COMMENTARY

Midwifery Facilitation: Exploring the Functionality of Labor Discomfort

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The Ground We Stand Upon

Few women today experience truly unmedicated birth. Recent United Kingdom statistics show that only 36.6 percent of all labors are anesthetic free (1). Why the increasing reliance on pharmacological methods of pain management for what is essentially a normal physiological process? This commentary explores the circumstances driving women to anesthetize themselves rather than embrace the holistic spectrum of the intrapartum experience. Maternity practitioners are accidentally complicit in the current emphasis on pain-relieving substances, rather than focusing on the normal process of birth physiology. To preserve and work within the midwifery scope of normality, midwives must reassess the current cultural and institutional ideologies surrounding labor pain.

The skilled art of midwifery practice emphasizes facilitating and supporting women as they experience the complex process of labor and birth. However, this process is stymied by the current fragmented system of care provision as well as by the institutionalized settings in which many births occur. Reemphasizing facilitation, from the Latin *facilis* "easy" from *facere* to "do, or make" (2), could alter midwives' outlook, and improve their abilities to assist women's transition through the experience of birth, rather than delivering them from labor sensations.

How women are facilitated has a direct influence on their experience of pain in labor. Odent states "it is not the final aim to make birth painless, but to make it as easy as possible" (3). The transition from relieving toward easing pain during labor could change women's uptake of pharmacology, potentially decreasing reliance on anesthetic strategies. To initiate this paradigm shift, a reenvisioning of communication with respect to labor pain is required. That pain is a pervading element defining labor is not in question. However, the model permeating much of current midwifery practice is of a chronic/pathological pain in need of solution by some form of intervention. In working holistically with women, this model must be renegotiated by midwives and the wider multidisciplinary team.

Birthing Scenery—Language and Behavior

Habitual patterns of language used by midwives, combined with cultural representations of birth, inform the pain paradigm currently operating in much of mainstream midwifery practice. Functional discomfort is normal during labor; however, current cultural references continue to describe birth as dramatic and often traumatic. These media-driven perspectives can be particularly toxic to primigravida women. Having no previous experience to draw upon, they may be filled with fear and anxiety as their labor approaches.

There is a deluge of negative birth narratives in the media, which are widely viewed and discussed by women with a morbid sense of acceptance. Labor is a rite of passage, with levels of discomfort widely accepted as a norm of childbearing. Women enter into labor expecting pain to be part of the process. The result of this predominant paradigm is that women's birth experiences are conceptually aligned with experiences of pathological pain. Although individually perceived and subjective in nature, "pain" is generally defined as "an unpleasant sensory and emotional experience related to actual or potential tissue damage" (4). The pain associated with pathological experience and

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the pain sensations experienced during labor must be clearly differentiated. Pathologically derived pain is associated with abnormality, connoting damage, and malfunction leading to perceived suffering. Labor pain is discomfort experienced as part of a physiological process during birth, and is functional in nature.

Continuing to use the term pain to describe straightforward labor has significant ramifications. By using the term "labor pain," midwives may be unwittingly pathologizing labor sensations, and aligning them with negative experiences deriving from physical damage. Habitual language used by midwives to describe labor discomfort includes metaphors such as "waves," or "surges." This likens the experience of contraction sensations to an external "natural" force imposed on women, rather than an inherent and subjective phenomenon of labor. On the surface, the intentions behind using these metaphors are kindly and supportive. However, women cannot possibly be in control of, or capable of containing, an external environmental force. Using environmental imagery, not physiologically accurate terminology, distances women from what is occurring in their own bodies, and contractions become forces to be feared and avoided.

The lack of open antenatal dialogue surrounding labor discomfort means that women enter the birth environment confronted with a barrage of metaphors and institutional language previously unexplored. Professionals using technical language amongst them can further alienate women and their immediate birth supporters. Midwives must reclaim terms such as "contraction" because through actively changing terms used during labor communication, positive associations of sensations can be highlighted. Midwives taking this position can facilitate women to approach the intensity of labor in a physiologically aware state, actively receptive and engaged, rather than passively awaiting the onset of a process which must be undergone and suffered.

The Current Labor Landscape

Women are unable to function at the peak of their endogenous potential if they reside in a hormonally fearful state. The current landscape of labor care generates a grave distrust of physiological birth to proceed normally, and makes women doubt their own capability to "cope" with "pain" and to negotiate labor without recourse to assistance/analgesia. Cultural media shows birth as technocratic (5), and the birthing process requiring management assisted by the technologies of modern obstetrics. The laboring body thus becomes situated as a conduit requiring close observation, and regarded as unpredictable and untrustworthy (6). The pathological pain model then easily transfers to women who may experience Dick-Read's "Cyclical Dimension of Pain" (7). That which women previously feared becomes reality, with psychological tension physically manifested (7), impacting labor progress. This can produce what Foureur terms "The Fear Cascade" (8), with fear disrupting the endogenous cocktail of oxytocin production, causing catecholamine release and subsequently stymieing the birthing body. This creates a situation directly opposed to birth physiology, and which directly correlates with perceptions of pain (9).

