



Nurses' Own Birth Experiences Influence Labor Support Attitudes and Behaviors

Ann P. Aschenbrenner, Lisa Hanson, Teresa S. Johnson, and Sheryl T. Kelber

Correspondence

Ann P. Aschenbrenner, PhD, RN, CNE, University of Wisconsin—Milwaukee, PO Box 413, Milwaukee, WI 53201-0413. aschen25@uwm.edu

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ABSTRACT

Objective: To describe the attitudes of intrapartum nurses about the importance of and intent to provide professional labor support (PLS); barriers to PLS, such as perceived subjective norms and perceived behavioral control; and relationships among attitudes, behaviors, and nurse and site characteristics.

Design: A cross-sectional, mixed-methods, descriptive design was guided by the Theory of Planned Behavior.

Setting: Three hospital sites in one region of a single Midwestern state.

Participants: Sixty intrapartum nurses participated.

Methods: The Labor Support Questionnaire and demographic questionnaire were administered online. The Labor Support Questionnaire is used to measure attitudes about the importance of and intended behaviors associated with labor support.

Results: *Nurse Caring Behaviors* was the highest rated PLS dimension. Participants' own personal birth experiences and length of current intrapartum experience were positively correlated with attitudes about and intent to provide PLS. Barriers to PLS included staffing, documentation, physicians, use of epidural analgesia, doulas, and birth plans.

Conclusion: Personal birth and work experience influenced attitudes about and intent to provide PLS and demonstrated the relationships described in the Theory of Planned Behavior. Intrapartum nurses may benefit from an examination of their personal experiences to see how they might influence attitudes about PLS. Enhanced training and expanded labor and birth experience for novice nurses or students may improve attitudes and intended behavior with regard to PLS. Further investigations of the factors that affect integration of PLS into care are important to promote healthy birth outcomes.

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Ann P. Aschenbrenner, PhD, RN, CNE, is a clinical associate professor and Program Director of the Master of Nursing Program, College of Nursing, University of Wisconsin—Milwaukee, Milwaukee, WI.

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Women need physical and emotional support during the intense and profound experiences of labor and birth. Friends, family members, doulas, midwives, or nurses can provide this support. Most U.S. women give birth in hospitals (MacDorman, Mathews, & Declercq, 2014), and historically labor support has been an important role of labor and delivery nurses. Outcomes related to the use of professional labor support (PLS) include women's increased satisfaction with care (Hodnett et al., 2008). Although researchers reported decreased oxytocin use (Gagnon, Waghorn, & Covell, 1997) and fewer cesarean births (Gagnon & Waghorn, 1999) with PLS, these results were not statistically significant. Nursing care has been shown to have a statistically significant independent influence on cesarean birth rates (Radin, Harmon, & Hanson,

1993). Despite these benefits, PLS has not been found to lead to the outcomes found in studies of nonprofessional labor support provided by untrained laypersons, trained doulas, or midwives (Hodnett, Gates, Hofmeyr, & Sakala, 2013).

Researchers found that lay support was associated with fewer cesarean births (Klaus, Kennell, Robertson, & Sosa, 1986; Madi, Sandall, Bennett, & MacLeod, 1999; Morhason-Bello, Adedokun, Ajengbede, Olayemi, Oladokun, & Fabamwo, 2009), shorter duration of labor (Klaus et al., 1986; Morhason-Bello et al., 2009), less use of oxytocics (Klaus et al., 1986; Madi et al., 1999), and less use of analgesia (Madi et al., 1999). Similar results were documented in studies of trained labor support, including shorter labors (Campbell, Lake, Falk, & Backstrand, 2006;

Reported benefits of professional labor support include increased maternal satisfaction; nonprofessional labor support is associated with shorter labor, fewer cesareans, and fewer epidurals.

Kashanian, Javadi, & Haghghi, 2010; Kennell, Klaus, McGrath, Robertson, & Hinkley, 1991; Langer, Campero, Garcia, & Reynoso, 1998), fewer cesareans (Kashanian et al., 2010; Kennell et al., 1991; McGrath & Kennell, 2008; Trueba, Contreras, Velazco, & Lara, 2000), fewer epidurals (Kennell et al., 1991; McGrath & Kennell, 2008), and less use of analgesia (Hodnett & Osborn, 1989) and oxytocics (Hodnett & Osborn, 1989; Trueba et al., 2000). These studies were conducted primarily outside the United States at sites at which usual care involved crowded labor rooms and little or no support.

