FOR FATHERS

A Push Present for Your Baby Mama?

Thinking about surprising your baby mama with a little box after she delivers your little bundle of joy? Push presents (a gift that a dad gives to a mom to commemorate the birth of their baby) are gaining popularity among new parents. Of course the baby she's birthing is the greatest gift either of you could imagine—but after all that heavy lifting (and pushing) some sort of tangible tribute might be a nice bonus.

Not sure what to get? How about gifting her with some well-deserved postpartum pampering—like a gift certificate for a facial or a massage or a mani-pedi? Or a month's worth of professional housekeeping (actually, a great present for both of you)? Is baby bling more her thing? Consider a charm necklace etched with baby's name or initials, a bracelet with baby's birthstone, or even a ring to symbolize how your love has grown with your baby's birth.

Worried that a push present might push your budget too far? Or you'd rather slide any extra cash into your little one's college fund? Remember, some of the most meaningful gifts come without a hefty price tag. Surprise her with a bouquet of balloons or flowers or a lawn sign that proclaims your new papa pride. And don't forget the card—with some heartfelt words (or if you're particularly inspired, a poem or a song) about how much your love has grown over the last 9 months, and how much you look forward to your lifetime together.

Not a fan of the push present fad? Don't feel pressured to buy anything if that's not your style or hers. After all, trends come and go—but being partnered with a coparent who's committed to doing his half is truly the gift that keeps on giving. What's more, being present is the best present of all—not only at your baby's birth, but throughout your days, months, and years together as partners in parenting and life. That's what's called priceless.

"I've read that fetal movements are supposed to slow down as delivery approaches. My baby seems as active as ever."

Every baby's different, even before he or she is born—especially when it comes to activity levels, and particularly as delivery day approaches. While some babies move a bit less as they get ready to arrive, others keep up an energetic pace right until it's time for that first face-to-face. In late pregnancy, there is generally a gradual decline in the number of movements, probably related to tighter quarters, a decrease in amniotic fluid, and improved fetal coordination. But unless you're counting every single movement, you're not likely to notice a big difference.

Nesting Instinct

"I've heard about the nesting instinct. Is it pregnancy legend, or is it for real?"

The need to nest can be as real and as powerful an instinct for some humans as it is for our feathered and four-legged friends. If you've ever witnessed the birth of puppies or kittens, you've probably noticed how restless the laboring mother becomes just before delivery—frantically running back and forth, furiously shredding papers in a corner, and finally, when she feels all is in order, settling into the spot where she will give birth. Many expectant humans do experience the uncontrollable urge to ready their nests, too, just prior to

Massage It, Mama

Got nothing but time on your hands as you wait for baby's arrival? Put your hands (or a special someone else's hands) to good use—and give yourself a rub. Perineal massage can help gently stretch a first-timer's perineum (that area of skin between your vagina and rectum), which in turn can minimize the "stinging" that occurs when baby's head crowns during childbirth. And here's another plus you'll appreciate: It may also help you avoid tearing and an episiotomy, according to some experts.

Here's how to give your perineum the right rub: With clean hands (and short nails) insert your thumbs or index fingers (lubricated with a little K-Y jelly or olive oil if you'd like—but don't use mineral oil or Vaseline) inside your vagina. Press down (toward your rectum) and slide your fingers across the bottom and sides of your perineum. Repeat daily during the last weeks of pregnancy, 5 minutes (or longer) each time. Not feeling the perineal massage concept—because it seems too weird or too time-consuming? It's certainly not a must-do. Though anecdotal evidence has long supported its effectiveness, clinical research has not yet backed it up. Even without the rubbing, your body will still stretch when the time comes. And don't bother with perineal massage if you've already popped out a baby or two. Your perineum doesn't need the extra stretching, and probably won't benefit from it either (though perineal massage during labor can help stretch out even an experienced perineum as baby's head emerges).

One word to the wise: If you do go the massage route, proceed gently. The last thing you want to do right before labor is pull too hard, scratch yourself, or irritate sensitive skin. Massage with care down there.

childbirth—even though they won't likely be delivering in a pile of papers or leaves and twigs. For some it's subtle. All of a sudden, it becomes vitally important to clean out and restock the refrigerator and make sure there's a 6-month supply of toilet paper in the house. For others, this unusual burst of manic energy plays itself out in behavior that is dramatic, sometimes irrational, and often funny (at least, to those watching it)—cleaning every crevice of the nursery with a toothbrush, rearranging the contents of the kitchen cabinets alphabetically, washing everything that isn't tied down or being worn, or folding and refolding baby's clothes for hours on end.

Though it isn't a reliable predictor of when labor will begin, nesting usually intensifies as the big moment approaches—perhaps as a response to increased adrenaline circulating in an expectant mom's system. Keep in mind, however, that not all women experience the nesting instinct, and that those who don't are just as successful in nurturing their nestlings as those who do. The urge to slump on the sofa during the last few weeks of pregnancy is as common as the urge to clean out closets, and just as understandable. Make that more understandable.

If a nesting urge does strike, make sure it's tempered by common sense. Suppress that overwhelming urge to paint the baby's nursery yourself—let someone else climb the ladder with the bucket and roller while you oversee

Sounds Like a Plan

How far along in labor should you be before calling your practitioner? Should you call if your water breaks? How can you make contact if the contractions start outside of regular office hours? Should you call first and then head for the hospital or birthing center? Or the other way around?

Don't wait until labor starts to get the answers to these important questions. Discuss all of these and other labor logistics with your practitioner at your next appointment (if you haven't already), and write down all the pertinent info if it's not handed to you in a printout. Otherwise, you'll be sure to forget the instructions once those contractions kick in. If you're using a doula, make sure you know when to call her, too.

Also, be sure you know the best route to your place of delivery, roughly how long it will take to get there at various times of the day, and what kind of transportation is available if you don't have someone to drive you (don't plan on driving yourself). And if there are other children at home, or an elderly relative, or a pet, be sure you've made plans for their care in advance.

from a comfy chair. Don't let overzealous home cleaning exhaust you, either—you'll need energy reserves for both labor and a new baby. Most important of all, keep the limitations of your species in mind. Although you may share this nesting instinct with members of the animal kingdom, you are still only human—and you can't expect to get everything done before that little bundle of joy arrives at your nest.

When Will You Deliver?

"I just had an internal exam and the doctor said I'll probably be going into labor very soon. Can she really tell?"

Your practitioner can make a prediction about when you'll give birth, but it's still just an educated guess—just as your original due date was. There are clues that labor is getting closer, which a practitioner looks for beginning in the 9th month, both by palpating outside and examining inside. Has lightening or engagement taken place? What level, or station, has the baby's presenting part descended to? Have effacement (thinning of the cervix) and dilation (opening of the cervix) begun? Has the cervix begun to soften and move to the front of the vagina (another indicator that labor is getting closer) or is it still firm and positioned to the back?

But "soon" can mean anywhere from an hour to 3 weeks or more. A practitioner's prediction of "you'll be in labor by tonight" could segue into a half month more of pregnancy, while a forecast of "labor's weeks away" could be followed the next day by baby's birth. The fact is that engagement, effacement, and dilation can occur gradually, over a period of weeks or even a month or more in some moms—and overnight in others. Which means that these clues are far from sure bets when it comes to pinpointing the start of labor.

So pack your bags just in case, but definitely don't keep the car running. You'll still have to play the waiting game, knowing for certain only that your day, or night, will come—sometime.

Do-It-Yourself Labor Induction?

So what happens if you're overdue and still as pregnant as ever (make that more pregnant than ever), with your baby showing no signs of budging? Should you just let nature take its course, no matter how long that course takes? Or should you take matters into your own hands and try some DIY labor induction techniques? And if you do take matters into your own hands, will it even work?

While there are plenty of natural methods you can use to try to bring on labor (and you can search for dozens online), it's hard to prove that any of them are effective. That's at least partly due to the fact that when they do appear to work, it's difficult to establish whether they actually worked—or whether labor, coincidentally, started on its own at the same time.

Still, if you're done with being pregnant (and who isn't by 40 weeks?) but your pregnancy isn't done yet, you might want to give these a try—they won't be harmful even if they don't end up kick-starting labor:

Walking. It has been suggested that walking can help ease the baby into the pelvis, thanks perhaps to the force of gravity or the swaying of your hips. Once baby puts pressure on the cervix—literally—labor might get going. If it turns out that your stroll doesn't jumpstart labor, you'll be no worse for wear. In fact, you might be in better shape for labor, when it actually does begin.

Sex. Sure, you're the size of a small hippo (and about as agile), but hoisting yourself into bed with your partner may be an effective way to mix business with pleasure. Or not. Some research shows that semen (which contains prostaglandins) can stimulate contractions when conditions are ripe (not before), and some have suggested (hopefully) that the release of oxytocin during orgasm might nudge the process along, too, once a woman has reached term. But not only has science failed to back that happy theory up—other research has found that women who continue to have sex late in pregnancy might carry their babies even longer than those who

The Overdue Baby

"I'm a week overdue. Is it possible that I might never go into labor on my own?"

Ah, the magic date—the one you synced up on your iCloud calendars, the one you confidently handed out to family and friends, the one your pregnancy app has been counting down for weeks—has arrived. And, as in about 30 percent of all pregnancies, the baby hasn't. Anticipation dissolves into discouragement. The stroller and crib sit empty for yet another day. And then a week. And then, in about 10 percent of pregnancies, most often those of first-time mothers, 2 weeks. Will this pregnancy never end?

Though expectant moms who have reached the 42nd week might find it hard to believe, babies are forever—but pregnancy isn't. In fact, studies show that about 70 percent of apparent post-term pregnancies aren't post-term at all. They are believed to be late only because of a miscalculation of the time of conception, usually thanks to irregular ovulation or a woman's uncertainty about the exact date of her last period. And in fact, when early ultrasound examination is used to confirm the

abstain. In the mood for love, or just so desperate you're ready to try anything? Get busy if you're game to try. After all, it may be the last time in a long time that you'll actually be able (or willing) to have sex. If getting busy brings on labor, great—if it doesn't, still great.

Other natural methods have potential drawbacks (even though they've been passed down from old wives to midwives to moms on message boards). So before you try these at home, discuss them with your practitioner first:

Nipple stimulation. Interested in some nipple tweaking (ouch)? How about some nipple twisting (double ouch)? Stimulating your nipples for a few hours a day (yes, hours) can release your own natural oxytocin and bring on contractions. But here's the caveat: Nipple stimulation—as enticing as hours of it may sound (or not)—can lead to painfully long and strong uterine contractions. Not to mention very sore nipples. So unless your practitioner advises it and is monitoring your progress, you may want to think 4 times—twice for each nipple—before you or your partner attempt nipple stimulation.

Castor oil. Hoping to sip your way into labor with a castor oil cocktail? Women have been passing down this yucky-tasting tradition for generations on the theory that this powerful laxative will stimulate your bowels, which in turn will stimulate your uterus into contracting. The caveat for this one: Castor oil (even mixed with a more appetizing drink) can cause diarrhea, severe cramping, and vomiting. Before you chugalug, be sure you're ready to begin labor that way.

Herbal teas and remedies. Raspberry leaf tea, black cohosh, and evening primrose may be just what your ancestors (and message board buddies) ordered for the overdue, and some studies show that these herbal remedies may actually help trigger or speed up contractions. Ask your practitioner about whether (and how much) of these remedies you should take and how. And turn to them only when you're already at term.

And while you're pondering the effectiveness of the DIY approach, remind yourself that you will go into labor—either on your own or with a little help from your practitioner—eventually.

due date, diagnoses of post-term pregnancy drop dramatically from the long-held estimate of 10 percent to about 2 percent.

Even if you do end up among those 2 percent of women who are truly overdue, your practitioner won't let your pregnancy pass the 42-week mark. In fact, most practitioners won't even let a pregnancy continue that long, choosing instead to induce by the time your baby has clocked in 41 weeks. Inducing labor at this point, by the way, doesn't seem to pose any increased chances of c-section and may in fact be associated with significantly lower blood loss for the mom and a significantly lower rate of meconium staining (see page 398) for the baby—plus it means you'll get to hold your baby sooner. And of course, if at any point test results show that the placenta is no longer doing its job well or that the amniotic fluid levels have dipped too low—or if there are any other signs that baby might not be thriving—your practitioner will take action, and depending on the situation, either induce labor or perform a cesarean delivery. Which means that even if you don't end up going into labor on your own, you won't be pregnant forever.

What to Take to the Hospital or Birthing Center

It's smart to think ahead about what you'll want to take to the hospital or birthing center (and to pack ahead, too). But it's also smart to think about traveling on the light side, packing only what you think you'll need—and not everything on this list:

For the Birthing Room

- This book, *What to Expect the First Year*, and *The What to Expect Pregnancy Journal and Organizer*, which has ample room for labor-and-delivery and meet-the-baby note keeping. Of course, you'll also have a phone with you—which means you'll have easy access to the What To Expect app.
- Several copies of your birth plan, if you're using one (see page 323)
- The cord blood collection kit, if you're planning to have your baby's cord blood banked
- A watch with a second hand for timing contractions (or you can use the digital timer on your phone)
- A portable music device (or your phone) loaded with your favorite playlist, if music soothes and relaxes you. Don't forget your chargers.
- A camera and/or video equipment (plus chargers) if you think the camera on your phone won't cut it
- A laptop or tablet (plus chargers)
- Favorite lotions or oils for massages
- A tennis ball or back massager, for firm countermassage
- Your own pillow, for comfort
- Sugarless lollipops or candies to keep your mouth moist
- A toothbrush, toothpaste, mouthwash, face wipes, and body wipes (you may find yourself desperate for a freshen-up)
- A robe if you don't feel like walking the halls during labor in only your hospital gown
- Heavy socks, in case your feet get cold

Your Birthing Room Guest List

"I'd really love to share our baby's birth with my sisters, my best friend, and of course my mom. Can they all be in the birthing room with my husband and me?"

