Training for Childbirth

BY

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Psychoprophylaxis or mind training is the basis of methods used in ante-natal tuition in Salisbury to-day. This training for labour, using simple, conditioned reflex actions taught in specific positions, includes relaxation — decontraction of muscle.

The training promotes an alert mind dealing with a series of understood controllable contractions, which require concentrated effort and deliberate action.

Two methods have evolved in training for childbirth, helping mothers to have their babies happily, consciously and with freedom from fear and misunderstanding.

The Dick-Read method, more passive, aiming at controlled relaxation and freedom from mental and physical tension, also teaches exercises for posture, strengthening of specific muscle groups and simple anatomy, and has great success with

some women. This method started in Britain and was largely perfected by Dr. Dick-Read in South Africa some 15 years ago.

At the same time a more scientific method was being developed in Russia and France based on the Pavlov theory of association between physical reactions and mental training—and there are now many clinics, ante-natal and maternity units all over Europe and Britain using modified forms of training. These modifications are all to suit local conditions, and the basic aims of understanding and controlled relaxation taught at comprehensive classes or during individual training usually result in an alert, co-operative mother.

A major aim of all bodies concerned with training for childbirth, as is the National Childbirth Trust in Britain, is that obstetrics should be humanised and that the lonely and often unnecessarily frightening part of having a baby should be removed, so that the mother's wish to take part in the birth of her child with understanding and a very real satisfaction should be recognised.

It is fully explained to the mothers why there must be muscular decontraction during rest periods between contractions, and certain exercises to relax muscles are taught throughout the last 10 to 12 weeks of pregnancy. Exercises to maintain good tone of muscles for labour are practised regularly and most of these are carried through into the post-natal period. Charts and photographs are used as visual aids in training. a record of a birth is heard and all fathers are given the opportunity to attend a class.

It is explained to mothers that while there is a common pattern in every labour, each individual labour develops an intimate pattern which is usually unpredictable and varies not only from person to person, but with the consecutive labours of any one person.

The mothers are taught that the common pattern is divided into two stages:

First Stage—Preparation

The uterus, being the only muscle capable of carrying out this work, needs a great proportion of the body's supply of oxygen to release the energy needed for the contractions during this stage. The early contractions are used for their practice value, allowing the mother to get used to her intimate pattern, the strength and rhythm of the contractions and the effort needed to deal with these contractions.

It is explained that during this stage the long fibres of the uterus are "packaging" the baby for delivery as they shorten, while simultaneously, and far more obviously to the mother, the cervix is thinning and drawing back to allow the baby to emerge into the birth canal. The mother expects to feel these contractions either above the pubic symphysis or across the back at the level of the sacrum, and occasionally in the groin.

She has to consider three things:

(1) Breathing during contractions.

(2) Relaxation between contractions.

(3) Varying position and breathing to suit herself, using previously practised methods.

This is the waiting stage; the mother is in the labour room and can nowadays be accompanied by her husband throughout this stage should the parents wish it, with the approval of their doctor and permission of the hospital staff.

Second Stage—Delivery

At the beginning of this stage a very real change of rhythm is experienced: the bearing down impulse is received from the uterus, in many cases very forcibly, although sometimes the mother is only aware of a state of uneasiness, weariness or mental turbulence. This is probably the most difficult stage for any mother to deal with—certainly from all reports the mothers feel it to be so; occasionally there is no apparent awareness of this stage and the mother receives no bearing down impulse until the cervix is fully dilated, when the delivery stage proper commences immediately.

It has been found that quite a large proportion of women fall asleep during the last hour or so of the first stage and are awakened suddenly by strong contractions. Probably the change of rhythm is the reason for this and usually the bearing down impulse is received immediately.

This impulse is generated by a very specialised group of uterine nerve endings, and from then on, as soon as dilatation is complete, the mother can join with the uterus in the delivery of the baby. She bears down strongly and willingly, remembering that some of these contractions are much more powerful than others, and using them accordingly; also many women need two or three of these contractions as "practice pushes" before they can really successfully co-operate with the uterus.

The climax of this second stage is the delivery of the baby, usually head first. The delivery of the placenta is sometimes felt as an anticlimax!

