of growing use of pharmacological pain relief, particularly epidural use, in the period 1987-2000, yet the number of women who were fearful of labour pain increased significantly. Their follow-up study showed an increase in women feeling ‘frightened’, ‘powerless’ and ‘helpless’ in labour. They found that as well as an increasing proportion of women expecting to have an epidural in labour, there was an increase in the number of women who did not want an epidural but ended up with one. This increase in fear over the last two decades is reported in several high income countries.

Recent national data for England show that in the period 1995-2006, overall epidural rates have risen little (27%-28%), and use of pethidine has dropped (42%-33%). This change in the trend during the 1990s may reflect a growing awareness of the negative consequences of drug use in labour and change in government policy towards more midwife-led care and greater information and choice for women.

An English study of over 1000 women, published in 1993, found that doctors’, and to a lesser extent midwives’, approaches to easing pain tended to be restricted to pharmacological methods; professionals were more likely to agree with each other about the efficacy of different methods than with women. Although attitudes and behaviour may have changed since then, in the 2007 study of women’s experiences of NHS maternity care in England, only 10.7% of women reported that they had used water or a birthing pool and almost 15% reported that they were not encouraged at all to move around and choose the position that made them feel most comfortable.

There is strong evidence that a woman’s satisfaction with the experience of childbirth is positively affected by having midwife-led care, greater continuity of caregiver, continuous support during labour, the quality of her relationship with her caregiver, and the quality of support provided. Despite this, many NHS trusts provide highly fragmented care, with 77.9% of women recently reporting they had not previously met any of the staff who looked after them during labour (NHS trust range, 56% - 91%). Many women saw a succession of different midwives (see Table 2), and a quarter were left alone during labour or shortly after the birth at a time when it worried them to be alone, replicating previous similar findings.

### Working with pain – the evidence

#### What women want

There is evidence that the majority of women value giving birth with a minimum of drugs, provided that they feel they can cope. Although the proportion of women preferring to give birth ‘drug free’ or with a ’minimum of drugs to keep the pain manageable’ fell during the period 1987-2000 (see Table 3), it

<table>
<thead>
<tr>
<th>Number of midwives</th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Four</th>
<th>Five or More</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Trusts average [n=153]</td>
<td>19.9%</td>
<td>37.3%</td>
<td>20.8%</td>
<td>10.1%</td>
<td>11.9%</td>
</tr>
<tr>
<td>Variations between Trusts</td>
<td>8 - 33%</td>
<td>27 - 48%</td>
<td>11 - 30%</td>
<td>4 - 19%</td>
<td>0 – 24%</td>
</tr>
</tbody>
</table>

Table 2. Number of midwives caring for individual women in labour. Adapted from Healthcare Commission Survey: Women’s experiences of maternity care in the NHS in England

Response to: Altogether, how many different midwives looked after you during your labour and the birth of your baby?

Table 3: Preferences for coping with pain during in labour

<table>
<thead>
<tr>
<th>Year</th>
<th>Primips</th>
<th>Multips</th>
<th>Primips</th>
<th>Multips</th>
</tr>
</thead>
<tbody>
<tr>
<td>1987</td>
<td>289</td>
<td>443</td>
<td>508</td>
<td>682</td>
</tr>
<tr>
<td>2000</td>
<td></td>
<td></td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>Most pain free possible</td>
<td>6</td>
<td>11</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>Minimum drugs</td>
<td>71</td>
<td>66</td>
<td>65</td>
<td>65</td>
</tr>
<tr>
<td>Drug free</td>
<td>23</td>
<td>23</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

was still the case that four in five women wanted either no drugs or a minimum of drugs. Approximately one in five women said their priority was for their labour to be as pain-free as possible.14

Although there has been a shift in attitudes and the use of epidurals, particularly prior to 1995 in England, with more women relying on an epidural to help them cope with fear and pain, studies in a range of high income countries have demonstrated that effective forms of pain relief are usually not associated with greater satisfaction with the experience of birth for women who have uncomplicated labours.14-23 or with women’s sense of psychological and physical wellbeing.28,29 Indeed, studies have shown that women who use non-pharmacological methods of pain relief are more likely to be satisfied with their experience of labour and birth than those who used pethidine or epidurals.14,23