Already planning your labor (and delivery) party? If you're like more and more moms-to-be, the guest list is getting longer and longer. Giving birth surrounded and supported by family and friends is a trend that's pretty popular in birthing circles.

Why is more potentially merrier on labor day? For many moms-to-be delivering at home or at a birthing center, it seems only natural to have the family around—including baby's older sibs. And for moms delivering in the hospital and choosing an epidural, there's more opportunity to socialize with little or no pain to deal with—or breathe through. Moms who plan to labor unmedicated may also appreciate the support of an extended support network. What's more, hospitals and birthing centers are accommodating the maternity mob, making some birthing rooms bigger

- Comfortable slippers with nonskid bottoms
- A scrunchie, clip, or hairband, if your hair is long, to keep it out of your face and tangle-free. A hairbrush and detangling comb, too, if you think they'll come in handy.
- Snacks for your coach, so he won't have to leave your side when his stomach starts growling. And snacks for you, too, if your practitioner allows eating during labor.

For the Postpartum Room

- A robe, comfy pj's, or a nightgown (with easy breastfeeding access if you're nursing), if you'd rather not wear hospital-issue
- A change of clothes for your coach, plus a toothbrush and anything else he might need for rooming-in
- Toiletries, including shampoo and conditioner, body wash, deodorant, and any makeup you can't live (or take pictures) without
- Your preferred brand of maxipads, though the hospital will provide some
- A couple of changes of underwear and a nursing bra
- A supply of healthy snacks to supplement hospital food (food delivery is also an option)
- A going-home outfit for you, keeping in mind that you'll still be sporting a sizable belly
- A going-home outfit for baby that's weather appropriate and practical (you'll need to accommodate the car seat straps). Add a receiving blanket and a heavy bunting or blanket if it's cold. Diapers will probably be provided by the hospital, but bring along a few extra, just in case.
- Infant car seat. Most hospitals will not let you leave with the baby unless he or she is safely strapped into an approved rear-facing infant car seat. Besides, it's the only safe way to travel with a baby—and it's the law. To avoid last-minute fumbles, attach the car seat base (and practice seat installation) well before your due date.

(more equipped to handle the overflow of guests) and more comfortable (complete with sofas and extra chairs for visitors to plop down on while they're waiting for the headliner to make his or her debut). And having a gaggle of girlfriends, a set or two of in-laws, and maybe a few other assorted relatives may be a win-win for birth attendants, too. Many practitioners reason that having more distraction, support, and back-rubbing hands makes a mom-to-be happier and more relaxed during labor—always a good thing, whether it's a medicated birth or not.

Clearly, there are lots of good reasons why you might want an encouraging entourage in the birthing room with you. Still, there are a few caveats to consider before you issue the invites: You'll have to get the practitioner-powers-that-be to sign off on your guest list (not all practitioners are crowd friendly, and some hospitals and birthing centers cap the number of guests you're allowed, or ask that young children not be part of the party). You'll also have to be sure your spouse is on board with the guest list (remember, even though you'll be doing most of the work,

Can You Eat Your Way to Labor?

Hungry for labor? Ready to do—or eat—anything that might trigger that first real contraction? Though there's no science backing them up, plenty of old wives (and new moms) will tell you about a last (pregnant) supper that ended with a trip down labor lane. Among the often heard: If your tummy can take the heat, dip into something spicy. Or order something that gets your bowels—and hopefully your uterus—in an uproar (a crate of bran muffins, chased down by a bucket of prune juice, perhaps?). Not in the mood for something so stimulating? Some women swear by eggplant, tomatoes, and balsamic vinegar (not necessarily together, though it sounds like a yummy Italian salad combo or pizza topping), while others claim pineapple buys a ticket on the Labor Express. Whatever you dig into, remember that unless your baby and your body are ready to take the labor plunge, it's unlikely that dinner's going to push you over the edge.

both of you are cohosting the birth, and he won't want to be relegated to the B-list). Think about, too, whether you'll really be comfortable with so many eyes on you during a very personal moment (there will be moaning, grunting, peeing, a little pooping—and you will be half naked). Something else to ponder: Will those you've invited (your brother, your father-in-law, or your other children, for example) be comfortable with what you're inviting them to view—and could their discomfort put you on edge when you most need to be relaxed? Will you want everyone standing around chatting when you're craving peace and quiet (and rest)? Will you feel obligated to entertain your guests or pay attention to your other kids when you need to be focused on birthing your baby?

If you decide you'd like the company, just remember to put flexibility on the list, too. Remember (and remind your guests) that there's always the possibility your intended uneventful vaginal birth may turn into an unexpected c-section, in which case only the expectant dad will be allowed to follow the party into the OR. Or that you'll decide—say somewhere around the second hour of pushing—that you're not up for guests anymore and they might be shown to the door for delivery. (And if you do end up regretting your decision to invite a crowd, don't worry about hurting anyone's feelings by sending the guests packing—as a woman in labor, your feelings are the only ones that matter.)

Not feeling like inviting a crowd? Don't let trends—or pushy relatives—guilt you into a full birthing room. What feels right for you and your partner is the right decision.

Being a Mom

"Now that the baby's almost here, I'm beginning to worry about how I'm going to take care of her. I don't know anything about babies or being a mom—I've never even held a newborn before."

Here's the very first thing you need to know about becoming a mom: Babies are born, but moms aren't. As much hype as maternal instincts get, the truth is that becoming comfortable as a mom takes more than hormones—it

FOR FATHERS

Rookie Nerves

Over the moon at the thought of becoming a dad for the first time—but also more than a little overwhelmed? Worried that fatherhood won't come as naturally to you as it does to other dads (those dads you see wearing babies and pushing strollers and swings everywhere you look)? Not to worry—few men are born fathers, any more than women are born mothers. Though parental love may come naturally, parental skills (the stuff you're probably stressed out about) have to be learned. Like every other new dad and mom, you'll grow from nervous rookie to confident pro one challenge, one bath, one all-night rocking session, one cuddle and coo at a time. Gradually, with practice, patience, persistence, and a lot of love (that'll be the easy part, once you gaze into that little face), the role that seems daunting—yes, terrifying—now will become second nature.

That said, though you'll learn plenty on the job—and from your mistakes, which every new parent makes plenty of—you might feel a little more comfortable with some basic training. Fortunately, classes that teach all the baby basics—from diapering to bathing, feeding to playing—are finding their way into communities across the country. There are classes you can take as a couple, as well as ones that are just for dads (including many run by Boot Camp for New Dads) in hospitals, community centers, and military bases nationwide. Ask about local options for classes at your next prenatal appointment or at your childbirth education class, check into them at the hospital or birthing center where you'll be delivering, or search for local classes at bootcampfornewdads.org. You can also learn the ropes by reading *What to Expect the First Year*. If you have friends or coworkers who have newborns, turn to them for some hands-on instruction. Ask them to let you hold, diaper, and play with their babies while they give you new-parent pointers.

While you're learning your baby basics, keep in mind that some of the most important skills you can bring to parenting are the ones you'll hopefully never have to use: infant safety and CPR. Take a class together before baby's arrival.

And remember, too, as you learn, that just as moms have different parenting techniques, so do dads. Relax, trust your instincts (surprise . . . dads have them, too), and feel free to find the style that works for both you and your baby. Before you know it, you'll be fathering with the best of them.

takes time and practice . . . practice that can only come on the job. Which means that for the first week or two, and often longer, a new mom (just like a new dad, by the way) can feel like she's not up for the job—especially as her baby does more crying than sleeping, the diapers leak, and many tears are shed over the "no tears" shampoo (on both sides of the bottle).

Slowly but surely—one dirty diaper, one marathon feeding session, one sleepless night at a time—every new mom (even the greenest . . . even you!) begins to feel like an old pro. Trepidation turns to assurance. The baby she was afraid to hold (won't it break?) is now cradled casually in her left arm while her right pays bills online or pushes the vacuum cleaner.

Stocking Up

Your kitchen, that is. Though shopping for strollers, diapers, and pint-size clothing understandably has been your priority these days, don't forget to take a time-out at the market. Even with swollen ankles and a supersize belly weighing you down, shopping is easier 9 months pregnant than it will be again for a long time—so take advantage and stock up now so you won't have to later with baby (and car seat, and diaper bag) in tow. Fill your pantry, fridge, and freezer to the brim with healthy foods that are easy to serve—cheese sticks, individual containers of yogurt, frozen fruit bars, frozen fruit for making smoothies, cereal, granola bars, soups, freeze-dried fruit, and nuts. Don't forget the paper products, too (you'll be using paper towels by the crateful, and disposable plates and cups can fill in when you don't get around to running the dishwasher). And while you're in the kitchen—and have the time—cook up some extra servings of your favorite freezer-friendly foods (lasagna, mini meat loaves, chili, pancakes, muffins), and store them in clearly marked single-meal containers in the freezer. They'll be ready to pop in the microwave when you're pooped (and hungry) postpartum.

Feel much more like dropping than shopping? Now's also a great time to explore online grocery delivery (if you haven't already)—which could come in pretty handy once your hands are full of baby.

She can dispense vitamin drops, give baths, and slip squirming arms and legs into onesies in her sleep—literally, sometimes. As she hits her mommy stride and settles into a somewhat predictable rhythm, parenting an infant becomes second nature. She feels those instincts kicking in, sending those nagging self-doubts packing—at least, most of them. She starts to feel like the mom she is, and—difficult though it may be to imagine right now—you will, too.

Though nothing can make those first days with a first baby a cinch, starting the learning process before your newborn is placed in your arms (and in your round-the-clock care) can make them seem a little less overwhelming. Any of the following can help soon-to-be moms (and dads) ease into their new roles: holding, diapering, and soothing a friend's or family member's infant, reading up on baby basics in *What to Expect the First Year*, and watching parenting videos or taking a class in baby care (and baby CPR).

For even more reassurance, talk to friends—online or next door—who have recently become parents (no one can teach you more about being a mom than another mom). You'll be surprised—and relieved—to know that just about everybody comes into the job with the same new mom (or new dad) jitters.

ALL ABOUT:

Prelabor, False Labor, Real Labor

It always seems so simple in the movies. Somewhere around 3 a.m., the expectant mom sits up in bed, puts a knowing hand on her (perfectly proportioned) belly, and reaches over to rouse her sleeping spouse with a calm (or crazed), "Honey, it's time."

But how, you wonder, does she know it's time? How does she recognize labor with such cool, clinical confidence when she's never been in labor before? What makes her so sure she's not going to get to the hospital, be examined by the resident, found to be nowhere near her time, and be sent home, amid snickers from the night shift, just as pregnant as when she arrived? The script, of course.

On your side of the screen (with no script in hand), you're more likely to awaken at 3 a.m. with complete uncertainty. Are these really labor pains or just more Braxton Hicks? Should I turn on the light and start timing? Should I bother to wake my spouse? Do I drag my practitioner out of bed in the middle of the night to report what might really be false labor? If I do and it isn't time, will I turn out to be the mom who cried "labor" once too often, and will anybody take me seriously when it's for real? Or will I be the only one in my childbirth class not to recognize labor? Will I leave for the hospital too late, maybe giving birth in the backseat (and making media headlines)? The questions multiply faster than the contractions.

The fact is that most women, worry though they might, don't end up misjudging the onset of their labor. The vast majority, thanks to instinct, luck, or no-doubt-about-it killer contractions, show up at the hospital or birthing center neither too early nor too late, but at just about the right time. Still, there's no reason to leave your judgment up to chance. Becoming familiar in advance with the signs of prelabor, false labor, and real labor will help allay the concerns and clear up the confusion when those contractions (or are they?) begin.

Prelabor Symptoms

Before there's labor, there's prelabor—a sort of pregame show that sets things up before the main event. The physical changes of prelabor can precede real labor by a full month or more—or by only an hour or so. Prelabor is characterized by the beginning of cervical effacement and dilation, which your practitioner can confirm on examination, as well as by a wide variety of related signs that you may notice yourself (though not all moms will experience them all):

Dropping. Usually somewhere between 2 and 4 weeks before labor starts in first-time mothers, the fetus begins to settle down into the pelvis. This milestone is rarely reached in second or later births until labor is about to kick off.

Sensations of increasing pressure in the pelvis and rectum. Crampiness (similar to menstrual cramps) and groin pain are common—and particularly likely in second and later pregnancies. Persistent low backache may also be present.

Loss of weight or no gain. Weight gain might slow down in the 9th month—and as labor approaches, you might

Ready or Not

To make sure you're ready for your baby's arrival when he or she is ready to arrive, start reading up now about labor and delivery in the next chapter.

even lose a bit of weight, as much as 2 to 3 pounds.

A change in energy levels. Some 9th-monthers find that they are increasingly exhausted. Others experience energy spurts. An uncontrollable urge to scrub floors and clean out closets has been related to the "nesting instinct," in which the female of the species—that's you—prepares the nest for the impending arrival (see page 383).

A change in vaginal discharge. If you've been watching your undies closely, you may find your discharge increases and thickens.

Loss of the mucous plug. As the cervix begins to thin and open, the "cork" of mucus that seals the opening of the uterus may becomes dislodged (see page 396). This gelatinous chunk of mucus can be passed through the vagina a week or two before the first real contractions, or just as labor begins. Not everyone notices the passing of their mucous plug—but if you're watching the toilet and toilet paper closely, it's usually hard to miss if you lose it.

