

## **Pushing for Primips** **by Gloria Lemay**

The expulsion of a first baby from a woman's body is a space in time for much mischief and mishap to occur. It is also a space in time where her obstetrical future often gets decided and where she can be well served by a patient, rested midwife. Why do I make the distinction between primip pushing and multip pushing? The multiparous uterus is faster and more efficient at pushing babies out and the multiparous woman can often bypass obstetrical mismanagement simply because she is too quick to get any.

It actually amazes me to see multips [women having second or more babies] being shouted at to "push, push, push" on the televised births on "A Baby Story". My experience is that midwives must do everything they can to slow down the pushing in multips because the body is so good at expelling those second, third and fourth babies. In most cases with multips, having the mother do the minimum pushing possible will result in a nice intact perineum. As far as direction from the midwife goes, first babies are a different matter. I am not saying they need to be pushed out forcefully or worked hard on. Rather, I say they require more time and patience on the part of the midwife, and a smooth birth requires a dance to a different tune.

Let's take a typical scenario with an unmedicated first birth at home. The mother has been in the birth process for about twelve hours. The attendants have spelled each other off through the night. Membranes ruptured spontaneously with clear fluid after eight hours in active phase and mother and baby have normal vitals. There is dark red show (about two tablespoons per sensation) and mother says, "I have to push!" This declaration on the part of the mother brings renewed life to the room. The attendants rally and think, Finally, we're going to see the baby. The long wait will be done. We'll be relieved to see baby breathe spontaneously. We can start the clean up and be home to our families. Typically, the midwife does a pelvic exam at this point to see if the woman is fully dilated and can get on with the pushing now. It is common to find the woman eight centimeters with this scenario. The mood of the room then turns to disappointment.

My recommendation with this scenario: Don't do that pelvic exam. A European-trained midwife that I know told me she was trained to manage birth without doing pelvic exams. For her first two years of clinic, she had to do everything by external observation of "signs." When a first-time mother says, "I have to push!" begin to observe her for external signs rather than do an internal exam. Reassure her that gentle, easy pushing is fine and she can "Listen to her body." No one ever swelled her own cervix by gently pushing as directed by her own body messages. The way swollen cervices happen is with directed pushing (that is, being instructed by a midwife or physician) that goes beyond the mother's own cues. It has become the paranoia of North American midwifery that someone will push on an undilated cervix. Relax, this is not a big deal, and an uncomfortable pelvic exam at this point can set the birth back several hours. The external signs you will be looking for are as follows:

1. When she "pushes" spontaneously, does it begin at the very beginning of the sensation or is it just at the peak? If it is just at the peak, it is an indication that there is still some dilating to do. The woman will usually enter a deep trance state at this time (we call this "going to Mars"). She is accessing her

most rudimentary brain stem where the ancient knowledge of giving birth is stored. She must have quiet and dark to get to this essential place in the brain. She usually will close her eyes and should not be told to open them.

2. Does she "push" (that is, grunt and bear down) with each sensation or with every other one? If some sensations don't have a pushing urge, there is still some dilating to do. Keep the room dark and quiet as above.

3. Are you continuing to see "show"? Red show is a sign that the cervix is still dilating. Once dilation is complete the "show of blood" usually ceases while the head molding takes place. Then you can get another gush of blood from vaginal wall tears at the point that the head distends the perineum.

4. Watch her rectum. The rectum will tell you a good deal about where the baby's forehead is located and how the dilation is going. If there is no rectal flaring or distention with the grunting, there is still more dilating to do. A dark red line extends straight up from the rectum between the bum cheeks when full dilation happens. To observe all this, of course, the mother must be in hands and knees or side-lying position.

I use a plastic mirror and flashlight to make these observations. The mother should be touched or spoken to only if it is very helpful and she requests it. Involuntarily passing stool is another sign of descent and full dilation. Simply put, where there is maternal poop there is usually a little head not far behind. Why avoid that eight-centimeter dilation check? First, because it is excruciating for the mother. Second, because it disturbs a delicate point in the birth where the body is doing many fine adjustments to prepare to expel the baby and the woman is accessing the very primitive part of her ancient brain. Third, because it eliminates the performance anxiety/disappointment atmosphere that can muddy the primip birth waters. Birth attendants must extend their patience beyond their known limits in order to be with this delicate time between dilating and pushing.

