Guide to labour-pain management

We’ve compiled this comprehensive guide—with insights from moms across Canada about what did and didn’t work for them—to help you prepare for delivery day.

Jun 24, 2015 Kalli Anderson

When Jennifer Beers, of Sudbury, Ont., found out she was pregnant with her first child, she was thrilled, but also scared. “I have a very low tolerance for pain, so the thought of giving birth was terrifying,” she says.
She chose to have a midwife as her primary healthcare provider, but Beers was set on getting an epidural: “In my mind, there was no other alternative,” she says. But after talking with her midwife and doing some research on her own, she realized there were pain-management options she hadn’t even considered. “I still thought I’d probably get the drugs, but I opened myself up to the possibility of trying other things.”

There are many methods to help you deal with the pain of labour. Which one is right for you?
Drug-free options
You can manage your pain naturally.

Helen McDonald, an associate professor of midwifery at McMaster University in Hamilton, Ont., has been attending births for 40 years. She says it’s normal for women to be afraid of the pain. “There are a lot of ways of making it more tolerable and less frightening,” she says, and women shouldn’t underestimate the power of drug-free coping techniques. “These sorts of strategies aren’t just old wives’ tales; they’re also supported by modern scientific understanding and clinical experience.”

Even if you don’t think you’ll do the whole delivery drug-free, these techniques can help you get through early labour, since you’ll likely have to endure many contractions before getting an epidural or other drugs, if you choose that route.

Continuous labour support
Sometimes called the “doula effect,” research has shown that continuous emotional support helps women cope with pain and reduces their use of pain medications—especially if the person is a doula (a trained professional, hired for the sole purpose of providing labour support and advocacy). But even the continuous presence of an attentive partner, family member or friend has been found to improve a woman’s experience.

“Constant attendance, comfort and reassurance will get women through even the most difficult situations,” says McDonald. Mary Sharpe, the director of the midwifery education program at Ryerson University in Toronto, agrees. “Women need to feel safe and supported by those around them to do whatever it is they need to do to cope.”

Massage and Pressure
London, Ont., mom Jennie Hoekstra was lucky to have her sister Jessie Greidanus, a massage therapist, at both of her births. “She massaged my lower back, applied pressure to my hips and even did some work with pressure points on my hands and feet to help me relax,” says Hoekstra, who found the combination of massage and cold compresses especially effective. “At one point, my sister pressed a can of frozen juice into my lower back as I hung with my arms wrapped around my husband’s neck, and that really helped with the pain,” she says.

Waterloo, Ont., mom-of-two Sara Hartley found that intense pressure on her lower back alleviated the pain of contractions. She lay on her side, or stood and swayed while resting her arms and sometimes her head on the bed, as her husband, Brian, used his hands, elbows and even his knees to push as hard as he could into her lower back every time she had a contraction. “Both the pressure, and knowing he was right there with me, really helped,” she says. Like many partners, Brian had felt helpless...
watching his wife deal with contractions, so he was glad to physically do something to ease her agony.

Movement Thanks to what we see on TV and in movies, many women still expect to spend their labour reclined in a bed. But studies have shown this isn’t the ideal position to help labour progress, nor does it allow you the freedom of movement you may need to cope with pain. Many women find walking, leaning, rocking or squatting very helpful.

Ward Murdock, an OB/GYN in Fredericton, and the president of the Society of Obstetricians and Gynaecologists of Canada, says he’s impressed with how much simply sitting and moving on a birthing ball (a large inflatable exercise ball) can help labouring women, and now recommends this to his patients. “I was quite amazed when we first brought the birthing balls into our ward a few years ago,” he says. “They are great for pain relief and for the positioning of the baby.”

Tub Time Marnie Robinson, from Toronto, had an at-home water birth with her third child. She found that being in the water helped her stay calm and relaxed. “I am one of those people who looks forward to a soak in the bath or hot tub after a long day,” she says. “In labour, that need was amplified.”

Studies have shown that labouring women who spend time immersed in water (usually a large tub or birthing pool, deep enough to get your belly underwater) may experience less painful contractions, fewer medical interventions and shorter labours. Baths during labour should not be warmer than body temperature, and you may want to avoid baths before active labour begins— or for longer than one or two hours at a time—as some studies suggest that prolonged baths early in labour can slow down your progress. One drawback of this method is that some women find it can be difficult to get into the position they prefer, or have their support person apply pressure.