Pink, or bloody, show. As the cervix effaces and dilates, capillaries frequently rupture, tinting the mucus pink or streaking it with blood (see page 397). This "show" usually means labor will start within 24 hours—though it could be as much as several days away.

Intensification of Braxton Hicks contractions. These practice contractions (see page 340) may become more frequent and stronger, even very painful.

Diarrhea. Some women experience loose bowel movements just before labor starts.

False Labor Symptoms

Is it or isn't it? Real labor probably has not begun if:

- Contractions are not at all regular and don't increase in frequency or severity. Real contractions won't necessarily fall into a neat textbook pattern, but they will become more intense and more frequent over time.
- Contractions subside if you walk around or change your position (though this can sometimes be the case in early "real" labor, too).
- Show, if any, is brownish. This kind of discharge is often the result of an internal exam or intercourse within the past 48 hours.
- Fetal movements intensify briefly with contractions.
- Contractions start and stop . . . and start and stop. This frustrating form of false labor—when contractions start becoming more regular (if not closely spaced) for a period of time, then taper off, then start up again and taper off again—is also known as prodromal labor, and it can linger on and off for days.

Keep in mind that false labor isn't a waste of time—even if you've driven all the way to the hospital or birthing center only to get sent home. It's your body's way of getting pumped, primed, and prepped, so when the time comes, it'll be ready—whether you are or not.

Real Labor Symptoms

No one knows exactly what triggers real labor (and more just-about-due moms are concerned with "when" than "why"), but it's believed that a combination of factors are involved. This very intricate process begins with the fetus, whose brain sets off a relay of chemical messages (which probably loosely translate into something like, "Mom, let me out of here!") that kick off a chain reaction of hormones in the mother. These hormonal changes in turn pave the way for the work of prostaglandins and oxytocin, substances that trigger contractions when all labor systems are "go."

You'll know that the contractions of prelabor have been replaced by true labor if:

- The contractions intensify, rather than ease up, with activity and aren't relieved by a change in position.
- Contractions become progressively more frequent and painful, and generally (but not always) more regular. Each contraction won't necessarily be more painful or longer (they usually last about 30 to 70 seconds) than the last one, but the intensity does build up as real labor progresses. Frequency doesn't always increase in regular, perfectly even intervals, either—but it does increase.
- Early contractions feel like gastrointestinal upset, or like heavy menstrual cramps, or like lower abdominal pressure. Pain may be just in the lower abdomen or in the lower back and abdomen, and it may also radiate down into the legs (particularly the upper thighs). Location, however, is not as reliable an indication, because false labor contractions may also be felt in these places.

In 15 percent of labors, the water breaks—in a gush or a trickle—before labor begins. But in many others, the membranes rupture spontaneously during labor, or are ruptured artificially by the practitioner.

When to Call the Practitioner

Your practitioner has likely told you when to call if you think you're in labor (when contractions are 5 to 7 minutes apart, for instance, though your practitioner may have given you different parameters). Don't wait for perfectly even intervals—they may never come. If you're not sure you're in real labor—but the contractions are coming pretty regularly—call anyway. Your practitioner will probably be able to tell from the sound of your voice, as you talk through a contraction, whether it's the real thing—but only if you don't try to cover up the pain in the name of good phone manners. Even if you've checked and rechecked the above lists and you're still unsure, call your practitioner. Don't feel guilty about waking him or her in the middle of the night (people who deliver babies for a living don't expect to work 9 to 5) or be embarrassed if it turns out to be a false alarm (you wouldn't be the first expectant mom to misjudge her labor signs, and you won't be the last). Don't assume that if you're not sure it's real labor, it isn't. Err on the side of caution and call.

Also call your practitioner immediately if contractions are increasingly strong but your due date is still weeks away, if you notice bright red blood, if your water breaks with or without labor, if your water breaks and it has a greenish-brown tint, or if you feel something slipping out into your cervix or vagina after your water has broken (it could be the umbilical cord).

CHAPTER 14

Labor and Delivery

Are you counting down the days? Eager to see your feet again? Desperate to sleep on your stomach—or just plain desperate to sleep? Don't worry—the end (of pregnancy) is near. And as you contemplate that thrilling moment—when your baby will finally be in your arms instead of inside your belly—you're probably also giving a lot of thought to (and coming up with a lot of questions about) the process that will make that moment possible: labor and delivery. When will labor start? More important, when will it end? Is that pee in my pants, or did my water just break? Will I be able to handle the pain? Will I need an epidural (and when can I have one)? A fetal monitor? An IV? What if I want to labor—and deliver—in a tub? Without any meds? What if I don't make any progress? What if I progress so quickly that I don't make it to the hospital or birthing center in time?

Armed with answers to these (and other) questions—plus the support of your partner and your birth attendants—you'll be prepared for just about anything that labor and delivery might bring your way. Just remember the most important thing that labor and delivery will bring your way (even if nothing else goes according to plan): that beautiful new baby of yours.

What You May Be Wondering About

Mucous Plug

"I think I lost my mucous plug. Does that mean labor is about to start?"

It may be a rite of pregnancy passage (some might say, a slightly yucky one) but passing the mucous plug isn't a sign that labor's about to start. It's not even

universally experienced among about-to-be-moms. The mucous plug—the clear, globby, gelatinous blob-like barrier that has corked your cervix throughout your pregnancy—often becomes dislodged as dilation and effacement begin. Some women notice the popping of this mucous plug (what exactly is that in the toilet?), others don't (especially if you're the flush-and-rush type). Though the passage of the plug is a sign that your body's gearing up for the big day, it's not a reliable signal that the big day has arrived—or even that it's around the corner. At this point, labor could be days, or even weeks, away, with your cervix continuing to open gradually over that time. In other words, there's no need to call your practitioner or frantically pack those last minute items into your bags just yet. There's also no need to worry about your baby's safety now that you're unplugged. In fact, your cervix continues to make mucus to protect the cervical opening and prevent infection, which means baby's still snugly sealed off—and it means that you can have sex, take a bath, and otherwise go about your business even after you've lost your plug.

No plug in your pants or your toilet? Not to worry. Many women don't lose it ahead of time, and that doesn't predict anything about the eventual progress of labor.

Bloody Show

"I have a pink mucousy discharge. Does it mean labor's about to start?"

Sounds like it's bloody show time—and happily, this particular production is a preview of labor very soon to come. Passing that bloody show, a mucousy discharge tinged pink or brown with blood, is usually a sign that the blood vessels in the cervix are rupturing as it dilates and effaces and the process that leads to delivery is well under way (and that's something to applaud!). Once the bloody show has made its debut in your underwear or on the toilet paper, chances are your baby's arrival is just a day or two away. But since labor is a process with an erratic timetable, you'll be kept in suspense until the first true contractions strike. Keep in mind, passing bloody show is different from passing the mucous plug. Though they definitely have mucous in common, bloody show is a discharge (and it's blood-tinged), while the mucous plug is more of a one-time gelatinous glob. Bloody show means it's almost show time, mucous plug means . . . maybe not so fast.

If your discharge suddenly becomes bright red (instead of blood-tinged or streaked), contact your practitioner right away.

Your Water Breaking

"I woke up in the middle of the night with a wet bed. Did I lose control of my bladder, or did my water break?"

A sniff of your sheets will probably clue you in. If the wet spot smells sort of sweet (not like urine, which has the harsher odor of ammonia), it's probably amniotic fluid your sheets are soaked in—and that's a sign that your membranes have probably ruptured (your water has broken). Another sign: You continue leaking the pale, straw-colored fluid. Another test: You can try to stem the flow of the fluid by squeezing your pelvic muscles (Kegel exercises). If the flow stops, it's urine. If it doesn't, it's amniotic fluid.

You are more likely to notice the leaking while you are lying down. It usually stops, or at least slows, when you stand up or sit down, since baby's head acts as a cork, blocking the flow temporarily. The leakage is heavier—whether

you're sitting or standing—if the break in the membranes is down near the cervix than if it is higher up.

Your practitioner has probably given you a set of instructions to follow if your water breaks. If you don't remember the instructions or have any doubts about how to proceed—call, night or day.

"My water just broke, but I haven't had any contractions. When is labor going to start, and what should I do in the meantime?"

It's likely that labor's on the way—and soon. Most women whose membranes rupture before labor begins can expect to feel the first contraction within 12 hours of that first trickle, while most others can expect to feel it within 24 hours.

About 1 in 10, however, find that labor takes a little longer to get going. To prevent infection through the ruptured amniotic sac (the longer it takes for labor to get going, the greater the risk), most practitioners induce labor within 24 hours of a rupture if a mom-to-be is at or near her due date, and a few induce as early as 6 hours after. Many women who have experienced a rupture actually welcome a sooner-than-later induction, preferring it to 24 hours of wet waiting.

The first thing to do if you experience a trickle or flow of fluid from your vagina—besides grab a towel and a box of pads—is call your practitioner (unless he or she has instructed otherwise). In the meantime, keep your vaginal area as clean as possible to avoid infection: Don't have sex (not that there's much chance you'd want to right now), use a pad (not a tampon) to absorb the flow, don't try to do your own internal exam, and, as always, wipe from front to back when you use the toilet.

Rarely, when the membranes rupture before labor begins and the baby's presenting part is not yet engaged in the pelvis (more likely when the baby is breech or preterm), the umbilical cord can become "prolapsed"—it is swept into the cervix, or even down into the vagina, with the gush of amniotic fluid. If you can see a loop of umbilical cord at your vaginal opening, or think you feel something inside your vagina, call 911. For more on what to do if the cord is prolapsed, see page 568.

Darkened Amniotic Fluid

"My membranes ruptured, and the fluid isn't clear—it's greenish brown. What does this mean?"

Your amniotic fluid is probably stained with meconium, a greenish-brown substance that is actually your baby's first bowel movement. Ordinarily, meconium is passed after birth as a baby's first stool. But sometimes—such as when the fetus has been under stress in the womb, and more often when the due date has come and gone—meconium is passed before birth into the amniotic fluid.

Meconium staining alone is not a sure sign of fetal distress, but because it suggests the possibility of distress, notify your practitioner right away. He or she will likely want to get labor started (if contractions aren't already in full swing) and will monitor your baby very closely throughout labor.

Low Amniotic Fluid During Labor

"My doctor said that my amniotic fluid is low and she needs to supplement it. Should I be concerned?"

Usually, nature keeps the uterus well stocked with a self-replenishing supply of amniotic fluid. Fortunately, even when levels do run low during labor, medical science can step in and supplement that natural source with a saline solution pumped directly into the amniotic sac through a very thin and flexible catheter inserted through the cervix into the uterus. This procedure, called amnioinfusion, can significantly reduce the possibility that a surgical delivery will become necessary because of fetal distress.

Irregular Contractions

"In childbirth class we were told not to go to the hospital until the contractions were regular and 5 minutes apart. Mine are less than 5 minutes apart, but they aren't at all regular. I don't know what to do."

Just as no two women have exactly the same pregnancies, no two women have exactly the same labors. The labor often described in books and online, in childbirth education classes, and by practitioners is what is typical—close to what many expectant moms can expect. But far from every labor is true-to-textbook, with contractions regularly spaced and predictably progressive.

If you're having strong, long (20 to 60 seconds), frequent (mostly 5 to 7 minutes apart or less) contractions, even if they vary considerably in length and time elapsed between them, don't wait for them to become regular before calling your practitioner or heading for the hospital or birthing center—no matter what you've heard or read. It's possible your contractions are about as regular as they're going to get and you're well into the active phase of your labor. Either way, better to play it safe than play it by the book.

Calling Your Practitioner During Labor

"I just started getting contractions and they're coming every 3 or 4 minutes. I feel silly calling my doctor, who said we should spend the first several hours of labor at home."

Better silly than sorry. It's true that most first-time moms-to-be (whose labors are usually initially slow-going, with a gradual buildup of contractions) can safely count on spending the first several hours at home, leisurely finishing up their packing and their baby prep. But it doesn't sound like your labor's fitting that typical first-timer pattern. If your contractions have started off strong—lasting at least 45 seconds and coming more frequently than every 5 minutes—your first several hours of labor may very well be your last (and if you're not a first-timer, your labor may be on an even faster track). Chances are much of the first stage of labor has passed painlessly and your cervix has dilated significantly during that time. This means that not calling your practitioner, chancing a dramatic dash to the hospital or birthing center at the last minute—or not getting there in time—might be sillier than picking up the phone now.

So by all means call. When you do, be clear and specific about the frequency, duration, and strength of your contractions. Since your practitioner is used to judging the phase of labor in part by the sound of a woman's voice as she talks through a contraction, don't try to downplay your discomfort, put on a brave front, or keep a calm tone when you describe what you're experiencing. Let the contractions speak for themselves, as loudly as they need to. For the

Emergency Delivery If You're Alone

You'll almost certainly never need the following instructions—but just in case, keep them handy.

1. Try to remain calm. You can do this.

2. Call 911 for the emergency medical service. Ask them to contact your practitioner.

3. Find someone nearby to help, if possible (call a neighbor, coworker, or friend).

4. Start panting to keep yourself from pushing.

5. Wash your hands and then your vaginal area with soap and water or use a wipe or hand sanitizer.

6. Spread some clean towels or sheets on a bed, sofa, or the floor, and gather other towels or blankets in case baby arrives. Unlock the door so that help can get in easily when it arrives, and then lie back, propping yourself up on pillows.

7. If despite your panting the baby starts to arrive before help does, gently ease him or her out by pushing each time you feel the urge.

