Complete contraction survival guide

What a contraction is and how the pattern changes

A uterine contraction is a coordinated tightening of the myometrium. You may feel pressure, cramping, abdominal firmness, pelvic heaviness, or pain that radiates into the back or thighs. The sensation commonly builds gradually, reaches a peak, and then subsides, leaving a period of relative recovery. The intensity and location are highly individual; some people experience prominent back pain, while others mainly feel abdominal tightening.

In early labour, contractions may be irregular and separated by variable intervals. They often become progressively more organized, with increasing duration, frequency, and intensity. During active labour, contractions are generally more regular and demanding, and cervical effacement and dilation usually accelerate. Later, contractions may feel very powerful and close together as the body approaches the second stage of labour. These descriptions are general rather than diagnostic: cervical change can only be assessed clinically when an examination is indicated and consented to.

Braxton Hicks contractions may also occur before labour. They can be uncomfortable, but they often remain irregular and may settle with rest, hydration, or a change of activity. A pattern that is becoming more regular or

difficult to talk through deserves a call to your maternity service, particularly if you are unsure whether labour has begun.

How to time contractions accurately

Timing can reduce uncertainty and give your clinician useful information. Use a contraction timer, clock, or written record. Start the timer when the tightening begins, stop it when the contraction ends, and note the next start time. The interval or frequency is measured from the beginning of one contraction to the beginning of the next, not from the end of one to the beginning of the next. Duration is the total length of the contraction itself.

Record the start time of each contraction.
Record when it ends or estimate its duration in seconds.
Calculate the start-to-start interval between consecutive contractions.
Continue for several contractions so that you can identify a trend rather than relying on one isolated event.
Note associated details, such as fluid leakage, vaginal bleeding, fetal movement, pain location, and whether rest or movement changes the pattern.

Share the pattern with your maternity team rather than focusing only on a single numerical threshold. Many services use a pattern of regular contractions that are several minutes apart and lasting about a minute as a reason to call or attend, but instructions differ according to parity, distance from hospital, gestational age, membrane status, and local policy. If your clinician has given you a personal plan, follow that plan.

A contraction-by-contraction coping plan

Try to treat each contraction as a temporary event with a beginning, middle, and end. Before it starts, release your shoulders, unclench your jaw, and choose one simple focus. As it builds, breathe slowly and steadily rather than holding your breath. A longer exhalation can help reduce unnecessary muscular tension. Between contractions, deliberately relax, change position if comfortable, take small sips of fluid, and allow your body to recover.

Movement is often useful in early labour. Walking, standing, leaning over a counter, rocking the pelvis, kneeling, or using an exercise ball may help you

find a tolerable posture. Side-lying can provide rest, especially when fatigue is accumulating. If you have an epidural, monitoring, mobility restriction, or another clinical consideration, ask your care team which positions are safe.

Warmth may be soothing. Depending on your clinician’s advice and local facilities, options can include a warm bath or shower, a heat pack applied with appropriate protection, massage, or firm pressure over the sacrum for back discomfort. TENS may also help some people, particularly in early labour. Avoid overheating, burns, unsafe water temperature, or any method that conflicts with your medical instructions.

Breathing, relaxation, and support during labour

Breathing does not eliminate pain, but it can provide rhythm and reduce panic during an intense contraction. In early labour, use comfortable, slow breathing. As the contraction peaks, keep the breath gentle and audible if that helps you maintain a regular pattern. If you notice rapid breathing, tingling, dizziness, or a sense of losing control, pause, relax your hands and face, and return to a slower exhalation. Tell your support person or clinician if these symptoms do not resolve.

A support person’s role is practical rather than performative. They can time contractions, offer water if permitted, provide counterpressure or massage, adjust pillows, protect your privacy, and communicate your preferences to staff. They should ask before touching you and stop if touch becomes irritating. Short, calm phrases such as "breathe out," "your body is working," or "you have a break now" may be more helpful than frequent questions.

Consider preserving your energy. Eat or drink only according to your maternity team’s guidance, particularly if there is a possibility of operative delivery or a condition affecting intake. Use the quiet intervals to urinate regularly if possible, rest, and keep the environment as calm as you can. You do not need to make every decision during the peak of a contraction; discuss analgesia and birth preferences during the recovery period.

When early labour becomes active labour

Labour is commonly described in stages. The first stage includes early, or

latent, labour and active labour. In early labour, the cervix begins effacing and dilating, and contractions may remain manageable or inconsistent for some time. Active labour is characterized by more progressive cervical dilation and contractions that are typically stronger, longer, and closer together. The transition toward full dilation can bring marked pressure, nausea, shaking, emotional intensity, or a strong urge to bear down, but these symptoms are not a reliable substitute for clinical assessment.

Do not judge labour progress solely by pain intensity. Pain perception varies, and a very painful contraction pattern does not by itself establish cervical dilation. Conversely, some people have significant cervical change without dramatic pain. Your maternity team may assess maternal observations, fetal heart rate, contraction pattern, membrane status, and other clinical findings when deciding whether you should remain at home, attend hospital, or receive additional support.

Once the cervix is fully dilated, the second stage involves birth of the baby. Follow the guidance of your midwife or obstetrician about pushing, breathing, and position. If you feel an involuntary urge to push before being assessed, use slow breathing or gentle panting if advised while contacting your care team, especially if you are not yet in a birth setting.

When to contact your maternity team or go in

Call your midwife, obstetrician, or maternity triage service when contractions become regular and increasingly difficult to cope with, when they meet the timing pattern you were given, or whenever you are uncertain. Contact them earlier if you have had a rapid previous labour, live far from the birth facility, have been advised to attend promptly, or have a high-risk pregnancy. Your team can tell you whether to continue monitoring at home or come in for assessment.

Suspected rupture of membranes warrants advice, even if contractions have not started. Note the time, amount, and colour of the fluid and use a maternity pad rather than inserting anything into the vagina. Clear or lightly pink fluid may occur, but green, brown, foul-smelling, or heavily blood-stained fluid requires urgent communication. Do not assume that a small intermittent leak is urine without discussing it with your care provider.

Seek urgent medical help for heavy vaginal bleeding, severe constant abdominal pain between contractions, fainting, chest pain, difficulty breathing, fever, severe headache or visual disturbance, or markedly reduced or absent fetal movement. If labour-like contractions occur before 37 weeks, contact your maternity service immediately because preterm labour requires prompt assessment. If you feel unsafe or cannot reach your maternity team, use local emergency services.

After arrival: communicating clearly and accepting help

Bring or communicate the essentials: gestational age, contraction timing, whether your membranes have ruptured, fluid colour, bleeding, fetal movement, allergies, medications, relevant medical or obstetric history, and your preferred pain-relief options. If you have a birth plan, treat it as a communication aid rather than a guarantee. Labour can change quickly, and adapting the plan is not failure.

Analgesia options vary by facility and may include non-pharmacological measures, inhaled analgesia, systemic medication, or neuraxial analgesia such as an epidural. Each option has indications, limitations, side effects, and timing considerations. Ask your clinician to explain the choices available to you; you can request pain relief at any stage, subject to clinical circumstances and local policy.

Contractions can be physically exhausting and emotionally disorienting. Needing reassurance, medication, monitoring, assistance with positioning, or an operative birth does not mean you coped badly. The safest and most compassionate approach is one that responds to your and your baby’s clinical needs while respecting your informed preferences.