Often when the primiparous woman says, "I have to push," she is feeling a downward surge in her belly but no rectal pressure at all. The rectal pressure comes much later when she is fully dilated, but in some women there is a downward, pushy, abdominal feeling. I have seen so many hospital scenarios where this abdominal feeling has been treated like a premature pushing urge and the mother instructed to blow, puff, inhale gas and so forth to resist the abdominal pushing. Such instruction is not only ridiculous but also harmful. A feeling of the baby moving down in the abdomen should be encouraged and the woman gently directed to "go with your body."

When I first started coaching births in the hospital I would run and get the nurse when the mother said, "I have to push." I soon learned not to do this because of the exams, the frustration and the eventual scenario of having to witness a perfectly healthy mother and baby operated on to get the baby out with forceps, vacuum or c-section. I have learned to downplay this declaration from first-time moms as much as possible, both at home and in the hospital. Especially if you have had a long first stage, you will have plenty of time in second stage to get people into the room when the scalp is showing at the perineum.

### **Feeling stuck**

I recommend that midwives change their notion of what is happening in the pushing phase with a primip from "descent of the head" to "shaping of the

head." Each expulsive sensation shapes the head of the baby to conform to the contours of the mother's pelvis. This can take time and lots of patience especially if the baby is large. This shaping of the baby's skull must be done with the same gentleness and care as that taken by Michelangelo applying plaster and shaping a statue. This shaping work often takes place over time in the midpelvis and is erroneously interpreted as "lack of descent," "arrest" or "failure to progress" by those who do not appreciate art. I tell mothers at this time, "It's normal to feel like the baby is stuck. The baby's head is elongating and getting shaped a little more with each sensation. It will suddenly feel like it has come down." This is exactly what happens.

Given time to mold, the head of the baby suddenly appears. This progression is not linear and does not happen in stations of descent. All those textbook diagrams of a pelvis with little one-centimeter gradations up and down from the ischial spines could only have been put forth by someone who has never felt a baby's forehead passing over his/her rectum!

Often the mother can sleep deeply between sensations and this is most helpful to recharge her batteries and allow gentle shaping of the babe's head. Plain water with a bendable straw on the bedside table helps keep hydration up. The baby is an active participant and must not be pushed and forced out of the mother's body until he/she is prepared to make the exit. In her book "Ocean Born" (1989) midwife Chris Griscom describes her experience of allowing her son to push his own way out of her womb:

[I ask] . . . the cervix what color it needs to open easily, the color flashes before my eyes and I begin to visualize myself drinking that color directly into the cervix. I sense a subtle but immediate response. There is a quickening now. The baby is moving down, as I've begun the dreaming. Spun off time's orbit, I sleep in the sea, until I feel it rise with the contraction. I surface like the dolphin, then dive again. Birth is coming. Gratitude for the ease of this passage floods me, and I feel salty, slow motion tears trace the outline of my face. Like a gigantic stone, the pressure of his head weighs down through my pelvic floor. With all my power I am pushing the stone . . . yes, I am also that stone myself. The motion catches me and I feel myself impelled faster and faster . . .

An explosion of light  
I see the belly of a huge Buddha,  
I am propelled into it  
Rapture  
Bliss  
Ecstasy.

### **Do not disturb**

For anyone who has taken workshops with Dr. Michel Odent, you will have heard him repeat over and over, "Zee most important thing is do not disturb zee birthing woman." We think we know what this means. The more births I attend, the more I realize how much I disturb the birthing woman. Disturbing often comes disguised in the form of "helping." Asking the mother questions, constant verbal coaching, side conversations in the room, clicking cameras—there are so many ways to draw the mother from her ancient brain trance (necessary for a smooth expulsion of the baby) into the present-time world (using the neocortex which interferes with smooth birth). This must be

avoided. A recent article on the homebirth of model Cindy Crawford describes how the three birth attendants and Cindy's husband had a discussion about chewing gum while she was giving birth. Cindy describes her experience: "It was absolutely surreal. There I was, in active labor, and they're debating about gum! I wanted to tell them to shut up, but at that point, I couldn't even talk." (Redbook, March 2000). This was in her own home, and she couldn't control the disturbance that was happening in her first birth. Needless to say, she had a long, painful, exhausting second stage.