8. As the top of the baby's head begins to appear, pant or blow (do not push), and press gently on your perineum (the area right under where the head is emerging) to keep the head from popping out suddenly. Let the head emerge gradually—don't pull it out. If there is a loop of umbilical cord around the baby's neck, hook a finger under it and gently work it over the baby's head.

9. Next, hold baby's head gently in both hands and, if you can, press it very slightly downward (do not pull), pushing at the same time, to deliver the front shoulder. As the upper arm appears, lift the head carefully, feeling for the rear shoulder to deliver. Once the shoulders are free, the rest of your baby should slip out easily.

10. Place baby on your abdomen or, if the cord is long enough (don't tug at it), on your chest—the skin-to-skin contact will warm baby. Quickly wrap blankets or towels over the baby.

11. Wipe baby's mouth and nose with a clean towel or cloth, and run your fingers from the inside corners of baby's eyes down the outsides of the nostrils to help drain the amniotic fluid. If help hasn't arrived and the baby isn't breathing or crying, rub his or her back, keeping the head lower than the feet. If breathing still hasn't started, clear out baby's mouth some more with a clean finger and give 2 quick and extremely gentle puffs of air into his or her nose and mouth.

12. Don't try to pull the placenta out. But if it emerges on its own before help arrives, wrap it in towels, and keep it elevated above the level of the baby, if possible. There is no need to cut the cord. If help is a long way off, tie the cord with a string or shoelace about 2 to 3 minutes after delivery.

13. Keep yourself and your baby warm and comfortable until help arrives.

same reason, don't have your partner do the speaking for you—even if you're not (understandably) in a chatty mood.

If you feel you're ready but your practitioner doesn't seem to think so, ask if you can go to the hospital/birthing center or to your practitioner's office and have your progress checked. Take your bag along just in case, but be ready to turn around and go home if

you've only just begun to dilate—or if nothing's going on at all.

Not Getting to the Hospital in Time

"I'm afraid I won't get to the hospital in time."

Fortunately, most of those sudden deliveries you've heard about take place on TV. In real life, deliveries (especially those of first-time moms) rarely occur without plenty of heads-up—and plenty of time to get to the hospital. But once in a really great while, a woman who hasn't felt any contractions, or has felt them only sporadically, suddenly feels an overwhelming urge to bear down. Often she mistakes it for a need to go to the bathroom (cue the "I delivered in the toilet" reenactment video).

Again, super unlikely to happen to you. Still, it's a good idea for both you and your coach to become familiar with the basics of an emergency delivery (see boxes facing page and page 402). Once that's done, sit back and relax, knowing you're prepared for something that you're far more likely to see on reality TV than really experience.

Having a Short Labor

"I always hear about women who have really short labors. How common are they?"

While they make for good stories, not all of the short labors you've heard about are as short as they seem. Often, an expectant mom who appears to have a quickie labor has actually been having painless contractions for hours, days, even weeks—contractions that have been dilating her cervix gradually. By the time she finally feels one, she's well into the final stage of labor.

That said, occasionally the cervix dilates very rapidly, accomplishing in a matter of minutes what the average cervix (particularly a first-time mom's cervix) takes hours to do. And happily, even with this abrupt, or "precipitous," kind of labor (one that takes 3 hours or less from start to finish), there is usually no risk to the baby.

If your labor seems to start with a bang—with contractions strong and close together—get to the hospital or birthing center quickly (so you and your baby can be monitored closely). Medication may be helpful in slowing contractions a bit to ease the pressure on your baby, on your own body, and on your emotional state (sometimes a mom-to-be who's having a very fast labor becomes understandably agitated, so slowing down the labor can help calm her).

Back Labor

"The pain in my lower back since my contractions began is so bad that I don't see how I'll be able to make it through labor."

What you're probably experiencing is known in the birthing business as "back labor"—and it definitely is a pain. A lot of pain. Technically, back labor occurs when the fetus is in a posterior position, with its face up and the back of its head pressing against your sacrum, or the back of your pelvis. (Ironically, this position is nicknamed "sunny-side up," though there's nothing cheerful about back labor.) It's possible, however, to experience back labor when the baby isn't in this position or to continue to experience it after the baby has flipped or been turned to a face-down position—possibly because the area has already become a focus of tension.

FOR FATHERS

Emergency Delivery Tips for the Coach

At Home or the Office

1. Try to remain calm while at the same time comforting and reassuring the mom. Remember, even if you don't know the first thing about delivering a baby, a mother's body and her baby can do most of the job on their own.

2. Call 911 to dispatch emergency medical service. Ask them to call the practitioner.

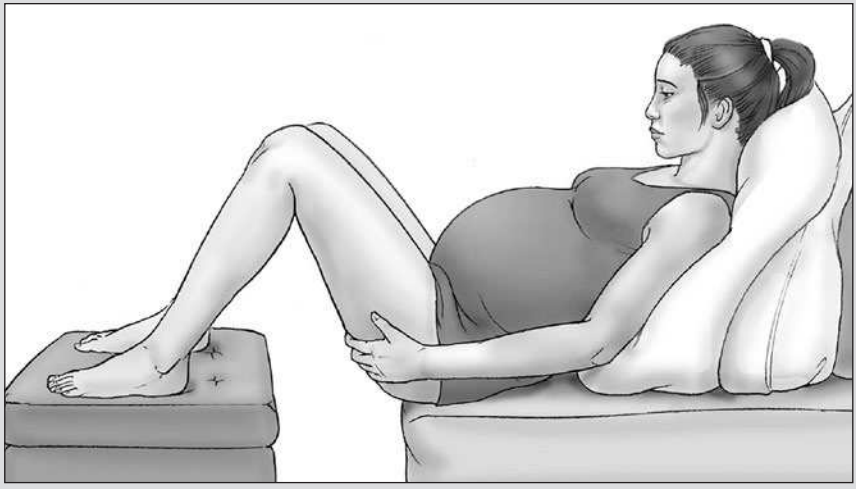
3. Have the mom start panting, to keep from pushing.

4. Wash your hands and the vaginal area with soap and water (or use a wipe or hand sanitizer).

5. If there's time, place the mom on the bed or sofa (or as a last resort on a desk or table) with her buttocks slightly hanging off, her hands under her thighs to keep them elevated. If available, an ottoman or footstool can support her feet. Protect delivery surfaces, if possible, with towels or sheets. If baby's head is already appearing, place a few pillows or cushions under the mom's shoulders and head to help raise her to a semi-sitting position, which can aid delivery. If baby's head hasn't appeared yet, having the mom lie flat or on her side may slow delivery until help arrives.

6. As the top of the baby's head begins to appear, have the mom pant or blow (not push), and press gently against her perineum (the area between the vagina and the anus) to apply slight pressure to keep the head from popping out suddenly. Let the head emerge gradually—never pull on it. If there is a loop of umbilical cord around the baby's neck, hook a finger under it and gently work it over the baby's head.

7. Next, take the head gently in both hands and press it very slightly downward (do not pull), asking mom to push at the same time, so you can deliver the front shoulder. As the upper arm appears, lift the head carefully, watching for the rear shoulder to deliver. Once the shoulders are free, the rest of the baby should slip out easily.



8. Place the baby on the mom's belly or, if the cord is long enough (don't tug at it), on her chest. Quickly wrap the baby in blankets, towels, or anything else that's clean.

9. Wipe baby's mouth and nose with a clean cloth and run your fingers from the inside corners of baby's eyes down the outsides of the nostrils to help drain fluid. If help hasn't arrived and the baby isn't breathing or crying, rub his or her back, keeping the head lower than the feet. If breathing still hasn't started, clear out baby's mouth some more with a clean finger, and give 2 quick and extremely gentle puffs of air into the nose and mouth.

10. Don't try to pull out the placenta. But if it emerges on its own before emergency assistance arrives, wrap it in towels, and keep it elevated above the level of the baby, if possible. There's no need to cut the cord, but you should tie it with a string or shoelace 2 to 3 minutes after birth if help hasn't arrived.

11. Keep both mom and baby warm and comfortable until help arrives.

En Route to the Hospital or Birthing Center

If you're in your car and delivery is imminent, pull over to a safe area, turning on your hazard lights. Call 911. If someone stops, ask for help contacting 911 or the local emergency medical service. If you're in a cab, ask the driver to radio or call for help.

If possible, help the mom into the back of the car. Place a coat, jacket, or blanket under her. Then, if help has not arrived, proceed as for a home delivery. As soon as the baby is born, quickly head to the nearest hospital unless the emergency dispatcher has told you help is on the way.

When you're having this kind of pain—which often doesn't let up between contractions and can become excruciating during them—the cause doesn't matter much. How to relieve it, even slightly, does. If you're opting to have an epidural, go for it (there's no need to wait, especially if you're in a lot of pain). It's possible that you might need a higher dose than usual to get full comfort from the back labor pain, so let the anesthesiologist know about it. Other options (such as narcotics) also offer pain relief. If you'd like to stay med-free, several measures may help relieve the discomfort of back labor—all are at least worth trying:

Taking the pressure off. Try changing your position. Walk around (though this may not be possible once contractions are coming fast and furious), crouch or squat, get down on all fours, lean or sit on a birthing ball, do whatever is most comfortable and least painful for you. If you feel you can't move and would prefer to be lying down, lie on your side, with your back well rounded—in a sort of fetal position.

Heat or cold. Have your coach (or doula or nurse) use warm compresses, a heating pad, ice packs, or cold compresses—whichever soothes best. Or alternate heat and cold.

Counterpressure and massage. Have your coach experiment with different ways of applying pressure to the area of greatest pain, or to adjacent areas, to find one or more that seem to help. He can try his knuckles, the heel of one hand reinforced by pressure from the other hand on top of it, a tennis ball, or a back massager, using direct pressure or a firm circular motion. Cream, oil, or powder can be applied periodically to reduce irritation.

Reflexology. For back labor, this therapy involves applying strong finger pressure just below the center of the ball of the foot.

Other alternative pain relievers. Hydrotherapy (a warm shower or jetted bath) can ease the pain somewhat. If you've had some experience with meditation, visualization, or self-hypnosis for pain, try these, too. They often work, and they certainly couldn't hurt.

Labor Induction

"My doctor wants to induce labor. But I'm not overdue yet, and I thought induction was only for overdue babies."

Sometimes Mother Nature needs a little help making a mother out of a pregnant woman. About 20 percent of pregnancies end up needing that kick in the maternity pants, and though a lot of the time induction is necessary because a baby is overdue, there are many other reasons why your practitioner might feel that nature needs a nudge, such as:

- Your membranes have ruptured and contractions have not started on their own within 24 hours (though some practitioners induce much sooner).
- Tests suggest that your uterus is no longer a healthy home for your baby because the placenta is no longer functioning optimally, amniotic fluid levels are low, or for another reason.
- Tests suggest that the baby isn't thriving and is mature enough to be delivered.
- You have a complication, such as preeclampsia or gestational diabetes, or a chronic or acute illness that makes it risky to continue your pregnancy.
- There's a concern that you might not make it to the hospital or birthing center on time once labor has started, either because you live a long distance away or because you've had a previous very short labor (or both).

If you're still unsure about your doctor's reasons for inducing labor, ask for a more substantial and satisfying explanation. To find out all you'll need to know about the induction process, keep reading.

"How does induction work?"

Induction, like naturally triggered labor, is a process—and sometimes a pretty long process. But unlike naturally triggered labor, your body will be getting some help with the heavy lifting if you're induced. Labor induction usually involves a number of steps (though you won't necessarily go through all of these steps):

- First, your cervix will need to be ripened (or softened) so that labor can begin. If you arrive with a ripe cervix, great—you'll probably move ahead to the next step. If your cervix is not dilated, not effaced, and not soft at all, your practitioner will likely administer a hormonal substance such as prostaglandin E in the form of a vaginal gel (or a vaginal suppository in tablet form) to get things started. In this painless procedure, a syringe is used to place the gel in the vagina close to your cervix. After a few hours or longer of letting the gel do its work, you'll be checked to see if your cervix is getting softer and beginning to efface and dilate. If it isn't, a second dose of the prostaglandin is administered. In many cases, the gel is enough to get contractions and labor started. If your cervix is ripe enough but contractions have not begun, the induction process continues. (Some practitioners use devices designed to

Membrane Stripping

Stripping the membranes (also known as membrane sweeping) is one way your practitioner may try to jump-start labor—sometimes as part of the induction process in the hospital, sometimes during a regular prenatal visit when a mom is at or very near term. It's different from membrane rupturing, though it can lead to it. Here's what you need to know about membrane stripping:

How's it done? Your practitioner will use his or her finger to gently separate the amniotic sac (aka bag of water) from the side of your uterus near the cervix. Once the sac is separated, your body releases hormones (prostaglandins) that can eventually help get those contractions you're waiting for started. Membrane stripping could be a one-time deal, or your practitioner may ask you to come back every few days to repeat the process if the first attempt didn't get labor going. Even if your practitioner chooses to strip the membranes only once, you'll likely be asked to come back every few days to be checked for progress.

What does it feel like? Having your membranes stripped can be a little uncomfortable, though some women don't feel a thing. You might experience some crampiness for 24 hours after your membranes have been stripped (which may or may not lead to the labor contractions you're hoping for). You may also notice slight reddish, pink, or brown spotting for a few days afterward. All this is normal and nothing to worry about, though if you have severe pain or bright red bleeding, call your practitioner right away.

But . . . does it work? There is some evidence that having your membranes stripped may fast-track you to the birthing room—just maybe not so fast (it could take 3 to 5 days or more before any of those real-deal contractions start). But since it's not a slam dunk for starting labor and it's no fun for moms, many experts say it shouldn't be done routinely.

ripen the cervix, such as a catheter with an inflatable balloon, graduated dilators to stretch the cervix, or even a botanical—called Laminaria japonicum—that, when inserted, gradually opens the cervix as it absorbs fluid around it and expands.)