Breathing Methods

There are four gears of breathing taught:

First Gear.—Deep, slow breathing—for all early contractions and at the commencement and cessation of all contractions. The mothers are taught to use the whole of their lung area, and in a few cases this gear suffices for the whole of the first stage.

Second Gear.—Panting breathing—for stronger contractions, when the mothers are taught to think of the upper part of the chest, the triangle between throat and clavicles; this is also used for the delivery of the head. Provided the medical attendants are aware of its value and instruct the mother clearly, it is very difficult for the mothers to feel exactly when the head is emerging from the birth canal in most cases.

Third Gear.—" Goldfish " or " blow-in-out " breathing—for very strong contractions or those early contractions of the second stage to prevent mothers from pushing because there is not yet full dilatation, although she is receiving bearing down impulses.

This breathing involves emptying the chest of air during the climax of the contraction, then allowing air to come in and out, using shallow breathing, with the mouth and eyes wide open; and the pattern can be repeated several times until the climax eases, and then first gear breathing is used to end the contraction. Since the rest period during these strong contractions is rarely more than 30 seconds, the mother is taught to decontract all muscles completely during each rest period, emphasising that this allows each contraction to start anew from a state of relaxation, thus preventing a build-up of tension.

Fourth Gear.—Holding — used for bearing down contractions, when a taut diaphragm is a valuable platform for the uterus and abdominal muscles to work against during the expulsion of the baby. The mothers are taught to practise holding their breath for about 30 seconds, as this means one familiar factor when the delivery stage is reached (the other is the accepted position) so that the mother can concentrate on using the contraction fully and so help to shorten the delivery stage. There is a great deal to remember during labour, and the mother is encouraged to consider various factors and told the reasons for their importance.

First Stage

(1) To remain calm and co-operative, not to interfere with the work of the uterus, which is carrying out the physical effort at this stage.

(2) To breathe deeply and slowly at the beginning and end of every contraction, with inspiration emphasised at the commencement of a contraction to build up a good supply of oxygen, with expiration emphasised at the cessation of each contraction to encourage the removal of carbon dioxide.

(3) To decontract the pelvic floor during each contraction, to avoid building up a tension syndrome in the pelvic area.

(4) To adjust her position and pattern of breathing to suit the strength of contractions, using familiar practised methods in order to occupy as much of the brain as possible, and to ride each contraction rather than be swamped by these contractions.

Second Stage

(1) To adjust to the change in rhythm and duration of contractions and to start using the bearing down impulse as fully as possible as soon as permission is given.

(2) To use the position for delivery approved by the local hospital.

(3) To co-operate and work with the medical attendants at all times.

(4) To deliver the baby with as full awareness as possible, thus receiving the greatest reward for her labour.

The use of certain drugs is explained, also the necessity for enema, shaving of the pubic and peroneal hairs and various other essentials which may seem incomprehensible to a mother unused to hospital procedure, and items such as how to get on and off a trolley when in labour.

Labour is an extremely emotional experience, and all the mothers are warned of this and against the danger of feeling they have failed for some reason. It must be appreciated that at least eight sessions of tuition are necesary for the mother to feel confident that she has understood and is familiar with the principle of psychoprophylactic training, although more mothers are coming for three or four sessions, or their second, third or even fourth babies, as a revision course.

It is of great importance that to be of full value to the mothers there should be close co-operation between all people concerned in the delivery of the baby, and this would ensure that methods were evolved for promoting the best possible memory for each mother of every birth she takes part in, so that each may feel the bringing of a human life into the world is a wonderful, interesting and rewarding experience.

Psychoprophylaxis is of greatest value for the normal birth, but even after a longer labour than expected or minor complications, the mother's lack of fatigue, understanding and comprehension of the birth and interest and joy at looking back on her labour are well worth the teaching to mothers who undergo unexpected difficulties.

The National Childbirth Trust in Britain has evolved a method, proving very successful in a high percentage of cases, for dealing with "menstrual pains"—also produced by uterine contractions—and this has also been tried in a few instances in Salisbury. The method is based on psychoprophylaxis, using breathing control, relaxation and specific exercises.

If there are any statements which are controversial I would be very willing to discuss, amend and correct such points.