

## **Pain that does not stop between contractions**



### **Why the pause between contractions matters**

In many labors, contractions have a recognizable rhythm. The uterus tightens, pain or pressure increases, the contraction reaches a peak, and then the muscle relaxes. Healthdirect describes normal labor contractions as painful tightenings that continue until the cervix is fully dilated, with pain that eases between contractions. That easing is not always complete comfort; many people still feel pelvic heaviness, backache, fatigue, nausea, or anxiety. But there is usually some change in intensity as the contraction passes.

When pain that does not stop between contractions occurs, the first question is whether the uterus is truly staying firm or whether another pain is overlapping the contraction pattern. For example, lower back pain in labor can persist if the baby's position places pressure on the sacrum, while contraction peaks come and go on top of that baseline ache. Similarly, pelvic pressure during contractions may become nearly constant when the baby descends, especially late in labor.

The pause matters because it is part of how clinicians assess labor progress, uterine activity, maternal coping, fetal tolerance, and the possibility of complications. A uterus that relaxes between contractions allows blood flow

through the placenta to recover. A person in labor also needs moments to breathe, hydrate, change position, and gather strength. If there is no rest, or if pain remains severe even when monitors or palpation suggest the uterus is not contracting, it is reasonable to ask for reassessment rather than trying to endure silently.

### **When active labor can feel almost continuous**

Active labor often changes the character of pain. Contractions become longer, stronger, and closer together. Medical News Today notes that active labor may include feelings of the uterus not relaxing between contractions. This sensation can be especially prominent when contractions are coming every two to three minutes, because the short interval between waves may feel like no break at all.

Transition, the late part of the first stage before full cervical dilation, can be particularly intense. Contractions may cluster, the urge to bear down may appear, and rectal or pelvic pressure can become overwhelming. A person may say, "It never stops," even if there are brief dips in intensity. That report should be taken seriously. It may signal rapid progress, inadequate analgesia, malposition-related pain, fear and exhaustion, or a need for additional monitoring.

It can help to describe the pain in layers. Is there a constant baseline pain plus surges? Does the abdomen remain hard to touch between peaks? Is the pain mainly in the front of the uterus, deep in the pelvis, or across the back? Does it improve with upright positions during labor, side-lying, water, breathing support, or sacral counterpressure during contractions? These details do not diagnose the cause, but they give the midwife, obstetric clinician, or labor nurse useful information.

Continuous-feeling pain is not automatically dangerous, but it is not something you need to normalize without support. If you are in a hospital, birth center, or triage unit, tell the team clearly: "I am not getting relief between contractions," or "My uterus feels hard all the time." If you are at home, call your maternity unit or healthcare professional for guidance, particularly if contractions are strong, close together, or difficult to walk or talk through.

## **Braxton Hicks, prodromal labor, and true labor**

Not all uterine tightening is established labor. Braxton Hicks contractions are often sporadic, irregular, and sometimes described as practice contractions. StatPearls explains that they are commonly considered false labor pains. They may be uncomfortable, but they often lessen with hydration, rest, or position change. They also do not usually become progressively stronger, longer, and closer together in the consistent pattern expected with true labor contractions.

Prodromal labor can be more confusing. It may feel more organized than Braxton Hicks and can last hours or recur over days, yet cervical change may be minimal. Medical News Today contrasts prodromal labor with active labor, noting that prodromal sensations are often more uncomfortable than painful and do not follow the same progressive pattern. However, lived experience varies; prodromal contractions can be tiring and emotionally draining, especially when sleep is disrupted.

True labor contractions tend to intensify over time, occur at more regular intervals, and do not reliably disappear with position changes. StatPearls highlights warning patterns such as strong contractions every five minutes for an hour and contractions a woman is unable to walk through as reasons to contact a healthcare provider. These are not strict rules for every pregnancy, but they are useful safety prompts.

Pain that does not stop between contractions is less typical for Braxton Hicks. If the pain is constant, severe, or associated with other symptoms, it should not be assumed to be false labor. A maternity professional may ask about gestational age, contraction timing, vaginal bleeding, rupture of membranes before contractions, fetal movement, previous cesarean or uterine surgery, and any pregnancy complications. Those factors change the urgency and type of evaluation needed.

### **Possible reasons pain may not ease**

There are several non-diagnostic explanations for why pain may feel continuous. One common reason is overlapping sensations: the uterus contracts in waves, while back pain, hip pain, pelvic pressure, or ligament discomfort persists underneath. A baby in a posterior or asynclitic position may contribute to

lower back pain in labor or pain radiating into the hips. In that situation, hands-and-knees for back labor, forward-leaning labor positions, or side-lying position during contractions may sometimes help comfort, though position changes should be guided by your clinical situation.