- If the amniotic sac is still intact, your practitioner may strip the membranes (see box, above). Or he or she may artificially rupture your membranes (see page 409) to try to get labor started.
- If you're still not having regular contractions, your practitioner will slowly administer intravenous Pitocin, a synthetic form of the hormone oxytocin (which is produced naturally by the body throughout pregnancy and also plays an important role in labor), until contractions are well established. The drug misoprostol, given through the vagina, might be used as an alternative to other ripening and induction techniques.
- Your baby will be continuously monitored to assess how he or she is dealing with the stress of labor. You'll also be monitored to make sure the drug isn't overstimulating your uterus, triggering contractions that are too

long or powerful. If that happens, the rate of infusion can be reduced or the process can be discontinued entirely. Once your contractions are in full swing, the oxytocin may be stopped or the dose decreased, and labor should progress just as a noninduced labor does. You can also get an epidural at this point if you'd like.

- If, after 8 to 12 hours of oxytocin administration, labor hasn't begun or progressed, your practitioner might stop the induction process to give you a chance to rest before trying again or, depending on the circumstances, the procedure may be stopped in favor of a cesarean delivery.

Eating and Drinking During Labor

"I've heard conflicting things about whether it's okay to eat and drink during labor."

Should eating be on the menu when you're in labor? That depends on who's placing the orders. Some practitioners red-light all food and drink during labor, on the theory that food in the digestive tract might be aspirated, or "breathed in," in the very, very unlikely case that emergency general anesthesia becomes necessary. These practitioners usually okay ice chips only, supplemented as needed by intravenous fluids.

Most other practitioners (and guidelines from ACOG), however, allow liquids and light solids (read: no stuffed-crust pizza) during a low-risk labor. These folks logically figure that a mom doing the hard work of labor needs both fluids and calories to stay strong and effective. Besides, they point out, the risk of aspiration (which, again, exists only if general anesthesia is used, which it rarely is except in emergency situations) is extremely low: 7 in 10 million births. Their position has even been backed up by research, which shows that moms who are allowed to eat and drink during labor have shorter labors by an average of 90 minutes. Non-fasting moms are also less likely to need oxytocin to speed up labor, require fewer pain medications, and have babies with higher Apgar scores than moms who are forced to fast. Check with your practitioner to find out what will and won't be on the menu for you during labor.

Even if your practitioner gives you the go-ahead on eating, chances are you won't be in the market for a major meal once the contractions begin in earnest (and besides, you'll be pretty distracted). After all, labor can really spoil your appetite. Still, an occasional light, easy-to-digest snack during the early hours of labor—Popsicles, Jell-O, applesauce, cooked fruit, a banana, plain pasta, toast with jam, or clear broth are ideal choices—may help keep your energy up at a time when you need it most (you probably won't be able to, or won't want to, eat during the later parts of active labor). When deciding—with your practitioner's help—what to eat and when, also keep in mind that labor can make you feel pretty nauseous. Some laboring moms throw up, even if they haven't been eating.

Whether you can chow down or not during labor, your coach definitely can—and should (you don't want him weak from hunger when you need him most). Remind him to have a meal before you head off to the hospital or birthing center (his mind's probably on your belly, not his) and to pack a bunch of snacks to take along so he

won't have to leave your side when his stomach starts growling.

Routine IV

"Is it true that I'll have to get an IV when I'm in labor—even if I'm pretty sure I don't want an epidural?"

That depends a lot on hospital policy. In some hospitals, it's routine to give all women in labor an IV, a flexible catheter placed in your vein (usually in the back of your hand or lower arm) to drip in fluids and medication. The reason is precautionary—to prevent dehydration, as well as to save a step later on in case an emergency arises that necessitates medication (there's already a line in place to administer drugs—no extra poking or prodding required). Other hospitals and practitioners omit routine IVs and instead wait until there is a clear need before hooking moms up. Check out policies in advance, and if you strongly object to having a routine IV, ask your practitioner if it can be skipped. It may be possible to hold off until the need, if any, comes up.

You'll definitely get an IV if an epidural is on the agenda. IV fluids are routinely administered before and during the placement of an epidural to reduce the chance of a drop in blood pressure, a common side effect of this pain relief route. The IV also allows for easier administration of Pitocin in case labor needs a nudge.

If you end up with a routine IV or an IV with epidural that you were hoping to avoid, you'll probably find it's not all that intrusive. The IV is only slightly uncomfortable as the needle is inserted—after that, you shouldn't even notice it (and if you do, tell your nurse). When it's hung on a movable stand, you can take it with you to the bathroom or on a stroll down the hall. If you very strongly don't want an IV but hospital policy dictates that you receive one, ask your practitioner whether a heparin lock might be an option for you. With a heparin lock, a catheter is placed in the vein, a drop of the blood-thinning medication heparin is added to prevent clotting, and the catheter is locked off. This option gives the hospital staff access to an open vein should an emergency arise but doesn't hook you up to an IV pole unnecessarily—a good compromise in certain situations.

Fetal Monitoring

"Will I have to be hooked up to a fetal monitor the whole time I'm in labor? What's the point of it anyway?"

For someone who's spent 9 months floating peacefully in a warm and comforting amniotic bath, the trip through the narrow confines of mom's pelvis will be no joyride. Your baby will be squeezed, compressed, pushed, and molded with every contraction. And though most babies sail through the birth canal without a problem, others find the stress of being squeezed, compressed, pushed, and molded too difficult, and they respond with decelerations in heart rate, rapid or slowed-down movement, or other signs of distress. A fetal monitor assesses how your baby is handling the stresses of labor by gauging the response of his or her heartbeat to contractions.

But does that assessment need to be continuous? Most experts say no, citing research showing that for low-risk moms with unmedicated deliveries, intermittent fetal heart checks using a Doppler or fetal monitor are an effective way to assess a baby's condition.

Episiotomy: No Longer a Common Cut

Chances are you've heard enough about episiotomies to know you'd rather not have one. Happily for most moms, the episiotomy—a surgical cut in a mom's perineum made to enlarge the vaginal opening just before the baby's head emerges—is no longer performed routinely at delivery. These days, in fact, midwives and most doctors rarely make the cut without a good reason, and only about 10 percent of delivering moms end up getting one.

It wasn't always that way. The episiotomy was once thought to prevent spontaneous tearing of the perineum and postpartum urinary and fecal incontinence, as well as reduce the risk in the newborn of birth trauma (from the baby's head pushing long and hard against the perineum). But it's now known that infants fare just fine without an episiotomy, and moms, seem to do better without it. Skipping the procedure doesn't seem to make the average total labor any longer, and moms often experience less blood loss, less infection, and less perineal pain after delivery without an episiotomy (though you can still have blood loss and infection with a tear). What's more, research has shown that episiotomies are more likely than spontaneous tears to turn into serious third- or fourth-degree tears (those that go close to or through the rectum, sometimes causing fecal incontinence, or the inability to control bowel movements).

But while routine episiotomies are no longer recommended, there is still a place for them in certain birth scenarios. Episiotomies may be indicated when a baby is large and needs a roomier exit route, when the baby needs to be delivered rapidly, when forceps or vacuum delivery needs to be performed, or for the relief of shoulder dystocia (a shoulder gets stuck in the birth canal during delivery).

If you do need an episiotomy, you'll get an injection (if there's time) of local pain relief before the cut, though you may not need a local if you're already anesthetized from an epidural or if your perineum is thinned out and already numb from the pressure of your baby's head during crowning. Your practitioner will then take surgical scissors and make either a median (also called midline) incision (a cut made directly toward the rectum) or a mediolateral incision (which slants away from the rectum). After delivery of your baby and the placenta, the practitioner will stitch up the cut (you'll get a shot of local pain medication if you didn't before or if your epidural has worn off).

If you haven't already, discuss the episiotomy issue with your practitioner. It's very likely he or she will agree that the procedure should not be performed unless there's a good reason. Document your feelings about episiotomies in your birth plan, too, if you like. But keep in mind that, very occasionally, episiotomies do turn out to be necessary, and the final decision should be made in the delivery or birthing room—when that cute little head is crowning.

So if you fit in that category, you probably won't have to be attached to a fetal monitor for your entire labor (you almost certainly won't be if you're delivering with a midwife). If, however, you're being induced, have an epidural, or have certain risk factors (such as meconium staining), you're most likely going to be hooked up to a monitor throughout your labor.

There are three types of continuous fetal monitoring:

External monitoring. In this type of monitoring, used most frequently, 2 devices are strapped to the abdomen. One, an ultrasound transducer, picks up the fetal heartbeat. The other, a pressure-sensitive gauge, measures the intensity and duration of uterine contractions. Both are connected to a monitor, and the measurements are recorded on a digital and paper readout. When you're connected to an external monitor, you'll be able to move around in your bed or on a chair nearby, but you won't have complete freedom of movement, unless telemetry monitoring is being used (see below).

During the second (pushing) stage of labor, when contractions may come so fast and furious that it's hard to know when to push and when to hold back, the monitor can be used to accurately signal the beginning and end of each contraction. Or the monitor may be removed entirely while you're pushing, to make sure it doesn't interfere with your concentration. In this case, your baby's heart rate will be checked periodically with a Doppler.

Internal monitoring. When more accurate results are required—such as when there is reason to suspect fetal distress—an internal monitor may be used. In this type of monitoring, a tiny electrode is inserted through your vagina onto your baby's scalp, and a catheter is placed in your uterus or an external pressure gauge is strapped to your abdomen to measure the strength of your contractions. Though internal monitoring gives a slightly more accurate record of the baby's heart rate and your contractions than an external monitor, it's used only when necessary (since its use comes with a slight risk of infection). Your baby may have a small bruise or scratch where the electrode was attached, but it'll heal in a few days. You'll be more limited in your movement with an internal monitor, but you'll still be able to move from side to side.

Telemetry monitoring. Available only in some hospitals, this type of monitoring uses a transmitter on your thigh to transmit the baby's heart tones (via radio waves) to the nurse's station—allowing you to take a lap or two around the hallway while still having constant monitoring.

Be aware that with both internal and external types of monitoring, false alarms are common. The machine can start beeping loudly if the transducer has slipped out of place, if the baby has shifted position, if mom has shifted position, if the monitor isn't working right, or if contractions have suddenly picked up in intensity. Your practitioner will take all these factors and others into account before concluding that your baby really is in trouble. If the abnormal readings do continue, several other assessments can be performed (such as fetal scalp stimulation) to determine the cause of the distress. If fetal distress is confirmed, then a cesarean delivery is usually called for.

Artifical Rupture of Membranes

"I'm afraid that if my water doesn't break on its own, the doctor will have to rupture the membranes. Won't that hurt?"

Most moms-to-be actually don't feel much at all when their membranes are artificially ruptured, particularly if labor's already well underway (there are far more significant pains

to cope with then). The procedure, done with an amniohook (a long, thin plastic device with a hook at the end, designed to puncture the sac), isn't likely to be any more uncomfortable than all those internal exams you'll be getting to check on your progress. Chances are, all you'll really notice is a gush of water, followed soon—at least that's the hope—by harder and faster contractions that will get your baby moving.

Artificial rupture of the membranes doesn't seem to decrease the need for Pitocin but does seem to shorten the length of labor—at least in labors that are induced—and many practitioners will turn to artificial rupture in an attempt to help move a sluggish labor along. If there's no compelling reason to rupture them (labor's moving along just fine), you and your practitioner may decide to hold off and let them rupture naturally. (Occasionally, artificial rupture may be performed to allow for another procedure, like internal monitoring.)

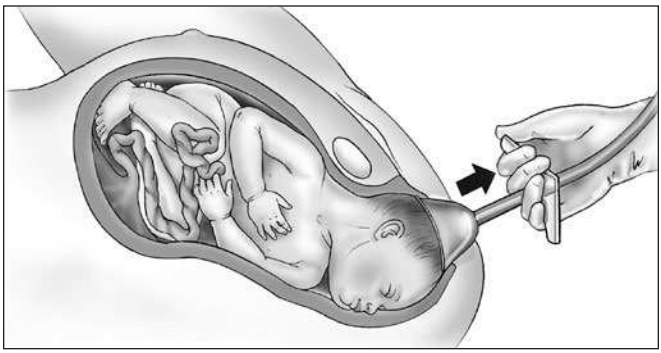
Once in a while, membranes stay stubbornly intact throughout delivery (the baby arrives with the bag of waters still surrounding him or her, which means it will need to be ruptured right after birth), and that's fine, too.

Vacuum Extractor

"Why would the doctor use a vacuum extractor during delivery? The idea of suctioning my baby's head out sounds like it would be painful for her and me."

Vacuum extractors can ease babies out of some pretty tight delivery spots. Don't think Hoover—the vacuum extractor is a simple plastic cup that's placed on the baby's head, and uses gentle suction to help guide her out of the birth canal (see illustration, below). The suction prevents the baby's head from moving back up the birth canal between contractions and can be used to help mom out while she is pushing during contractions. Vacuum extraction is used in about 5 percent of deliveries and offers a good alternative to both forceps (which are rarely used these days; see next question) and c-section under the right circumstances.

What are the right circumstances? Vacuum extraction might be considered when the cervix is fully dilated and the membranes have broken but a mom is just too exhausted from labor to push effectively or to keep pushing, or if she has a heart condition or very high blood pressure that might make strenuous pushing risky. The



Vacuum Extractor

procedure might also be used if the baby needs to be delivered in a hurry because of possible distress (assuming the baby is in a favorable position—for example, close to crowning).

