Introduction

The noises, vocalisations, and behaviours of healthy women in normal labour have long fascinated me. As an independent midwife, and formerly as a community midwife working within the UK’s National Health Service (NHS), I have primarily attended births in women’s homes and in midwife-led birth centres, both free-standing and alongside units. These births started spontaneously and continued under the influence of normal birth hormones (Buckley 2009, Odent 2009). I hope to make a small contribution to the vital task of documenting midwifery perceptions and knowledge around normal birth, by careful and calm observation of women in normal labour, as suggested by Gutteridge (2013).

Respecting women’s instinctive behaviours and body knowledge is vital to this close observation. It may offer an alternative to a rather dangerous tendency among some health care providers to deny women’s lived reality in birth (Reed 2011), where midwives seek to define women’s experience and body knowledge according to the standardised care offered by what is termed the ‘Industrial Model of Care’ (Kirkham 2012).

My midwifery practice is informed by a wish to do as little harm as is consistent with the mother and baby’s holistic wellbeing, encompassing the physical, mental, emotional and spiritual aspects of pregnancy, labour, birth and afterwards. This includes a desire to be ‘invisible’ in the birth room, using quietness, calmness and stillness in both my mind and my body, to foster an environment that allows the women to feel private and undisturbed, enabling her birth hormones to flow freely and her

‘Childbirth is power in its purest and most natural form – it is wild and uncontrollable and takes us on a journey of surrender. Birth is about so much more than babies being born. It is about a mother finding her inner strength at her most vulnerable and powerful moment, which begins her unique and lifelong journey of mothering that child’ (Kauer 2012:31).
body to inform her mind about how to behave and to be (Anderson 2002, Buckley 2009, Odent 2009, Fahy et al 2010).

Using strategies such as attention to birth noises and vocalisations is part of a wider personal goal to learn to 'read' the tides and patterns of birth to assess passage through this wonderful, exhilarating, challenging, monumental event — without necessarily needing to rely on the more usual clinical midwifery practice of regular vaginal examinations and complying with the rather limited view of normal labour and birth progress promoted in many midwifery and obstetric guidelines.

The final section of this article gathers information on what birthing mothers have said to me after their births about what they found helpful and unhelpful to hear from their midwives during labour.

**Drinking tea intelligently**

It is a truism that observing an event changes its nature. I try to be present 'holding the space' in a birth room but seeking to be as unobtrusive and as invisible, as possible: 'present yet unobtrusive' as Anderson (2000:101 put it. The late, and much missed, independent midwife and midwifery lecturer Tricia Anderson used to talk about 'drinking tea intelligently' (Anderson 2004). She was talking about how much information a midwife might glean from apparently drinking tea, whilst using all her senses; sight, hearing, smell, proprioception, and even her instincts, to carefully notice all that was occurring in the birth room, both in the birthing woman and in her companions. This skill, when well-honed and used judiciously, can offer the appropriately experienced midwife confidence that all is well, that the birth is unfolding just as it should and that neither mother nor baby are in difficulty.

Many authors have explored and explained the role of hormones such as oxytocin, beta-endorphins and adrenaline in the birth process (Anderson 2002, Buckley 2009, Odent 2009, Gaskin 2010). The importance of facilitating a birth environment that preserves and sustains the conditions for the timely and appropriate physiological release of these hormones is widely understood but much more challenging to achieve in a bright, clinical delivery room on a busy delivery suite than it is during the velvet dark small hours of the night in the quiet of a woman’s home. Ina May Gaskin proposes ‘Sphincter Law’ (Gaskin 2008) and emphasises the birthing mother’s need for privacy, lack of interruption and a sense of safety. By helping to protect and preserve the sort of birth environment that helps women generate good strong levels of oxytocin and beta-endorphins, the midwife plays a vital role and can assist the mother to sink into her ‘birth trance; present but not present in the world, turned inwards mentally and emotionally as she digs deep within herself for the strength and power to do what she must and surrender to the work of her body as it opens the space for her baby. This is women’s work: surrendering to the birth process with as much grace as can be managed, using whatever behaviours and noises help her.

Apart from noticing a birthing woman’s level of awareness or interactions with the external objective world, as midwives we often pay close attention to the postures she adopts spontaneously, to her body movements, to changes in her emotional state (Lemay 2000, Gutteridge 2013).

Midwives often say that the most common intervention women experience in modern society is moving outside their own homes to give birth (Anderson 2002). Much has been written about creating home-like environments for birthing women in birth centres and hospital delivery suites. As midwives, whatever workplace we find ourselves in, we need to remember we are
the servants of the birthing women and not their instructors. We may guard the birth space but we should not feel that we command it. We can create and facilitate the sort of environment that supports normal birth, but we need to be ready to respond intuitively to each woman’s needs and behaviours, to assist her to feel as uninhibited and spontaneous as the circumstances permit.