Vocalizations, Breath and Visualization Moaning, deep breathing and focusing inward are natural responses for many women as they deal with intense contractions. Mary Sharpe says it’s normal, even helpful, for women to be very vocal during labour and birth. “A lot of breathing techniques people used to tell women to do—the fast in and out—are nice and quiet, but they can cause hyperventilation,” says Sharpe. She’s found that breathing in through the nose and out through the mouth while making loud, low sounds (sometimes called “toning”) and visualizing the cervix opening, tends to work better to help women relax.
Marion Young, a mom in Victoria, practised toning as part of her preparations for the birth of her son Jaxon. After the labour, which she managed to do drug-free, she couldn’t remember making the sounds. “But my husband said, ‘Babe, we toned the whole time!’ I guess I practised enough that I wasn’t even conscious of it in the moment. I was in a kind of meditative state.”

Taking the edge off
There are several minimally invasive, low-risk treatments you can try.
Acupuncture
A growing body of research has found acupressure and acupuncture to be effective at helping with labour pain. Acupuncturist Estefania Orta is one of the owners of Acumamas, a Vancouver business that will send a registered acupuncturist to your home or hospital room during birth. Orta says acupuncture doesn’t numb the pain, but works to calm a woman’s nervous system. “If your sympathetic nervous system is activated and you’re in ‘fight or flight’ mode, that’s not conducive to having a baby. Our aim is to work with points that help you relax and focus on the task of coping.” If a woman needs mobility during labour, Orta will usually only insert a few needles at a time between contractions, often in points on the ear or hand, so women are still free to move around.

Sterile Water Injections
For women dealing with back labour (severe lower-back pain), several recent studies have found intracutaneous sterile water injections to be an effective form of relief. Sometimes called intradermal water blocks, this procedure involves injecting small amounts of sterile water under the skin in four places in the lower back. The injections can dramatically reduce the sensation of back pain almost immediately, and relief lasts between 45 minutes and two hours. There is a catch: The injections themselves are extremely painful, described as a sharp bee-sting sensation that lasts about 20 to 30 seconds as water goes in and stretches the surrounding skin.

Marnie Robinson’s midwife gave her sterile water injections when she was experiencing severe back pain during labour with her third child. “I was thinking, ‘How does this voodoo even work?’ But I was willing to try anything,” she remembers. “The pain went from being unbearable to more of a dull discomfort that I could work through. I was astonished.”

TENS machines
A TENS (Transcutaneous Electrical Nerve Stimulation) machine is a portable, battery-operated device with two or more electrodes attached to it. During labour, the electrodes stick to your lower back (in the same area as the sterile water injections) and deliver little electrical impulses that some women find help reduce the sensation of contractions, especially if they’re experiencing back labour. Hoekstra used a TENS machine in the early stages of active labour. “It felt like a little electric shock,” she says. “It seemed to take the edge off the early contractions.”

Nitrous Oxide
Labouring women have used nitrous oxide (a.k.a. “laughing gas”) for more than 100 years. University of British Columbia midwifery professor Saraswathi Vedam says nitrous oxide doesn’t usually make you feel drugged or high, “it’s more a feeling of not being as present—you just can’t concentrate on the pain.” She says this can
actually be a drawback for some women who may dislike the feeling of being dissociated from the experience. It’s a self-administered gas, which means you need to hold a mask or tube and inhale deeply as a contraction begins. And although it can sometimes cause nausea or dizziness, it is expelled from the body quickly and has not been found to pose any risks to the health of the baby.

Hartley used nitrous oxide during her first birth. “I didn’t really know if it was working, but I kept doing it anyway because it at least helped me focus on the breathing,” she says. Hartley noticed the effect much more when she used the gas while getting stitched up after birth. “My head got swimmy and I could feel the pain lessening, so it was probably working during labour, I just couldn’t tell.”

Gimme the drugs
Pharmaceutical relief is the most effective option out there.

Spinal and Epidural Anaesthesia
Anaesthetics are drugs that cause a loss of sensation in a specific area of the body—like the freezing you get at the dentist. Epidurals and spinals are both injections of
anaesthetic given in the lower back (about 10 centimetres above the tailbone) and are extremely effective.

“They provide the best pharmacological pain relief,” says McDonald. “Everything else reduces pain, but the epidural pretty much takes care of it.” More than half of Canadian women (56.7 percent in 2011) give birth with an epidural, although the rates of use vary widely among provinces.

For a spinal, the anaesthesiologist uses a very thin needle to inject anaesthetic directly into the spinal fluid. It’s usually used for a Caesarean section, during a forceps- or vacuum-assisted vaginal delivery, or any time that pain relief is only needed for a set amount of time. It kicks in very quickly: You’ll go numb in your belly and lower body within five to 10 minutes, and the effect lasts about 60 to 90 minutes. It can’t be given more than once.

With an epidural, the needle is inserted between the bones of the lower back. The anaesthesiologist will leave a catheter (a little tube) in place, which allows the medication—usually a combination of a local anaesthetic and a small amount of fentanyl, an opioid that resembles morphine—to be topped up by the anaesthesiologist or via a pump attached to the catheter. Some hospitals let women control the pump themselves by pressing a button to increase the medication. When the anaesthetic first enters the body, most women feel a slight warmth in their legs, then within about 20 minutes the pain is relieved from their bellies down. Most women receive a low-dose epidural so they will still have a bit of feeling in their legs and feet.