Babies born with vacuum extraction experience some swelling on the scalp, but it usually isn't serious, doesn't require treatment, and goes away within a few days. If the vacuum extractor isn't working successfully to help deliver the baby, a cesarean delivery will likely be performed.

Before turning to vacuum extraction, your practitioner may suggest (time permitting) letting you rest up for a few contractions before trying to push again (sometimes even a short break can give you the second wind you need to push your baby out effectively). A change of position (getting on all fours, squatting with a birthing bar, sitting on a birthing ball) might also push delivery along by enlisting the force of gravity to shift baby's head.

Ask your practitioner any questions you have about the possible use of vacuum extraction (or forceps, see next question), including whether you'll need an episiotomy before a vacuum delivery. The more you know, the better prepared you'll be for anything that comes your way during childbirth.

Forceps

"How likely will it be that I'll need forceps during delivery?"

Pretty unlikely these days. Forceps—long, curved tonglike devices designed to help a baby make his or her descent down the birth canal—are used in only a very small percentage of deliveries (vacuum extraction is more common; see previous question). Not because they aren't as safe as vacuum extraction or a c-section (they are actually even safer for the baby when used correctly), but because fewer and fewer doctors have been trained in how to use them or have used them enough to feel comfortable using them. The possible reasons for using forceps are the same as those for vacuum delivery.

Forceps

If forceps are used in your delivery, your cervix will have to be fully dilated, your bladder empty, and your membranes ruptured first. Then you'll be numbed with a local anesthetic (unless you already have an epidural in place). You'll also likely receive an episiotomy to enlarge the vaginal opening to allow for placement of the forceps. The curved tongs of the forceps will then be cradled one at a time around the temples of the baby's crowning head, locked into position, and used to gently deliver the baby (see illustration above). There may be some bruising or swelling on the baby's scalp from the forceps, but it will usually go away within a few days after birth.

If an attempt at a forceps delivery is unsuccessful, you'll likely have a c-section.

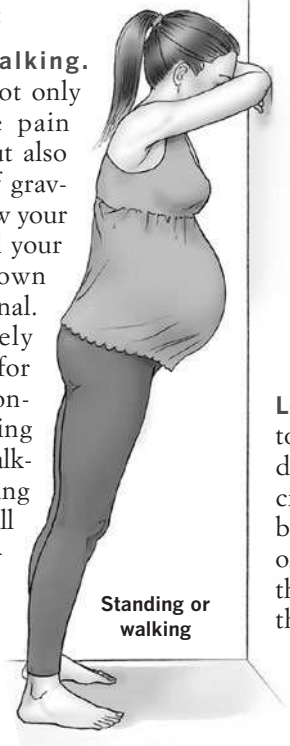
Labor Positions

"I know you're not supposed to lie flat on your back during labor. But what position is best?"

There's no need to take labor lying down, and in fact, lying flat on your back is probably the least efficient way to birth your baby: first because you're not enlisting gravity's help to get your baby out, and second because there's the risk of compressing major blood vessels (and possibly interfering with blood flow to the baby) when you're on your back for an extended period of time. Expectant moms are encouraged to labor in any other position that feels comfortable and to change their position as often as they can (and want to). Getting a move on during labor, as well as varying your position often, not only eases discomfort but may also yield speedier results.

You can choose from any of the following labor and delivery positions (or variations of these):

Standing or walking. Getting vertical not only helps relieve the pain of contractions but also takes advantage of gravity, which may allow your pelvis to open and your baby to move down into your birth canal. While it's unlikely you'll be heading for the track once contractions are coming fast and furious, walking (or just standing leaning against a wall or your coach) during the early stages of labor can be an effective move.

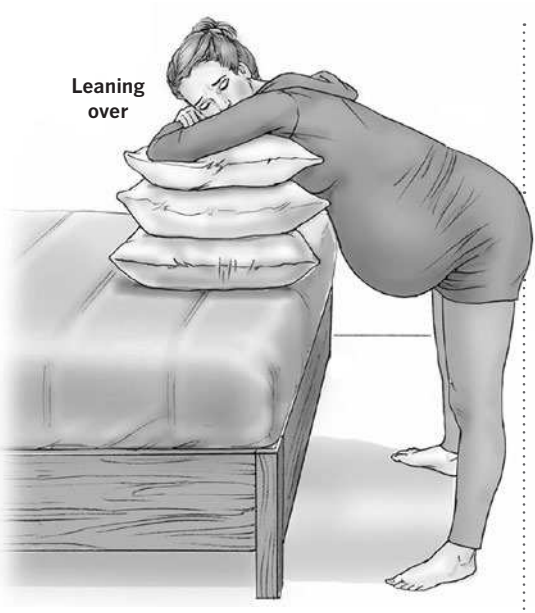


Standing or walking

Rocking. Sure, your baby's not even born yet, but he or she will still enjoy a little rocking—as will you, especially when those contractions start coming. Slip into a chair or remain upright, and sway back and forth on your own or in the arms of your partner (or rock on a birthing ball; see facing page). The rocking motion may allow your pelvis to open and encourage your baby to descend. And again, staying upright allows you to use the force of gravity to help in the process.

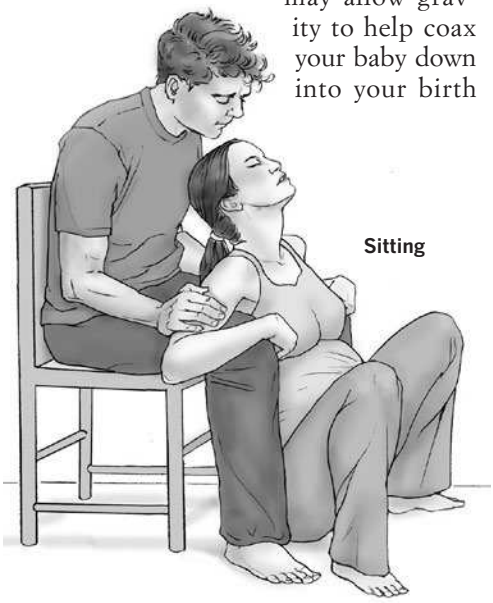
Rocking

Leaning over. Many laboring moms-to-be find it relaxing to lean forward during contractions—and it's an especially helpful position if you've got back labor. Stack a bunch of pillows on a bed or table and lean forward on them, resting your head and arms on the pillows and relaxing your body.



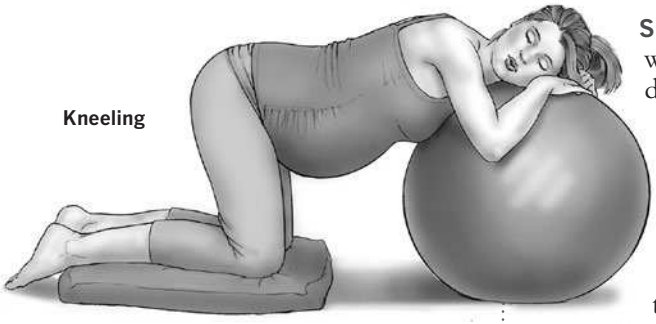
This position is also helpful if you want to sway or rock but don't have the energy to hold your body up.

Sitting. Whether in bed (the back of the birthing bed can be raised so you're almost sitting upright), in your partner's arms, or on a birthing ball, sitting can ease the pain of contractions and may allow gravity to help coax your baby down into your birth canal. Another option, if it's available, is a birthing chair, specifically designed to support a woman in labor. A plus: Moms get to see more of the birth in this position.



On a birthing ball. Sitting on one of these large exercise balls can help open up your pelvis—and it's a lot easier than squatting for long periods. The curve of the ball gives a slight counterpressure to the perenium during labor. If you'd rather lean forward on your hands and knees (see illustration, next page), take advantage of the curve of the ball to rock back and forth (or side to side or even in gentle circles). Using the ball for support this way can help with back labor and can also take the strain off your wrists while still allowing you to labor in whatever position feels best for you.

Kneeling. Got back labor? Kneeling over a birthing ball, a chair, or over your spouse's shoulders can be soothing and productive when the back of baby's head is pushing against your spine. It

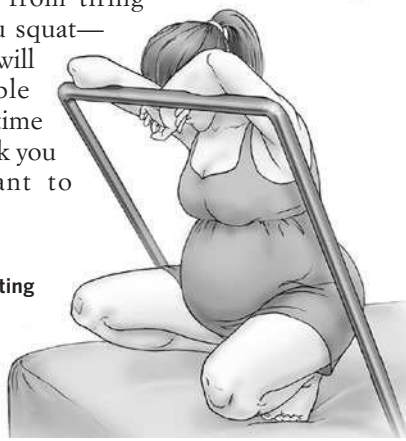


Kneeling

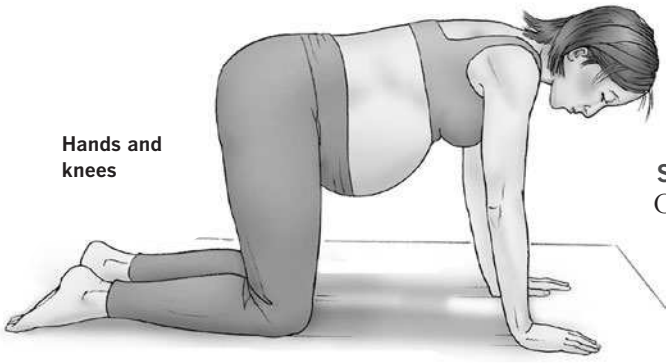
encourages the baby to move forward, taking that load off your back. Even if you don't have back labor, kneeling can be an effective labor and delivery position. Because it allows you to shift and transfer some of the pressure toward the lower spine while you push your baby out, kneeling seems to reduce childbirth pain even more than sitting does.

Hands and knees. Getting on all fours is another way to cope more comfortably with back labor—and to help get that puppy out faster. This position allows you to do pelvic tilts for comfort while giving your spouse or doula access to your back for massage and counterpressure. You might even consider delivering in this position (no matter what kind of labor you're having), since it opens up the pelvis and uses gravity to coax baby down. (You can also use a birthing ball in this position; see above.)

Squatting. You probably won't be able to stand and deliver, but once you get closer to the pushing stage of childbirth, you might want to consider squatting. There's a reason why women have delivered their babies in a squatting position for centuries: It works. Squatting allows the pelvis to open wide, giving your baby more room to move on down. You can use your partner for squatting support (you'll probably be a little wobbly, so you'll need all the support you can get), or you can use a squatting bar, which is often attached to the birthing bed (leaning on the bar will keep your legs from tiring out as you squat—ask if one will be available ahead of time if you think you might want to use it).



Squatting



Hands and knees

Side lying. Too tired to sit? Or squat? Just need to lie down? Lying on your side (left side is best) is much better than lying on

Side lying

your back, since it doesn't compress the major veins in your body. It's also a good delivery option, helping to slow a too-fast birth as well as easing the pain of some contractions.

In a tub. Even if you're not open to a water birth (or if the option isn't open to you), laboring in a tub can help ease the pain of contractions, enhance relaxation, and even help speed your progress. No tub in your birthing room? A warm shower can help relieve pain, too.

In a tub

Remember that the best labor position is the one that's best for you. And what's best in the early phases of labor might make you miserable when you're in the throes of labor, so change positions as often—or as little—as you want. If you're being continuously monitored, your positions are somewhat limited. It'll be hard to walk, for instance—but you'll have no problem squatting, rocking, sitting, getting on your hands and knees, or lying on your side. Even if you have an epidural, sitting, side lying, or rocking are all options for you.

Being Stretched by Childbirth

"I'm concerned about stretching during delivery. Will my vagina ever be the same again?"

Mother Nature definitely had moms in mind when thinking up vaginas. Their incredible elasticity and accordion-like folds allow this amazing organ to open up for childbirth (and the passage of that 7- or 8-pound baby) and then—over a period of weeks after delivery—return to close to original size. In other words, your vagina's definitely designed to take it.

The perineum is also elastic but less so than the vagina. Massage during the months before delivery (and during delivery) may help increase its elasticity and reduce stretching in a first-time mom (though it's not a must-do; see page 384). Likewise, exercising the pelvic muscles with Kegels during this period may enhance their elasticity, strengthen them, and speed their return to normal tone.

Most women find that the slight increase in vaginal roominess typically experienced postpartum is imperceptible and doesn't interfere at all with sexual enjoyment. For those who were previously too snug, that extra room can be a real plus—making sex more of a pleasure and in some cases, literally, less of a pain. Very occasionally, however, in a woman who was "just right" before (or a couple who were a perfect fit before), childbirth does stretch the vagina enough that sexual satisfaction decreases. Often, the vaginal muscles tighten up again in time. Doing Kegels faithfully and frequently helps speed that process. If 6 months after delivery you still find that your vagina's too slack for comfort, talk to your doctor about other possible treatments.

FOR FATHERS

Handling the Sight of Blood

Most expectant dads—and moms—worry about how they'll handle seeing blood at delivery. But chances are you won't even notice it, never mind be bothered by it—for a couple of reasons. For one, there typically isn't very much blood to see. For another, the excitement and wonder of watching your baby arrive is likely to keep you both pretty preoccupied (that, and the efforts of birthing, of course).

If at first glance the blood does bother you (and it's really likely it won't), keep your eyes focused on your spouse's face as you coach her through those last pushes. You'll probably want to turn back to the main event for that momentous moment—at that point, blood is going to be the last thing you'll notice.

The Sight of Blood

"The sight of blood makes me feel faint. I'm not sure if I'll be able to handle watching my delivery."