Midwifery is a heavy responsibility. We have an ‘extraordinarily powerful position’ (Anderson 2000). We are working with women who are not just in extreme pain, and experiencing distortions of time and space, but also — most particularly — they are hyper-suggestible (Anderson 2000). We can use this position for good or ill. We must bravely shoulder the burden of responsibility and not shirk it. We must avoid abusing our power with every fibre of our being. Anderson (2000) argues that when her power is used wisely and appropriately, the skilled midwife can give the mother a sense of security which allows her to enter the birth trance and thus facilitate the birth process itself.

Birth companions too have a vital role in supporting the birthing woman and protecting their birth spaces. Life partners, relatives, doulas and student midwives may all undertake this work. What they say or do, or refrain from saying or doing, should ideally be informed by the woman’s expressed needs — or if these are left unsaid, birth companions may wish to take their clues from the birthing woman.

How a woman may vocalise during labour

Some observations I have made of women’s behaviours and vocalisations during birth are now described to foster debate and encourage further exploration. I am reluctant to use the word ‘stages’ to refer to aspects of birth. Although textbooks can sound almost like a low ‘moo’, deep, visceral and powerful.

If sufficiently uninhibited, in between contractions, a woman may express deep love and affection for her partner. She may even acknowledge other labouring women around the world, in the past or the future, who have also done the work of birth. Expressing her love boosts her own oxytocin levels and helps the birth proceed smoothly.

With power and intensity growing and labour changing, a woman will often express in words, facial expressions, or through cries of despair, her disbelief that she can continue. She may call out to a deity, for her mother, for help. She may say she wants to stop now and continue tomorrow or to go home (even if she is at home). All these and many similar vocalisations will be very familiar to those whose work takes them to the birth spaces of women in normal unmedicated labour. There is nothing wrong here, nothing to fix, nothing to do except be watchfully and lovingly ready. She may need to hear ‘It is supposed to feel like this’ or ‘you are safe’. As midwives we can and should use our voices now to murmur in quiet low tones how wonderful the birthing woman is, how brave, how strong. Words of tender support and loving appreciation from her partner or other birth companions can be a soothing balm to her distress. Some partners may need encouragement to express themselves verbally. Gentle kisses and caresses from partners can also work wonders, if the mother permits.

We should (if appropriate) acknowledge that she is in extreme pain, but add that she can do this and that her baby is close. ‘How close?’ she may say. We know we cannot and should not answer this with a quantifiable number. My oft-used response is along the lines of
saying in soothing tones, ‘soon your beautiful baby will be in your arms. You will feel the beautiful baby’s warm wet head against your breast. Those deep dark eyes will look deep into yours. You will see the sweet little rosebud mouth, the tiny fingers. You will breathe in your baby’s sweet scent’. I will judge how little or how much to say by the mother’s response and how much time there is between surges (at this point usually very little). She may sigh out her appreciation or ask for more to be said.

Around this time, for some women there may be a plateau or break in the contraction pattern. This is the ‘rest and be thankful’ phase. This is not stalled labour. Nothing is wrong. Nothing needs to be done. Respectful stillness and patiently waiting should characterise the behaviour of the midwife and others in the birth room. This is a wonderful opportunity for birth companions to rest or to refresh themselves, but first and most importantly, the birthing women must be left to rest.

At some point the birthing mother’s energy and demeanour changes. In this early birth phase she may say (with some urgency!) ‘it’s coming!’ She may be physically restless, changing postures and positions frequently. This is a time for the midwife to use all her senses: careful visual awareness, well-tuned hearing, scent awareness. Is the Rhombus of Michaelis visible (Sutton 2003)? Is the pink or purple line visible (Shepherd 2010)? Is the triangle of skin above the anus spreading open between the buttocks as they flatten? Is there any anal pouting? As she roars, moos or breathes her way through these massive surges are there any catches in her voice at the end of the surge? Is the rich, ripe ‘birth scent’ perceptible (Wickham et al 2004)? All these may precede or happen simultaneously alongside pushing urges. These signs are so familiar to midwives that no further explanation is needed.

As the baby descends within the pelvis, unmedicated women in spontaneous labour frequently speak of their bodies ‘splitting open’ (Anderson 2000, Lemay 2001). Odent (in Anderson 2000) postulates that the intense pain and ‘near death’ like experiences during this time that women speak about afterwards lead to a massive release of endorphins, which despite what they are feeling and saying, allows them to have the peaceful floating calm which can be observed now.