Studies suggest that the core of birth anxiety may be in women's fear that they will be unable to "cope" with labor's sensations (10). Walsh suggests that some midwives may also experience a level of "professional unease" (11) around birth. Antenatal catastrophizing behaviors manifest as negative cognitive-affected responses to perceptions of anticipated pain (12) based on fear of a pain experience yet to come. Midwives must attempt to prevent catastrophizing behavior by providing accurate, appropriate physiological knowledge, and enabling women to identify individual management strategies. This will help to allay women's fear of their own bodies, and enhance self-efficacy and confidence.

The menu model (13) of pharmacological "relieving" analgesics is offered in an ascending ladder (14) of efficacy in sensation eradication. The problem with this pharmacological emphasis is that it suggests that women need help. Thus, immediate and pervasive offers of analgesia may destabilize women's endogenous and psychological resources. Although often presented as "humanitarian," this excessive focus on medication becomes reductionist, and can both undermine women's self-confidence, and diminish midwives' capacity to facilitate women's innate capabilities (15). This can result in a systemic "de-skilling" of facilitation on both sides of the midwife–mother relationship. Discomfort is easily eliminated if positioned as having no "worth" other than causing maternal distress. The ever-present availability of analgesia in obstetric environments extends women's reliance on interventionism, and diminishes their capacity for self-efficacy and self-governance. By viewing discomfort as a problem to be anesthetized rather than a functional process, the "labor = pain" attitude persists. Furthermore, the almost endemic infiltration of fear and distrust within obstetric environments impacts midwives' ability to be "with women" in the midst of intense, unmedicated labor. However, midwives hold great sway over decisions made in labor, and how midwives present labor pain can significantly influence how women feel able to cope (16).

Toward a Physiological Terrain

Accurately explaining the physiology, and incorporating the notion of "discomfort" during unmedicated

labor, can initiate change toward a mindful "working with" (17) approach to birth. To view labor as an esthetic, in the moment, peak experience means highlighting the functionality of labor's physiological processes. Returning to an anthropological understanding of birth in a physiological context is ideal, and yet highly challenging, in the risk-averse culture of modern childbearing. Many women do want to experience the whole spectrum of labor, facilitated by environments such as midwife-led units. These spaces offer no epidural analgesia, but instead create a conducive environment with supportive midwifery presence.

Many first-time mothers feel conflicted toward analgesic management, and fear being judged for requesting epidural/anesthetic support. Midwives must explain labor processes and options early enough during prenatal care to challenge individual perceptions and birth fear. Women's endogenous capability can be championed, ensuring their locus of control. Women who recognize that labor's physiological discomfort contains a biological, functional purpose tend to access less pain management (18), and have a more positive outlook toward labor. Using women's capabilities to harness their endogenous cocktail of labor hormones helps women to function optimally, with their hormones responding to progressive levels of discomfort. If women feel safe and empowered within the care dynamic, the bio-behavioral and equally powerful responsive (8) states of "tend and befriend" or "calm and connect" (19) can be fostered, diametrically opposing the "fight-or-flight" state. Reducing recourse to anesthetics reduces the incidence of iatrogenic and detrimental forms of intervention. This positively impacts satisfaction, enabling control and self-advocacy to take precedence.

Midwives need to thoroughly discuss women's expectations around management of labor discomfort during prenatal care visits. It is significantly easier when midwives can assist women in formulating their birth plan, thus facilitating physiological management of functional discomfort. Information should also be provided on the relationship between catastrophizing and perceived pain experiences, and women should be prepared psychologically for the experience of birth (20). Conceptions of pain can then become experiences of "functional discomfort," accurately highlighting the process women go through during birth. By employing physiologically based language during antenatal and intrapartum interactions, midwives can help women navigate the peaks, valleys, and ultimately transient nature of labor discomfort during their journey into motherhood.

Choosing physiologically and architecturally sensitive birth spaces enables women and midwives to function symbiotically in their respective roles. Women become empowered, experiencing self-directed birth decisions based on their individual needs. Meaningful interactions on both sides of the midwife–woman relationship safeguard women from negative pain management and birth dissatisfaction.