Here's some good news for the squeamish. First of all, there isn't all that much blood during childbirth—not much more than when you have your period. Second, you're not really a spectator at your delivery—you'll be a very active participant, putting every ounce of your concentration and energy into pushing your baby those last few inches. Caught up in the excitement and anticipation (and, let's face it, the pain and fatigue), you're unlikely to notice, much less be unsettled by, any bleeding. If you ask friends who've given birth before, few will be able to tell you just how much blood, if any, there was at their deliveries.

If you still feel strongly that you don't want to see any blood, simply keep your eyes off the mirror at the moment of birth (and look away, too, in the unlikely event that an episiotomy is performed). Instead, just look down past your belly for a good view of your baby as he or she emerges. From this vantage point, virtually no blood will be visible. But before you decide to opt out of watching your own delivery, watch someone else's by viewing a childbirth on YouTube. You'll probably be much more awestruck than horrified.

Delaying Cord Clamping

"What's this I hear about not clamping the umbilical cord right away after the baby is born?"

It's a part of the birth that used to go pretty much unnoticed in the birthing room, at least by parents, who were too busy basking in the glow of baby's first moments—gazing into those just-opening eyes, enjoying those first cuddles, counting fingers, toes, and blessings—to realize (or care) that the doctor had already clamped the umbilical cord within just a few moments of delivery.

While midwives delivering babies in birthing centers and at home have long taken their time with umbilical cord clamping, it has traditionally been done in a flash in hospital settings—without fanfare, and certainly without delay (wham-bam-clamp-you-mom). The reason for this quick clamping? Because it was believed to reduce the risk of hemorrhaging (mom losing too much blood after delivery).

But the latest research seems to show that faster may not be better—and that delayed cord clamping not only

Wear and Tear During Delivery

When a little baby with a pretty big head tries to squeeze through a much narrower opening, there's a good chance that opening will not only be stretched out to accommodate it, but also might tear a little. In fact, it's common, given the pressure from a baby's head pushing through, to experience tears and lacerations in the perineum (the area between your vagina and your anus) and sometimes the cervix as well. As many as half of all women who deliver vaginally will experience at least a small tear during delivery (though your chances of tearing in second and subsequent labors are lower). First-degree tears (where only the skin is torn) and second-degree tears (when skin and vaginal tissue are torn) are the most common types of tears.

In most cases, a tear requires stitches (they're generally required in tears that are longer than 2 cm, or about 1 inch). After the tear is repaired, you'll likely experience tenderness at the site as it heals over the next week to 10 days. But here's the good news: Recovering from a small tear that happens naturally is a lot easier than healing after an episiotomy—a procedure that's (thankfully) rarely used these days in uncomplicated births (see box, page 408).

To reduce the possibility that you'll tear, some experts recommend perineal massage (see page 384) for a few weeks before your due date if you're a first-time mom. (If you've delivered vaginally before, you're already stretched, so do-ahead massage probably won't accomplish much.) During labor, the following can also help: warm compresses to lessen perineal discomfort, perineal massage with oils or lubricants, standing or squatting and exhaling or grunting while pushing to facilitate stretching of the perineum. During the pushing stage, your practitioner will probably use perineal support (applying gentle counterpressure to the perineum so your baby's head doesn't push out too quickly and cause an unnecessary tear) and perineal massage.

doesn't increase the risk of a mom hemorrhaging, but may offer real benefits to baby. A clamping delay after delivery allows the placenta to give a few more pulses of blood to the newborn, and this extra dose of blood can represent as much as 30 to 40 percent of a baby's blood volume. And pumping up that blood supply can significantly improve a baby's iron and hemoglobin levels, preventing anemia in the first 6 months of life. And how's this for a possible (if unexpected) perk: Delayed cord clamping may boost social and fine motor skills later in life.

How long a wait is long enough? That depends who you ask. Many midwives routinely wait until the cord stops pulsating, which can take several minutes, often more. The World Health Organization (WHO) already recommends waiting 1 to 3 minutes after birth to cut the umbilical cord. ACOG and the AAP recognize the benefits of delaying clamping until 60 seconds after birth, but say there's not enough evidence to recommend delaying beyond the 1-minute mark. They point to a slightly increased risk (about 2 percent) of newborn jaundice in babies whose cord clamping was delayed longer than 1 minute (due to the extra blood baby receives)—and to the fact that babies born in the U.S. are rarely iron deficient (making the extra blood inconsequential). The exception: preemies, who can

Lotus Birth

If delaying cord clamping might be beneficial—what about not cutting the cord at all? That's the theory behind the controversial practice of lotus birth: Instead of cutting the cord, parents opt to leave the umbilical cord and placenta attached to their baby until it dries out and falls off by itself—a process that can take 3 to 10 (or more) days. Advocates say this allows the baby to reap the benefit of complete blood transfer from the cord and placenta.

Problem is, there are no scientific studies on the safety of the practice, and experts haven't been reassuring. They say that without active blood circulation, the cord and placenta are essentially dead tissue that will rot (and smell). Bacteria can colonize in the placenta and potentially be a source of infection that can spread to the newborn. Which means that lotus birth most likely isn't a smart trend to embrace, and may even be downright dangerous.

Still curious? Be sure to discuss the practice with your practitioner before making the decision to try it.

definitely benefit from the extra blood and the lowered risk of anemia. Both ACOG and AAP recommend delaying cord clamping for at least a minute when a baby is born preterm.

Still, the birthing room times (and the timing of cord clamping) are changing. Despite the lack of an official thumbs-up from ACOG and AAP, many doctors (and most midwives) allow—and even encourage—a longer-than-1-minute delay in clamping at all births. Wondering what your practitioner's cord clamping practice is? Now, before the cord is delivered (along with your baby and the placenta), is the time to ask—and to specify any preferences you have in your birth plan. For healthy moms with normal pregnancies, a 2- to 3-minute delay might be just what the doctor ordered (and it won't interfere with cord blood harvesting).

ALL ABOUT:

Childbirth

After 9 months at it—graduating from queasiness and bloating to heartburn and backache—you almost certainly know what to expect when you're expecting by now. But what should you expect when you're laboring and delivering?

That's actually hard to predict (make that impossible). Like every pregnancy before it, every labor and delivery is different. Still, just as it was comforting to know what you might expect during those months of growing your baby, it'll be comforting to have a general idea of what you might have in store for you during those hours of childbirth. Even if it turns out to be nothing like you expected (with the exception of that very happy and cuddly ending).

Stage One: Labor

Phase 1: Early Labor

This phase is usually the longest phase of labor—but fortunately, it's also by far the least intense. Over a period of hours, days, or weeks (often without noticeable or bothersome contractions), or over a period of 2 to 6 hours of no-doubt-about-it contractions, your cervix will efface (thin out) and dilate (open) to between 4 to 6 cm.

Contractions in this phase usually last 30 to 45 seconds, though they can be shorter. They are mild to moderately strong, may be regular or irregular. They may start as far apart as 20 minutes, but will become progressively closer together (about 5 minutes apart by the end of early labor), though not necessarily in a consistent pattern.

What you may be feeling. During early labor, you might experience any or all (or none) of the following:

- Backache (either constant or with each contraction)
- Menstrual-like cramps

Stages and Phases of Childbirth

Childbirth progresses in 3 stages: labor, delivery of the baby, and delivery of the placenta. First up (unless a planned c-section eliminates this stage entirely) is labor, which is divided into three phases: early labor, active labor, and transitional labor. All women who deliver vaginally will experience all 3 phases of labor (though some moms may barely notice much of the first phase at all), but moms who end up requiring a cesarean delivery at some point during labor may skip one or more of those phases. Though every labor is different, the timing and intensity of contractions can help pinpoint which phase of labor you're in at any particular time, and so can some of the symptoms you're experiencing along the way. Periodic internal exams will confirm your progress. (Keep in mind that different practitioners define phases differently, which is why you'll notice a range of centimeters dilated within each phase below.)

Stage One: Labor

- **Phase 1: Early (Latent)**—Thinning (effacement) and opening (dilation) of the cervix to between 4 to 6 cm; contractions are 30 to 45 seconds long, 20 minutes apart or less (getting to about 5 minutes apart by the end of early labor).
- **Phase 2: Active**—Dilation of cervix from between 4 to 6 cm to between 7 to 8 cm; contractions are 40 to 60 seconds long, coming 3 to 4 minutes apart.
- **Phase 3: Transitional**—Dilation of cervix from between 7 to 8 cm to 10 cm (fully dilated); contractions are 60 to 90 seconds long, about 2 to 3 minutes apart.

Stage Two: Pushing and delivery of the baby

Stage Three: Delivery of the placenta

- Lower abdominal pressure
- Indigestion
- Diarrhea
- A sensation of warmth in your abdomen
- Loss of mucous plug; bloody show (blood-tinged mucus)
- Rupture of your membranes (your water breaking), though it's more likely that they'll rupture (or be ruptured) during active labor.

Emotionally, you may be all over the map—from relaxed, relieved, excited, and chatty to tense, anxious, and apprehensive. You may also be impatient while you're waiting (and waiting) for labor to get more active.

What you can do. Of course you're full of anticipation, but it's important to relax—or at least try to relax. This could take a while.

- If contractions start during the night but your water hasn't broken, try to sleep (you might not be able to later, when the contractions are coming fast and furious). If you can't sleep—what with all the adrenaline pumping—get up and do things around the house that will distract you. Bake some muffins or cook up a batch of chili or chicken breasts to add to your postpartum freezer stash, do the laundry, or log on to see if anyone else in the WhatToExpect.com community is in the same early labor boat.
- If it's daytime, go about your usual routine, as long as it doesn't take you far from home (remember to take your cell phone with you). If you're at work, you might want to head home (it's not like you're going to get anything done anyway). If you have nothing planned, find something relaxing to keep you occupied. Go for a walk, watch TV, text friends and family or keep them posted on Facebook, finish packing your bag. Feel like starting labor and delivery fresh—even if you won't end up that way when it's over? Take a shower and wash your hair.
- Alert the media. Okay, maybe not the media (yet)—but you'll definitely want to put your partner on alert if he's not with you. He probably doesn't have to rush to your side just yet if he's at work—unless he really wants to—since there's not much for him to do this early on. If you have hired a doula, issue a bulletin to her, too. And if you have older children who will need watching while you're laboring, alert the babysitter.
- Eat a light snack or meal if you're hungry (broth, toast with jam, plain pasta or rice, Jell-O or pudding, an ice pop, a banana, watermelon, or something else your practitioner has suggested)—now's the best time

Call Your Practitioner If . . .

Your practitioner probably told you not to call until you're in more active labor, but may have suggested that you call early on if labor begins during the day or if your membranes rupture. Definitely call immediately, however, if your membranes rupture and the amniotic fluid is murky or greenish, if you have any bright red vaginal bleeding, if you feel no fetal activity (try the test on page 315), or if there's an extremely marked slowdown or other dramatic change of fetal movement.

FOR FATHERS

What You Can Do During Early Labor

If you're around during this phase, here are some ways you can help out:

- Practice timing contractions. The interval between contractions is timed from the beginning of one to the beginning of the next. Time them periodically (you'll both get frustrated if you time early contractions too often), and keep a record. When they are coming less than 10 minutes apart, time them more frequently.
- Spread the calm. Right now, your most important job is to keep your partner relaxed. And the best way to do that is to keep yourself relaxed, both inside and out. It's possible to spread stress without even realizing it, communicating it not just through words but touch and expressions (so no tensed-up foreheads, please). Doing relaxation exercises together or giving her a gentle massage may help. It's too soon, however, to begin using breathing exercises—save them for when they're needed so she doesn't burn out. For now, just breathe.
- Offer comfort, reassurance, and support. She'll need them from now on.
- Keep your sense of humor, and help her keep hers—time flies, after all, when you're having fun. It'll be easier to laugh now than when contractions are coming fast and hard (she probably won't find very much of anything funny then).
- Try distraction. Suggest activities that will help keep both your minds off her labor: playing games on the iPad, watching a silly sitcom or reality show, baking something for the postpartum freezer stash, taking short strolls.
- Keep up your own strength so you'll be able to reinforce hers. Eat periodically but empathetically (don't go wolfing down a Big Mac when she's sticking to pudding). Prepare a sandwich to take along to the hospital or birthing center, but avoid anything with a strong odor. She probably won't be in the mood to be sniffing salami or onions on your breath.

to stock up on energy foods. But don't eat heavily, and avoid hard-to-digest foods (burgers, potato chips, pizza). You may also want to skip anything acidic, such as orange juice or lemonade. And definitely drink some water—it's important to stay hydrated.

- Make yourself comfortable. If you're achy, take a warm shower or use a heating pad where it hurts. You can also take some acetaminophen (Tylenol) if your practitioner approves, but don't take aspirin or ibuprofen (Advil, Motrin).
- Time contractions (from the beginning of one to the beginning of the next) for half an hour if they seem to be getting closer than 10 minutes apart and periodically even if they don't. But try not to be a constant clock-watcher.
- Remember to pee often, even if you're not feeling the urge to. A full bladder could slow down the progress of labor.
- Use relaxation techniques if they help, but don't start breathing exercises yet or you'll burn out on them long before you really need them.

On to the Hospital or Birthing Center

Sometime near the end of the early phase or the beginning of the active phase (probably when your contractions are 5 minutes apart or less, sooner if you live far from the hospital or are likely to face traffic, or if this isn't your first baby), your practitioner will tell you to pick up your bag and get going. The going will be easier, of course, if your coach can be reached and get to you quickly (or you have a backup plan if he can't, like taking a taxi or having a friend drive you—don't try to drive yourself). It will also be a smoother ride if you've planned your route in advance, are familiar with parking, and know which entrance will get you to labor and delivery fastest. En route, get as comfortable as you can (recline the seat, if possible, bring a blanket if you have chills) but don't forget to fasten your seat belt.