As the woman slips into the active birth phase, her birth noises may increase in volume and change in nature. She, or rather her whole body, pushes. After each group of pushes, she rests. Using the time between pushing contractions to rest and relax as deeply as possible helps her to gather her forces for the next effort.

There is no need to instruct her. Her best teacher at this point is her body and its inner demands. Encouraged to allow her body to lead her, she is more likely to make several short but effective pushes than the long hard pushes so often seen in the media using the damaging and dangerous Valsalva manoeuvre (Perez-Botella & Downe 2006).

Listening to the pitch of her vocalisations and observing her facial expressions (if this can be done unobtrusively) will help the midwife to know that progress is being made. The well-understood link between relaxation or tension in the jaw and in the perineum may help women and their midwives at this point. Some mothers may appreciate a gentle suggestion to use the breath to release tension in the perineum perhaps by panting or using ‘horse-lips’ (Gaskin 2008). It is not uncommon to hear ‘it burns!’ or ‘it stings!’ just before the purple walnut (first sweet soft folded part of the baby’s head to become visible externally) is seen. This is harder to visualise with the mother on all fours or in a birth pool, but mirrors and a torch can sometimes be useful. Some women may appreciate the use of hot towels on the perineum as their bodies blossom open to their widest. Their soft sighs of appreciation help reduce jaw and perineal tension still further. Having a floppy face is a wonderful way to help give the baby more space to slide down to birth.

Time is not really relevant to birthing women (Buckley 2009), but feeling disheartened at this point by how long it is taking to push the baby out is not uncommon. The birthing woman may ask how much longer it will be or whether the baby will ever come. Experienced midwives will be able to read from external physiological changes that the baby is already well down and close to the outside world. If the woman is willing, a gentle suggestion to feel if she can reach her baby’s head may turn any negativity into joyful anticipation. It is right and proper that her fingers should be the first to touch her baby. She may find it helpful to leave her hand in her yoni and to ease her baby downwards into her own hand in this manner.

As the baby emerges, an active and conscious participant in the birth process, the mother (and father perhaps) will reach for their baby in joyful amazement. A heavy sacred silence fills the room.
broken by the baby’s first breaths and cries, followed by the parents greeting their newborn and expressing their love and delight. High-pitched voices are used instinctively (Odent 2009), which are easier for the baby to respond to. Midwives will want to keep the birth room calm, dark, quiet and uninterrupted. The mother holds her baby close to her heart, stroking, caressing, kissing, smelling and soothing. A huge oxytocin rush is generated by such actions and further facilitated by the midwife keeping the birth environment dark, warm and undisturbed, as it should be. Together these will both facilitate the normal, easy birth of the placenta and membranes and minimise the risk of postpartum haemorrhage (Fahy et al 2010). This is time for the new family. Phone calls can wait and will disrupt this precious time. The father will also want to stroke and greet the baby too, by being close to the mother as she holds the baby. Many women value extra physical warmth at this point. Duvets, blankets, long socks, and warm wheat pillows will prevent or minimise the post-birth shivers that may be observed as a result of physiological changes in the mother (Gutteridge 2012). It may be helpful to remember that a warm woman releases her placenta smoothly and simply.

At some point after birth the mother will notice, and tell the midwife about, after cramps. Where these are strong — and they seem to become stronger the more babies they have, from women’s reports — it can be helpful to explain that they can be welcomed as they help protect the mother by helping the placenta be born and the birth process be completed. The baby may be seeking to latch at the breast and when this is encouraged the cramps may become more effective and helpful. The mother may speak of ‘something’ inside her or ‘something coming’. She can follow her instincts or be encouraged to birth her placenta. If any midwifery input is needed, a suggestion to try a more upright posture, often sitting on a toilet or birth stool, may allow the placenta and membranes to slip down and out with minimal effort from the mother. Mothers who prefer to remain lying with their babies may simply ease their placenta out in this position with spontaneous little pushes, or the midwife may offer suggestions such as coughing enthusiastically or fist breathing to expel the placenta and membranes. Some mothers may wish to squat and to draw out their own placenta.

When and how the umbilical cord should be secured, and the baby separated from the placenta, are complex matters worthy of a separate article. Delayed cord separation offers benefits to the baby including optimal blood volume with its consequent physiological benefits, and to the mother because its role in supporting placental size reduction, optimal hormonal interplay...
“Woman may find midwifery and medical terms unhelpful, incomprehensible or confusing, especially during labour. This makes an undesirable emotional distance between the mother and the midwife”

and physiological release and birth of the placenta and membranes. Whenever the cord is separated the baby will cry (unless a lotus birth is planned). Ideally then, this task can be undertaken with the baby resting in the mother’s arms so as the baby cries she can offer instant comfort and reassurance.