Numerous observational studies show that when culturally diverse groups of women have been supported to cope with the pain of labour they have described childbirth as a difficult, yet empowering, experience, providing a sense of achievement.30-34 However, for those women who positively ‘desire or need’ pharmacological pain relief, satisfaction is related to their expectations being met.26

Continuity of midwifery care
It is easier for women and for midwives to adopt a working with pain approach when women know the midwife caring for them during labour.9,31 A systematic review showed that women receiving midwife-led care were nearly eight times more likely to be attended in labour by a midwife they knew than those assigned to other models of care, were more likely to use no pain relief and to have a higher perception of control.24 Continuity of caregiver throughout pregnancy, labour and birth reduces the amount of pain relief women have during labour, and increases their satisfaction with their maternity care, perhaps as a result of developing a trusting relationship.26-29

Emotional support
Support has a major impact on how women cope with pain in labour. A Cochrane review of continuous support for women in labour concluded that ‘emotional’ support, comfort measures, information and advocacy may enhance normal labour processes as well as women’s feelings of control and competence, and thus reduce the need for obstetric intervention.23 In early labour, when the majority of women are at home without professional support, comfort and encouragement from family members, a friend or doula is important.46 Without support, women are more likely to go to hospital before labour is well established and to have epidural analgesia and other interventions.41,44 Once admitted, a birth companion continues to play an important role, offering love, reassurance, praise and, sometimes, acting as an advocate.

Women have described how midwives supporting and guiding them through pain, on their own terms, enabled them to feel confident and positive about their capabilities and inner strengths.31,32,45 Supportive interactions have more impact on women’s experience than the level of pain per se.26,30 Discussion about potential support activities is important to pregnant women46 and a birth talk at 36 weeks provides an opportunity to explore the nature of labour pain with women and their birth companions.47

The physical environment and philosophy of care
Opportunities to adopt a working with pain approach can be affected by the environment in which a woman labours.9 Privacy and protection from disturbance promote neuro-hormonal cascades of a woman’s endogenous oxytocin and opioids, optimising the physiological process of labour and her ability to cope with pain.48 She may go into an altered state of consciousness in which her mind lets go and the involuntary processes takes over.35,48

The philosophy of care provided in birth centres and at home is usually consistent with a ‘social model of care’ in which birth is seen as a normal physiological process and it is usual for women to labour without use of drugs for pain relief.59-52 Those developing new birth centres focus on creating a social, ‘homely’ space.53 Observational studies indicate that women perceive home birth as less painful than hospital birth 23,54-56 and that women planning to giving birth at home or in a birth centre are less likely to use epidural analgesia.11,54,57 Increasing privacy and non-disturbance can be addressed in all birthing environments.29,58,59

Natural and low-technology comfort aids
There are a number of low-tech comfort aids that can help women cope with labour. These include immersion in water and other self-administered methods of easing pain. Immersion in water during the first stage of labour significantly reduces women’s perception of pain and use of epidural/spinal analgesia.60 Women using upright positions are also less likely to have epidural analgesia.11,61

Despite varying effectiveness in relieving pain, Simkin’s systematic review indicated that the majority of women felt positive about using acupuncture,
many women, including those who had hoped for a labour free of pharmacological pain relief, found that they had underestimated the pain in labour.**6,66, However, in labour their degree of reported control was less than hoped for.**6 As women’s fears about pain in labour are often related to anxieties about losing control, addressing this antenatally is important if women are to feel confident and satisfied with their experience of childbirth.**6,46,7

Parents can be helped to develop strategies for coping with pain based on their own repertoire for coping with pain and anxiety.**6 Women and practitioners also need to be well informed about factors that both facilitate and hinder straightforward labour and birth and the ability to adopt a working pain approach.**46

**Summary**

The working pain approach is based on the principle that pain is one aspect of the physiology of normal labour; to be respected, not to be feared. Many women want to avoid pharmacological pain relief and, where labour is progressing normally, factors including a trusting relationship with caregivers, continuous support, midwife-led care, preparation for labour, a home or birth centre setting, and use of a birth pool each help to make this a realistic expectation.

References

Blackwell Science; 2000.