Once you reach the hospital or birthing center you can probably expect something like the following (since protocols differ, your experience may be a little different):

- If you've preregistered (and it's best if you have), the admission process will be quick and easy. If you haven't preregistered, you (or better yet, your coach) will have to go through a more lengthy process, so be prepared to fill out a bunch of forms and answer a lot of questions.
- Once you've arrived at labor and delivery, a nurse will probably take you to your room (likely an LDR, or labor, delivery, and recovery room). If it's not clear you're in active labor you may be brought first to a triage (assessment) room (this is standard practice in some hospitals).
- Your nurse will take a brief history, asking (among other things) when the contractions started, how far apart they are, whether your membranes have ruptured, when and what you last ate.
- Your nurse will ask for your signature (or your spouse's) on routine consent forms.
- Your nurse will give you a hospital gown to change into and might request a urine sample. He or she will check your pulse, blood pressure, respiration, and temperature, look for leaking amniotic fluid, bleeding, or bloody show, and will listen to baby's heartbeat with a Doppler or hook you up to a fetal monitor, if necessary. He or she may also evaluate baby's position.
- Your nurse, your practitioner, or a staff doctor or midwife will examine you internally to see how dilated and effaced your cervix is. Have questions? Now's a great time to ask them. Have a birth plan? Now's a good time to hand it to the nurse so it can be added to your chart.

If at any time during the intake it's determined that you're not actually in active labor, you may be sent home (don't worry—you'll be back!) or asked to stay for a few hours before checking you again.

Phase 2: Active Labor

The active phase of labor is usually shorter than the early phase, lasting an average of 2 to 3½ hours (with, again, a wide range of normal). The contractions are more concentrated now, accomplishing more in less time, and they're also increasingly intense (in other words, painful). As they become

stronger, longer (40 to 60 seconds, with a distinct peak about halfway through), and more frequent (generally 3 to 4 minutes apart, though the pattern may not be regular), the cervix dilates to 7 to 8 cm. With fewer breaks in the action, there's less opportunity to rest between contractions.

What you may be feeling. You'll likely be in the hospital or birthing center by now, and you can expect to feel all or some of the following (though you won't feel pain if you've had an epidural):

- Increasing pain and discomfort with contractions (you may not be able to talk through them now)
- Increasing backache
- Leg discomfort (aches in the legs, thighs, or butt) or heaviness
- Fatigue
- Increasing bloody show
- Rupture of your membranes (if they haven't earlier)

Emotionally, you may feel restless and find it more difficult to relax—or your concentration may become more intense and you may become completely absorbed in your labor efforts. Your confidence may begin to waver ("How will I make it through?"), along with your patience ("Will this labor never end?"), or you may feel excited and encouraged that things are really starting to happen. Whatever your feelings, they're normal—just get ready to start getting "active."

What your practitioner or nurse will be doing. During active labor, assuming all is progressing normally and safely, your birth attendants will check and monitor you as needed, but also allow you to work through your labor with your coach and other support people without interference. You can expect them to:

- Take your blood pressure
- Monitor baby with a Doppler or fetal monitor
- Time and monitor the strength of your contractions
- Evaluate bloody show
- Start an IV if you're going to want an epidural or if hospital policy dictates
- Administer an epidural (or other pain relief) if you choose to have one (the anesthesiologist will have to be called in for this)
- Possibly, rupture your membranes if they're still intact
- Jump start your labor if it's progressing very slowly by administering Pitocin
- Periodically examine you internally to check how labor is progressing and how dilated and effaced your cervix is

Don't Hyperventilate

With all the breathing going on during labor, some moms start to hyperventilate or overbreathe, causing low levels of carbon dioxide in the blood. If you feel dizzy or lightheaded, have blurred vision or a tingling and numbness of your fingers and toes, let a nurse or your doula know. You'll be given a paper bag to breathe into (or told to breathe into your cupped hands). A few inhales and exhales will get you feeling better in no time.

When Labor Slows Down

Feel like lingering over labor? Of course not—you'd like to keep labor moving. And making good progress during labor—which happens most of the time—requires three main components: strong uterine contractions that effectively dilate the cervix, a baby that is in position for an easy exit, and a pelvis that is roomy enough to permit passage of the baby. But in some cases, labor doesn't progress by the book, because the cervix takes its time dilating, the baby takes longer than expected to descend, or pushing isn't getting you (or your baby) anywhere. Contractions can also slow down after an epidural kicks in, too—but keep in mind that expectations for the progress of labor and delivery are different for those who have an epidural (first and second stage may take longer, and that's typically nothing to worry about).

To get a stalled labor back up and running, there are a number of steps your practitioner (and you) can take:

- If you're in early labor and your cervix just isn't dilating or effacing, your practitioner may suggest some activity (such as walking) or just the opposite (sleep and rest, possibly aided by relaxation techniques). This will also help rule out false labor (the contractions of false labor usually subside with activity or a nap).
- If you're not dilating or effacing as quickly as expected, your practitioner may try to rev things up by administering Pitocin (oxytocin), prostaglandin E, or another labor stimulator. He or she might even suggest a labor booster that you can take into your own hands (or your coach's): nipple stimulation.
- If you're already in the active phase of labor, but your cervix is dilating

They'll also be able to answer any questions you might have (don't be shy about asking or having your coach ask) and provide additional support as you go through labor.

What you can do. It's all about your comfort now. So:

- Don't hesitate to ask your coach for whatever you need to get and stay as comfortable as possible, whether it's a back rub to ease the ache or a damp washcloth to cool your face. Speaking up will be important. Remember, as much as he's going to want to help, he's going to have a hard time anticipating your needs, especially if this is his first time coaching labor.
- Start your breathing exercises, if you plan to use them, as soon as contractions become too strong to talk through. Didn't plan ahead and practice? Ask the nurse or doula for some simple breathing suggestions. Remember to do whatever relaxes you and makes you feel more comfortable. If the formulaic breathing exercises aren't working for you, don't feel obligated to stick with them. Or ask the nurse (or your doula) to help you redirect your breathing.
- Try to relax fully between contractions, so you can conserve energy that you'll need later. This will become increasingly difficult as they come more frequently, but it will also become increasingly important as your energy reserves are drained.

slowly (less than 1 to 1.2 cm per hour if you're having your first baby and 1.5 cm per hour if you've delivered before), or if your baby isn't moving quickly enough down the birth canal (at a rate of more than 1 cm per hour if you're a first-timer or 2 cm per hour if you're not), your practitioner may rupture your membranes and/or start (or continue) administering oxytocin. Some practitioners (especially midwives) will encourage a woman to labor longer than this before resorting to interventions—as long as baby's heart rate is good and mom doesn't have a fever.

- If you're a first-time mom, you'll probably be allowed to push for 3 hours if you haven't had an epidural and 4 hours if you have. If you're a second-timer or more, you'll probably be allowed to push for 2 hours if you haven't had an epidural and 3 hours if you have had one. If the pushing goes on too long, your practitioner will reassess your baby's position, see how you're feeling, perhaps attempt to birth your baby using vacuum extraction or (less likely) forceps, or decide to do a cesarean delivery.

To keep the ball (and the baby) rolling throughout labor, remember to urinate periodically, because a full bladder can interfere with the baby's descent. (If you have an epidural, chances are your bladder is being emptied by a catheter.) Full bowels may do the same, so if you haven't moved your bowels in 24 hours, give it a try. You might also try to nudge a sluggish labor along by using gravity (sitting upright, squatting, standing, or walking). When it comes to giving slow pushing a push, a semi-sitting, semi-squatting, or all-fours position may help deliver results.

Most practitioners will turn to a cesarean delivery after 24 hours of active labor (sometimes sooner) if sufficient progress hasn't been made by that time. Some will wait longer, assuming both mom and baby are doing well.

- If you'd like some pain relief, now's a good time to ask for it. An epidural can be given as early as you feel you need it and as soon as an anesthesiologist can get to your room.
- Stay hydrated. With your practitioner's green light, drink clear beverages frequently to replace fluids and to keep your mouth moist. If you're hungry, and again, if you have your practitioner's okay, have a light snack (like a Jell-O or Popsicle). If your practitioner doesn't allow anything else by mouth, sucking on ice chips can be refreshing.
- Stay on the move if you can (you won't be able to get around much if you have an epidural). Walk around, if possible, or at least change positions as needed (see page 412 for suggested labor positions). Taking a shower or soaking in a tub now can help ease your pain, if you don't have an epidural.
- Pee periodically. Because of tremendous pelvic pressure, you may not notice the need to empty your bladder, but a full bladder can prevent baby's descent and keep you from making the progress you'll definitely want to be making. No need to trek to the bathroom if you have an epidural (not that you could anyway), because you've probably been given a catheter to empty your bladder.

FOR FATHERS

What You Can Do During Active Labor

Labor's getting more active, and that means you'll be getting busier supporting your laboring spouse. Here are some ways you can help her:

- Hand a copy of the birth plan to the nurse so that it can be placed in your partner's chart (if it hasn't been already). If the shift changes, make sure the new nurse is in the loop, too.
- If mom wants pain relief, let the nurse or practitioner know. Support whatever decision she makes—to continue unmedicated or to go for pain relief (even if this decision represents a change of plans).
- Take your cues from her. Whatever mom wants, mom should get. Keep in mind that what she'll want may change from moment to moment (the TV blaring one second, TV off the next). Ditto for her mood and her reaction to you. Don't take it personally if she doesn't respond to, doesn't appreciate—or is even annoyed by—your attempts to comfort her. Ease up, if that's what she seems to prefer—but be prepared to step it up 10 minutes later if she wants. Remember that your role is important, even if you sometimes feel unneeded, unwanted, or just plain in the way. She'll appreciate you in the morning (or whenever it's all over).
- Set the mood. If possible, keep the door to the room closed, the lights low, and the room quiet to promote a relaxed and restful atmosphere. Soft music may also help (unless she'd rather watch TV—remember, she's the boss right now). Continue encouraging relaxation techniques between contractions and breathing with her through the contractions—but don't push if she's not into them or if the relaxation agenda is starting to stress her out. If distractions seem to help her, turn to cards or game apps, light music, or TV. But distract her only as much as she seems to want to be distracted.
- Pump her up. Reassure her and praise her efforts (unless your verbal reassurance is making her more edgy), and avoid criticism of any kind (even the constructive type). Be her cheerleader (but keep it low-key, since she probably won't appreciate full-on exuberance). Particularly if progress is slow, suggest that she take her labor one contraction at a time, and remind her that each pain brings her closer to seeing the baby. If she finds your cheers irritating, however, just support her gently. Stick to sympathy if that's what she seems to need.
- Keep track of the contractions. If she's on a monitor, ask the practitioner or the nurse to show you how to read it. Later, when contractions are coming one on top of the other, you can announce each new contraction as it begins—the monitor may detect the tensing of the uterus before she can, and can let her know when she's having one if she can't feel them, thanks to an epidural. You can also encourage mom through those tough contractions by telling her when each peak is ending. If there is no monitor, ask a nurse to show you how to recognize the arrival and departure of contractions with your hand on her abdomen (unless she doesn't want it there).
- Massage her neck or back, or use counterpressure or any other techniques you've learned, to make her more comfortable. Let her tell you what kind of stroking or touching or massage helps. If she prefers not to

be touched at all, comfort her verbally. Remember, what feels good one moment might rub her the wrong way the next, and vice versa.

- Remind her to take a bathroom break at least once an hour if she doesn't have a catheter. She might not feel the urge, but a full bladder can stand in the way of labor progress.
- Suggest a change of positions. You'll find a variety of labor positions to try starting on page 412. Or suggest a shower or a soak in the tub to help ease the pain.
- Be the ice man. Find out where the ice machine is, and keep those chips coming. If she's allowed to sip on fluids or snack on light foods, offer them periodically. Popsicles may be especially refreshing, so ask the nurse if there's a stash you can help yourself to.
- Keep her cool. Use a damp washcloth, wrung out in cold water, to help cool her body and face. Refresh it often.
- If her feet are cold, offer to get out a pair of socks and put them on her (reaching her own feet won't be easy).
- Be her voice and her ears. She has enough going on, so lighten her load. Serve as her go-between with medical personnel as much as possible. Intercept questions from them that you can answer, and ask for explanations of procedures, equipment, and use of medication, so you'll be able to tell her what's happening. For instance, now might be the time to find out if a mirror will be provided so she can view the delivery. Be her advocate if she's unhappy about a procedure or policy, but stay calm as you intervene on her behalf so she doesn't get more upset.

Phase 3: Transitional Labor

Transition is the most demanding phase of labor but, happily, typically the quickest. Suddenly, the intensity of the contractions picks up. They become very strong, 2 to 3 minutes apart, and 60 to 90 seconds long, with very intense peaks that last for most of the contraction. Some moms, particularly those who have given birth before, experience multiple peaks. You may feel as though the contractions never disappear completely and you can't completely relax between them. The final 2 to 3 cm of dilation, to a full 10 cm, will probably take place in a very short time: on average, 15 minutes to an hour, though it can also take as long as 3 hours.

What you may be feeling. You'll feel plenty when you're in transition (unless, of course, you've had an epidural), and may experience some or all of the following:

- More intense pain with contractions
- Strong pressure in the lower back and/or perineum
- Rectal pressure
- An increase in your bloody show as more capillaries in the cervix rupture
- Feeling very warm and sweaty or chilled and shaky (or you might alternate between the two)
- Crampy legs that may tremble uncontrollably
- Nausea and/or vomiting
- Drowsiness between contractions as oxygen is diverted from your brain to the site of the delivery
- A tightening sensation in your throat or chest
- Exhaustion