In contrast to lay support, PLS primarily occurs in an intrapartum hospital setting. A number of personal and environmental factors have been studied for their effects on PLS. Work demands such as hospital unit staffing were negatively related to PLS (Carlton, Callister, Christiaens, & Walker, 2009; Davies & Hodnett, 2002). Subjective norms, that is, a person's beliefs that others value a behavior, may also influence behavior (Ajzen, 2002). A contemporary example of how subjective norms may influence PLS involves the prevalence of the use of epidural analgesia in hospitals, and the intent of nurses to provide continuous labor support differs depending on epidural use (Payant, Davies, Graham, Peterson, & Clinch, 2008). Professional labor support for women who have epidural analgesia may not be socially supported by staff on an intrapartum unit (Carlton et al., 2009; Payant et al., 2008), and researchers suggested that the prevalence of the use of epidural analgesia jeopardizes nurses' abilities to remain current in labor support skills (Carlton et al., 2009). Nurses may find it difficult to maintain knowledge and expertise for labor support when women do not often give birth naturally without epidural analgesia.

Nurses also were influenced by managerial or unit-based views on PLS (Angus, Hodnett, & O'Brien-Pallas, 2003; Miltner, 2002; Sleutel, Schultz, & Wyble, 2007). In addition, attitudes about labor support practices (Davies & Hodnett, 2002; Sauls, 2007), facility culture (Sleutel et al., 2007), and relationships with physicians (Angus et al., 2003; Carlton et al., 2009; Sleutel, 2000;

Sleutel et al., 2007) also were reported to influence PLS. For example, nurses frequently viewed the labor-controlling behaviors of physicians, such as offering epidural analgesia and augmenting and monitoring labor, as limiting their ability to provide appropriate care for women in labor (Angus et al., 2003; Sleutel, 2000; Sleutel et al., 2007). Miltner's (2002) observational study of intrapartum nursing care showed that nurses' actions focused on the family and on patient education unrelated to the labor process, rather than on the promotion of labor progress or the woman's comfort. This lack of focus on actions to promote labor progress and comfort may provide a plausible explanation for a dearth of positive outcomes related to PLS.

In addition, nurses' ages and experience were directly related to the time they spent in the provision of labor support (Barrett & Stark, 2010). Older nurses and those with more PLS experience showed more confidence and competence in the provision of PLS than younger, less-experienced nurses (Barrett & Stark, 2010). Nurses with more experience in PLS provided more coping alternatives to women during labor (Sleutel et al., 2007). To our knowledge, the relationship between nurses' own personal birth experiences and PLS has not been reported in the literature.

Although the intrapartum environment; nurse characteristics and attitudes; subjective norms; and managerial, peer, and physician support may influence PLS, to our knowledge investigators have not evaluated the interactions of these factors and their effect on labor and birth outcomes. The objective of our study was to describe intrapartum nurses' attitudes about and intent to provide PLS; to describe barriers to PLS, such as perceived subjective norms and perceived behavioral control; and to identify relationships among attitudes, behaviors, and nurse and site characteristics.

Conceptual Framework

The conceptual framework for this study was adapted from the Theory of Planned Behavior (Ajzen, 2002). According to this theory, actual behavior depends on the intent to act, which is determined by attitudes, subjective norms, and perceived behavioral control related to the behavior. Attitudes are an individual's tendency to respond in a negative, neutral, or positive manner. Subjective norms (beliefs that a behavior

Lisa Hanson, PhD, CNM, FACNM, is a professor and Program Director of Midwifery Program, College of Nursing, Marquette University, Milwaukee, WI and a staff certified nurse-midwife for the Aurora Midwifery and Wellness Center, Milwaukee, WI.

Teresa S. Johnson, PhD, RN, is an associate professor in the College of Nursing, University of Wisconsin–Milwaukee, Milwaukee, WI and a research nurse consultant for Wheaton-Franciscan Healthcare–All Saints, Racine, WI.

Sheryl T. Kelber, MS, is a biostatistician in the Harriet H. Werley Center for Nursing Research and Evaluation, University of Wisconsin–Milwaukee, Milwaukee, WI.

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