Human birth is mammal birth. A cat giving birth to her kittens is a good model to look to for what is the optimal human birth environment: a bowl of water, darkness, a pile of old sweaters, quiet, solitude, privacy and protection from predators. When given this environment, 99.7 percent of cats will give birth to kittens just fine. We spend so much money in North America on labor, delivery and recovery (LDR) rooms and now, adding postpartum, LDRP rooms. Yes, it is an advancement that women are not moved from room to room in the birth process, but there is so much more that can disturb the process: lighting, changing staff, monitoring, beeping alarms, exams, questions, bracelets, tidying, assessing, chattering, touching, checking, charting, changing positions and so on.

When midwives come back from the big maternity hospital in Jamaica, they bring an interesting observation about birth. The birthing women are ignored until they come to the door of the unit and say, "Nurse, I have to go poopy." They are then brought into the unit and within twenty-five minutes give birth to the baby. Cervical lips are unheard of. Most times, the head is visible when the woman gets onto the birth table. Her entire eight-centimeter-to-head-visible time is done in the company of the other birthing mothers, and she is cautioned not to go near the midwives until the expulsive feeling in her bum is overwhelming. Cesarean section and instrument delivery rates are very low.

### **Reversing the energy**

Birth is better left alone and pushing should be at the mother's cues. Having said that, I want to address the exceptions to the rule. After hours of full dilation with dwindling sensations, what if the mother is languishing? The sense of anxiety and fatigue in the room builds, and nothing is served by allowing this to go on too long. Such situations often occur at first births, where the mother insists on having her whole family present. This dynamic is one reason why I forbid vaginal birth after cesarean (VBAC) moms to have spectators at their births. Birth is best done in privacy even if the woman desires on a conscious level to have visitors. In this type of situation the midwife can help by changing the direction of the flow. Normally we think of the baby coming "down and out." In this scenario, nothing is moving. It's a bit like having your finger stuck in one of those woven finger traps. The more the mother attempts to bring the baby down the more tired and tight the process becomes. At this point, it can be helpful to get the mother into knee/chest position and tell her to try to take the baby's bum up to her neck for a few pushes. This will sound like strange instruction but, if she has learned to trust you, she will give it a whirl. Reversing the energy and moving it the opposite direction can perform miracles. After five or six sensations in this position with minimal exertion of the mother, the fetal head often appears suddenly at the perineum. For those of you who know Eastern martial arts, you will

understand this concept of reversing directions in order to gain momentum. This is midwife Tai Chi!

### **Facing Fear**

Psychological factors in birth are a never-ending source of fascination to some birth attendants. I try to keep it simple. My job is to facilitate birth not practice psychology. When I start to be afraid at births, the last thing I want to hear is someone else's fears in addition to mine. This is a natural inclination but not helpful for moving energy and getting babies into the world. I have learned to notice when I'm fearful and respond to my fears by saying out loud to the mother, "Linda, what's your biggest fear right now?"

Linda may take some time but eventually she'll say something that I never imagined she's holding as a fear. Usually it is enough for her to simply express it. Sometimes she needs some reassuring input. I find always that when fear is expressed it begins to disappear or at least lose its grip on the birth. Be bold about addressing fear and uncommunicated worry. One first-time Mom responded to my question "What's your biggest fear right now?" with "I'm afraid I won't be able to open up and let my baby out." As soon as the words were out, her baby gave a big push and the head was visible at the introitus.