Toward an Esthetic Not Anesthetic Outlook

The devolution from women-focused practice to task-oriented working, with subsequent lack of relationship-based care, makes practicing with an esthetic midwifery process more crucial. This could not only liberate and empower women during birth, but also emancipate them from the chronic pathological pain paradigm systematically undermining their physiological capabilities.

This esthetic physiological approach maintains focus on the present rather than projecting into the future or bringing negative pain associations from the past. While continuous one-to-one care with a known practitioner is the exception rather than routine, this approach can be challenging to implement. Perhaps then, women are driven to anesthetize themselves, through fear of the unknown: place, person, and process of birth. If equipped with rigorous psycho-prophylactic antenatal education, women could envisage a different type of birthing, perhaps one of a peak, esthetic, and transformational experience. A paradigm shift away from pain avoidance toward a "working with" philosophy enables midwives to accompany women through their experiences of functional discomfort. With this type of mindful midwifery presence, the midwife then truly could be an agent of facilitation.

References

1. Health and Social Care Information Centre Hospital Episode Statistics online. National Health Service Maternity Statistics 2013-2014. Accessed March 13, 2015. Available at: http://www.hscic.gov.uk/searchcatalogue?productid=17198&q=%22nhs+maternity+statistics%22&topics=0%2fHospital+care&sort=Relevance&size=10&page=1#top.
2. Lynd J. The first book of etymology, designed to promote precision in the use, and facilitate the acquisition of a knowledge of the English language for beginners (1847). Philadelphia, Pennsylvania: E.C & J Biddle, 1860. Available at: http://archive.org/details/firstbooketymol01lyndgoog.
3. Odent M. *Childbirth in the Age of Plastics*. London: Pinter & Martin Ltd., 2011, 75.
4. International Association for the Study of Pain [IASP] 2015. Accessed February 12, 2015. Available at: http://www.iasp-pain.org/Taxonomy#Pain.
5. Davis-Floyd R. The technocratic, humanistic, and holistic models of birth. *Int J Gynecol and Obstet*, 2001;75 (1):5–23.
6. Morris T, McInerney K. Media representations of pregnancy and childbirth: An analysis of reality television programs in the United States. *Birth* 2010;37(2):134–140.

7. Dick-Read G. *Childbirth Without Fear*. 4th ed, London: Pinter and Martin Ltd., 2013, 37.
8. Foureur M, Creating birth space to enable undisturbed birth. In: Fahy K, Foureur M, Hastie C, eds. *Birth Territory and Midwifery Guardianship*. Edinburgh: Books for Midwives, 2008:57–77.
9. Jones L, Othman M, Dowswell T, et al. Pain management for women in labour: An overview of systematic reviews, *Cochrane Database Sys Rev* 2013;3:CD009234.
10. Simkin P., Anchetta R (Eds), Dysfunctional Labour: General Considerations. In: *The Labor Progress Handbook Early Interventions to Prevent and Treat Dystocia*. 3rd edn. New York, New York: Wiley Blackwell, 2011:15–46.
11. Walsh D. *Evidence and Skills for Normal Labour and Birth. A Guide For Midwives*. 2nd ed. Oxford, UK: Routledge, 2012.
12. Quartana P, Campbell C, Edwards R. Pain Catastrophising: A critical review. *Exp Rev Neurotherapeutics* 2009, 9 (5):745–758.
13. Leap N. Being with women in pain – do midwives need to rethink their role? *Br J Midwifery* 1997, 5 (5):263.
14. Watson D, Murtagh M, Lally J, et al. Flexible therapeutic landscapes of labour and the place of pain relief. *Health Place* 2007;13:865–876.
15. Sanders R, Lamb K. An exploration of the benefits and drawbacks of intrapartum pain management strategies. *Br J Midwifery*, 2014, 22 (9):642–649.
16. Aune I, Amundsen H, Aas L. Is a midwife's continuous presence during childbirth a matter of course? Midwives' experiences and thoughts about factors that may influence their continuous support of women in labour. *Midwifery* 2014;30:89–95.
17. Leap N, Anderson T. The role of pain in normal birth and the empowerment of women. In: Downe S (Ed). *Normal Childbirth Evidence and Debate*. 2nd ed. London: Churchill Livingstone Elsevier, 2008:29–46.
18. Christiaens W, Verhaeghe M, Brake P. Pain acceptance and personal control in pain relief in two maternity care models: A cross-national comparison of Belgium and the Netherlands. *BMC Health Ser Res* 2010;10:268–278.
19. Uvnas-Moberg K. *The Oxytocin Factor Tapping the Hormone of Calm*. London: Love and Healing. Pinter and Martin Ltd., 2011.
20. O'Hare J, Fallon A. Women's experience of control in labour and childbirth. *Br J Midwifery* 2011;19(3):164–169.