Though clearly the birthing mother, the baby and father are the most important players in the magnificent drama that is childbirth, the role of the midwife is not insignificant. In one study women unanimously believed that ‘the contribution of the midwife was critical, having the power to make or break a woman’s birth experience’ (Anderson 2000). Many midwives speak quietly to each other of how their bodies seem to resonate with the physical sensations of birth when they attend birthing women. Those who menstruate may whisper of swifter flow from their own wombs during another woman’s labour. Others may speak of feeling that their bowels are full (when they are not) as the baby descends within the birthing woman’s pelvis. Still others may feel pressure in odd parts of their heads which, if they have time to be still and consider, may reflect the sensation the unborn child is experiencing as it spirals down and out though the mother’s internal pelvic structures. These experiences are more likely to be perceptible when the midwife herself is calm and still, when she completely trusts the birth process and has no fear for the mother or baby.

Midwives’ words

During my training as a hypnobirthing teacher, I reflected long and hard on the use of language by myself and others during birth. It became clear to me that a woman in her Birth Trance or Ecstatic Birth state (Buckley 2009) is the same as someone in hypnosis or a woman using Hypnobirthing to achieve a state of deep relaxation and connection with her subconscious mind. The subconscious responds to the present tense and ignores negatives (Mongan 2007, Graves 2012). As midwives we need to be particularly careful about the words we use and the tone in our voices as we say them. Women who have used hypnobirthing as part of their preparation for birth may respond very readily to positive affirmations during difficult times in labour when they are very open to suggestion. We also need to remember the woman’s lack of connection to the outside world in deep labour.

Careful use of language and sympathetic attitudes are vital ways to engage with the mother’s inner dialogue. The psychological relaxation engendered by this permits the woman to allow her physical body to release into the flow of birth. In deep relaxation or during near-death experiences, the brain generates theta waves which are associated with euphoria and lack of temporal or physical awareness (Davis 1989 in Anderson 2000).

The concepts included in some phrases heard often in birth spaces may reflect valid midwifery assessments of the current situation, and changes in management may well be appropriate and necessary, but positive, accessible, inclusive and loving language is more likely to be helpful and accessible by birthing mothers.

Woman may find midwifery and medical terms unhelpful, incomprehensible or confusing, especially during labour. This makes an undesirable emotional distance between the mother and the midwife. For example ‘are you the Trial of Scar lady?’ or ‘when did you SROM?’ Expressions which suggest the midwife has negative attitudes to the mother, the baby or to progress in birth may be perceived as unhelpful or even unkind and demeaning by the mother. For example, ‘how often are the pains?’, ‘you are only 3cms’, ‘what a naughty baby!’, or ‘this is taking too long’. Sometimes, words used incautiously may make the mother feel the midwife is lacking in empathy (even when she is not). For example, ‘get angry with your baby and really push him out’, ‘you are not pushing properly’, or ‘you are not trying hard enough’.

Midwifery expressions that women have told me after the birth that they found valuable during birth include:
Words of appreciation

’You are strong and powerful’
’You are wonderful’
’How lucky your baby is to have such a courageous mother’

Offering empathy and reassurance

’It is supposed to feel like this’, on observing an expression of fear on the face of a woman as she approaches the birth phase and experiences a rapid rise in pain levels.

Connecting the mother to hope and anticipation

’Your baby will be in your arms soon’, this can be very helpful in transition when she may be feeling despondent. Many women like descriptions of the newborn in their arms, said in a low soothing voice, emphasising all the senses, especially sight, touch and smell.

Affirmations about her physical capacity

’Your body is strong. Your bones are moving to let your baby slither down’. This can be used if the birthing woman expresses fear about a sense the pelvis is splitting in birth phase. Or ’your body is opening beautifully. I can see healthy stretchy skin easing open a little more each time. You can open as much as you need’ if she expresses concern about the burning, stretching feelings as crowning approaches.

Afterthoughts

There is much to learn about the subtleties and wonders of birth through observation and compassionate midwifery practice. Our midwifery body of knowledge needs to be debated, documented and shared, and birthing women should have a core voice in this work. Through discussions between mothers and midwives we may be able to winkle out wisdom, perhaps once known, but now ‘beyond the veil’. An open-minded approach to women’s ways of knowing and learning may be valuable. Story telling, sharing, laughing, crying, holding the space, acknowledging each woman’s lived experience all have their place. The possibility of expanding our understanding of women’s amazing bodies and capacities will lead us to a humble acceptance that we still have much to learn.

References

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Essentially MIDIRS • April 2013 • Volume 4 • Number 4 | 23