Tara Steinberg from Montreal had epidurals for both her labours, never feeling a desire to experience natural childbirth. The way she sees it: “If you don’t have to suffer, why would you?” Steinberg describes the feeling of the anaesthetic kicking in as “bliss,” and the only side effects she remembers were limited mobility and some difficulty pushing during the second stage of labour.

Epidurals aren’t without their downsides. It’s common for women to experience itchy skin, and they won’t be able to get out of bed while the catheter is in place. And for about one in eight women, the epidural doesn’t work or only gives partial relief, such as freezing more on one side of the body than the other. Women who get an epidural are also more likely to experience a drop in blood pressure during labour, and they have a higher rate of deliveries assisted with forceps or a vacuum.

Although epidural anaesthesia is generally considered low-risk for babies, research has found that when women have developed fevers during labour—which is sometimes associated with epidurals—their babies are more likely to be treated with antibiotics after birth for suspected sepsis. As well, drops in the mother’s blood
pressure during labour can affect the supply of oxygen to the baby. Some studies have found that babies exposed to epidural medications may be less alert at birth, or experience difficulty breastfeeding, but much of the research in these areas has been contradictory or inconclusive.

The most serious risks of epidurals for the mother—nerve damage, paralysis, coma and death—are extremely rare (approximately 0.004-percent chance). Stephen Halpern, the head of obstetrical anaesthesiology at Sunnybrook Health Sciences Centre in Toronto, likes to tell his patients, “If you took the elevator to get up here, you already took a bigger risk than you take getting an epidural.”

Narcotics: morphine and fentanyl
If you’re interested in medical pain relief that doesn’t result in a loss of bodily sensation or increase your risk of an assisted vaginal delivery, you may want to try morphine or fentanyl—either as an injection into your muscle or through an IV. These drugs provide an analgesic effect, which means they dull your feelings of pain but don’t have a deep-numbing effect. Both medications tend to make women feel relaxed, sleepy and even sedated, but they can also cause disorientation and dizziness.

Because the medications cross the placenta, they can cause your baby’s heart rate to drop, she may take longer to start breathing on her own after birth, have problems feeding or seem less alert and responsive. It is believed that fentanyl has less of an effect on the baby than morphine when given during active labour. (The fentanyl that you get with an epidural is a much smaller dose and hasn’t been observed to have the same effects on the baby.)

Melissa Brown of Sparwood, BC, had both morphine and fentanyl during labour with her son Jack. She wanted to avoid getting an epidural, because she wanted to feel physically present and she didn’t like the idea of the needle poking into her spine. Brown spent most of her labour working with her doula on medication-free pain-relief methods, but ultimately decided to go the hospital for medication. When she first arrived, she was given morphine. “I basically slept for six hours straight while on morphine—it was rest I needed at that point,” recalls Brown.

Then, the morphine started to wear off. She was too far dilated for more, but writhing in pain, so she asked for an epidural, but the anaesthesiologist was two hours away in another town. Brown was given fentanyl instead, which she remembers not liking at all. “I didn’t notice the pain, but I was way too high. I remember laughing hysterically and feeling out of control and nauseated.” Brown has since spoken to other women who, conversely, hated the feeling of morphine and preferred fentanyl. Her son was born healthy and strong.
Epidural FAQs

How popular is the epidural?
More than half of Canadian women (56.7 percent in 2011) give birth with an epidural, although the rates of use vary widely among provinces.

When is it too late for an epidural?
Timing depends on the anaesthesiologist and the hospital, but generally you’ll be told it’s too late if the epidural won’t have time to take effect before your baby is born, or if you aren’t able to sit still for the five to 10 minutes required to insert the catheter.

Can you get an epidural if a midwife is your primary caregiver?
Yes, but depending on the hospital, you might have to be officially transferred into the care of an obstetrician, although the midwife will stay on as a support person.

Did you know?
About one in 100 women who get epidurals will experience severe headaches in the days and weeks following the procedure. These can occur when the epidural needle
goes in too far, puncturing the sac of spinal fluid and allowing too much fluid to escape. Be sure to let your healthcare provider know right away if you experience headaches after an epidural, as treatment is available.

So what happened with Jennifer Beers, who started off terrified at the prospect of a painful labour? She ended up giving birth without an epidural, using nitrous oxide and sterile water injections. At one point she asked for an epidural, but before they could implement it, it was time to push, and minutes later her son Cameron was born. Her advice to other moms who are nervous about giving birth? “Yes, it hurts, but there are lots of ways to deal with the pain. Get educated about your options, but try not to stress too much about making the perfect plan.”

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