### **Linguistics and concepts**

Midwives have lots of research support encouraging them to be patient with the second stage and wait for physiological expulsion of the baby. Recognizing ways in which we can support the mother to enter that deep trance brain wave state that leads to smooth birth is imperative. I find it very helpful to have new language and concepts for explaining the process to practitioners. Dr. Odent has taught me to wait for the "fetus ejection reflex." This is a reflex like a sneeze. Once it is there you can't stop it, but if you don't have it, you can't force it. While waiting for the "fetus ejection reflex," I imagine the mother dilating to "eleven centimeters." This concept reminds me there may be dilation out of the reach of gloved fingers that we don't know about, but that some women have to do in order to begin the ejection of the baby. I also find it valuable to view birth as an "elimination process" like other elimination processes—coughing, pooping, peeing, crying and sweating. All are valuable (like giving birth is) for maintaining the health of the body. They all require removing the thinking mind and changing one's "state." My friend Leilah is fond of saying, "Birth is a no brainer." After all "elimination processes" are finished, we feel a lot better until the next time. Each individual is competent to handle their bodily elimination functions without a lot of input from others. Birth complications, especially in the first-time mother, are often the result of helpful tampering with something that simply needs time and privacy to unfold as intended.

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## **Pushing Situations: Hospital vs. Home**

*by Gloria Lemay*

*A hospital CNM wrote:*

My physician colleague called me in as a consultant for one of his ladies last week. Primip at forty weeks plus three days, spontaneous labor, admitted at five centimeters and spontaneous rupture of membranes (SROM) around 8 p.m., with pretty bad back pain, resolved after injection of sterile water papules. Around 11 p.m. she was complete and wanting to push. When he called me it was 2:30 a.m., she had been pushing for most of that time and occasionally it seemed like the baby would move down, and then nothing. He had her pushing in all kinds of positions. I came in and worked with her for a long time. The baby was doing fine throughout and mom wanted to keep on trying. Around 4 a.m. we started seeing signs of fetal stress (tachycardic to the 170s), and mom was also getting more and more exhausted. Baby didn't seem all that big, but was occipitoposterior (OP) and asynclitic. Went to OR, baby born around 5 a.m. with major molding of caput, delivered OP asynclitic and I heard the surgeon grunt as she and the family practitioner doc were pulling out the shoulders—a 4,110 gram (nine pounds, six ounces) baby boy. We tried every trick we knew to get that baby turned and out, it just didn't work.

Caroline, CNM

*Homebirth midwife reply:*

We had a homebirth of a primip 4,876 gram (ten pounds, seven ounces) boy the other morning which sounds a lot like your situation. Mom was forty-two weeks plus four days. Tall and big boned. She had four days of ROM prior to starting up. Good temperatures and fetal heart tones in that time. No exams. Complained about her back all through. Her babe's head was plus one and she was fully dilated at 8 a.m. after a twelve-hour first stage. Then she slept and the sensations spaced right out. She got up to the toilet for a while, she went into the pool for a while, and then would start the whole cycle again—sleep, toilet, pool and sidelying on the bed. Mickey Mouse pushing that produced no advancement, but we didn't disturb her or encourage anything strong. At 2 p.m. we got her up and had her squat and bear down with some oomph. She pushed out a big boy on all fours into her husband's hands with just a first-degree tear. Shoulders were a breeze. The birth attendant, who used me for a consultant in this case, called me in early and we both took turns to work with her through the night so everyone was rested and there was continuity in the coaching. The other big advantage we had was being out of hospital, which gave us a lot more room to be "creative" and wait without the pressure of "science" and protocols looming in everyone's mind. The toilet in one's own home is a good place to let go, and we were able to "feed" her things from her own fridge that kept her strength up.

In our province the governing board wants midwives to do a certain number of hospital births a year in order to be licensed. I would have such a hard time working in that environment, especially with first-time moms. When I think back on the years I did labour coaching in the hospital, I recall having a horrible time with primips. They almost always stalled out. We asked Dr. Michel Odent one time if it was OK to have the first baby at home. He replied,

"Zis is zee most important birth to have at home because if a woman has a beautiful, sexual experience with her first birth then perhaps she can go to the hospital with her second or third. She will never let them do anything to her because she knows her body works from that first birth." And then, we have Dr. Michael Rosenthal who says, "The first intervention in natural childbirth is the one the woman does herself when she walks out the front door of her house. It is from that first intervention that all the others follow."

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