Another reason is contraction frequency. When contractions are very close, the body may have only seconds of partial relief. Fatigue, dehydration, vomiting, anxiety, and lack of sleep can lower coping capacity and make the valleys between contractions hard to perceive. Pain may also feel continuous when the cervix is changing rapidly or when fetal descent through the pelvis creates constant pressure on the pelvic floor and rectum.

Medical factors can also require prompt assessment. Persistent severe abdominal pain may raise concern for conditions that clinicians need to evaluate urgently, especially if it is accompanied by abnormal bleeding, uterine tenderness, fever, faintness, shoulder-tip pain, reduced fetal movement, abnormal fetal heart rate, or a history of uterine surgery. This article cannot determine whether any of those are present in your case, and online descriptions are not enough to rule out complications.

Medication and monitoring can affect perception too. An epidural may reduce contraction pain but leave pressure, one-sided discomfort, or breakthrough pain. Oxytocin augmentation, if used, can increase contraction frequency and requires monitoring to ensure adequate uterine relaxation. If you are receiving any labor medication and feel pain that does not release, tell the team immediately so they can assess contraction pattern, fetal wellbeing, analgesia effectiveness, and maternal vital signs.

### **How to describe it to your maternity team**

Clear language helps clinicians respond quickly. Instead of rating pain only from zero to ten, describe the pattern. Useful statements include: "The pain peaks, but it never goes below a seven," "My abdomen stays tight between contractions," "I have constant pain on one side," "The back pain does not stop," or "I feel pressure like I need to push." If you can, note when the pattern began and whether it is changing.

Timing contractions can provide context, but do not let a timer delay care if

something feels wrong. Record the start of one contraction to the start of the next, the length of each contraction, and whether there is a clear rest interval. Also mention whether you can talk, walk, breathe, or change position during the contraction. StatPearls specifically notes contractions that cannot be walked through as a warning sign to contact a healthcare provider.

Report associated findings plainly. These include vaginal bleeding, fluid leakage, green or foul-smelling fluid, fever, severe headache, visual symptoms, chest pain, shortness of breath, dizziness, new swelling, reduced fetal movement, or pain around a previous uterine scar. If your waters have broken, say when it happened and what the fluid looked and smelled like. If you are preterm, have a high-risk pregnancy, or have had a previous cesarean birth or uterine surgery, mention that early in the call.

You deserve to be believed and assessed. Pain expression varies widely, and severe continuous pain is not a character test. If you feel dismissed, it is appropriate to repeat the specific concern: "I understand contractions are painful, but I am worried because the pain is not easing between them." A support person can help by timing contractions, observing whether the abdomen softens, keeping track of fetal movement reports, and advocating calmly for reassessment.

### **Seeking support and staying safe**

If you are at home and pain does not ease between contractions, contact your midwife, obstetric unit, or local maternity triage service. They may advise coming in for assessment, especially if contractions are frequent, strong, or you are unable to walk or speak through them. If you have urgent warning signs, emergency services may be more appropriate than waiting for a routine callback.

While waiting for advice, avoid self-diagnosing. If you have been given an individualized birth plan or pregnancy-specific instructions, follow those. Otherwise, focus on safety: stay near a phone, have transportation ready, avoid being alone if possible, and gather essential documents. If fetal movement is reduced or there is significant bleeding, do not spend time trying multiple comfort measures before seeking urgent care.

Comfort strategies can still matter when the maternity team has advised it is

safe to remain at home or continue laboring. Slow breathing, warm water if permitted, supported upright positions, hands-and-knees position for back labor, gentle hip movement, and counterpressure can reduce suffering for some people. Hydration and emptying the bladder may also improve comfort. These measures are supportive, not a substitute for evaluation when pain is persistent or severe.

In a clinical setting, assessment may include palpating the uterus between contractions, fetal heart rate monitoring, maternal vital signs, abdominal examination, cervical assessment when appropriate, and review of contraction frequency. The goal is not only to confirm labor progression but also to ensure that both you and the baby are tolerating labor. Asking for pain relief is also valid. Options depend on location, stage of labor, medical history, fetal status, and your preferences.

The central message is compassionate caution: labor can be profoundly intense, and near-continuous pain can occur in active labor, but pain that does not stop between contractions deserves attention. You are not overreacting by asking for help, clarification, or reassessment.