A Practical Approach to Labor Support

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ABSTRACT

In the United States, intrapartum nurses are present at 99% of births. These nurses have a unique opportunity to positively affect a laboring woman's comfort and labor progress through the use of labor support behaviors. These nonpharmacologic nursing strategies fall into four categories: physical, emotional, instructional/informational, and advocacy. Implementation of these strategies requires special knowledge and a commitment to the enhanced physical and emotional comfort of laboring women.

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Intrapartum nurse
Labor positions
Labor support

Quality nursing care for laboring women combines a variety of skills and behaviors to ensure a positive birth experience. Labor support behaviors (LSB) by nurses provide nonpharmacologic pain relief and support to laboring women. Sauls (2004) defined labor support as the “intentional human interaction between the intrapartum nurse and the laboring woman that assists the client to cope in a positive manner during the process of giving birth” (p. 125). Association of Women’s Health, Obstetric and Neonatal Nurses’ (AWHONN, 2000) Clinical Position Statement on this topic stated that “continuously available labor support by a professional registered nurse is a critical component to achieve improved birth outcomes.” This article offers instruction for many supportive behaviors the intrapartum nurse can implement with laboring women. Antepartum nurses and childbirth educators may also utilize LSB in preparing clients for labor.

Choosing LSB

Intrapartum nurses use their assessment skills to choose appropriate LSB for their patients’ varying needs. Nurses may choose a combination of supportive behaviors. For example, when assisting women to change positions (physical LSB), the nurse conveys respect by providing privacy and protecting modesty (advocacy LSB). A single LSB may also fall into more than one category. Bryanton, Fraser-Davey, and Sullivan (1994) noted that praise and encouragement overlap both the emotional and informational categories.

Physical LSB

Physical support and comfort enhance labor progress and increase satisfaction with the birth experience.
Proper positioning in labor and birth can reduce pain, analgesia use, and perineal trauma and enable more effective uterine contractions.

Sims’ Position to Slow Fetal Descent or Facilitate Rotation. Sims’ positions can help to slow down fetal descent, allowing control over pushing efforts and preventing perineal lacerations (Albers, 2003; Simkin & Bolding, 2004). It can also facilitate anterior rotation of a fetus (Ridley, 2007). This can be accomplished by instructing the woman to lie on the side of the fetal spine. For example, if the fetus is in right occiput posterior position, the woman lies on her right side. Gravity pulls the fetal occiput and trunk to the right occiput transverse position and eventually to right occiput anterior. Wedge a pillow between the woman’s back and bed, and place a pillow under the abdomen for support (Adams & Bianchi, 2006). Once the fetus is in proper alignment for descent, encourage an upright sitting position.

Lunge. The lunge is used during labor to decrease back pain and facilitate rotation of a fetus in the occiput posterior position (Simkin, 2002). If the fetus is in the left occiput posterior position, instruct the woman to place her left foot on the chair while turning the left leg outward. The femur acts as a lever at the hip joint, prying the ischium outward creating more space for rotation or correction of asynclitism. While supporting the woman, instruct her to lean into the foot on the chair. Hold the lunge for 3 seconds, then return to upright. Repeat this motion three to five times during each contraction for several successive contractions (Adams & Bianchi, 2005).

Dangle. The dangle position assists fetal descent by reducing external pressure on the sacrum or hips (Simkin & Ancheta, 2005). The nurse or partner stands behind the woman, using a wide base of support, and places the arms under the woman’s axillae. When contraction begins, the woman flexes her knees and drops her weight to dangle. The nurse or partner supports the weight of the woman during the contraction.

Squatting. Squatting increases the diameter of the pelvis, facilitating rotation and fetal descent (AWHONN, 2000). Women who squatted experienced less pain, less genital tract trauma, and shorter second stage (Albers, 2003; Mayberry, Gennaro, Strange, Williams, & De, 1999; Soong & Barnes, 2005). A squatting bar can be attached to the bed to help stabilize and provide balance. As contraction begins, instruct the laboring woman to hold onto the bar for support. Feet should be hip distance apart and remain flat. If the woman is too fatigued to support her weight, kneeling can be encouraged. The towel pull can also be used to achieve the same benefit. For the woman with epidural analgesia, a modified squat may be achieved by having the woman sit on a birthing bed with the foot of the bed in the lowest position.

Environmental Control
Environmental control creates a comforting atmosphere. Adjusting room temperature and lighting while decreasing distracting noises contributes to physical comfort. Therapeutic use of music can have a calming effect. Music activates the right brain and can effectively mediate pain (Chang & Chen, 2004; Phumdoung & Good, 2003). Music selection is based on what the woman finds relaxing and comforting. Phumdoung and Good found that soft music without lyrics during the active phase of labor significantly decreased the sensation and distress of pain. Antepartum nurses and childbirth educators can encourage women to bring music of their choice.

Positioning
Proper positioning in labor and birth can reduce pain, analgesia use, and perineal trauma and enable more effective uterine contractions (Mayberry et al., 2000). The optimal position is determined by assessment of the woman, her phase of labor, fetal position, and the woman’s desires. Although only a few positions such as Sims’ sitting, and squatting have been supported by research to show a positive effect on client outcomes, the positions mentioned in this article have been reported by laboring women and nurses to provide satisfaction during labor and birth.

Sitting. Sitting positions during labor assist the natural force of gravity to encourage fetal descent, improve the quality and effectiveness of labor contractions, and decrease pain (Gilder, Mayberry, Gennaro, & Clemmens, 2002). Upright positions include sitting in a rocking chair, on a birth ball, or on the toilet.

Towel Pull. The towel pull technique encourages effective pushing when used in upright positions by involving abdominal muscles in expulsive efforts. As contraction begins, the woman leans forward and pulls on one end of the towel, while the nurse or partner provides resistance. As the woman pulls the towel, abdominal muscles naturally contract, providing external pressure on the uterus.

For the woman with epidural analgesia, a modifi ed squat

(hodnett, gates, hofmeyr, & sakala, 2003; manogin, bechtel, & rami, 2000). A variety of LSB are listed in table 1.
Touch

Touch conveys an attitude of caring and encourages comfort, but a pat on the hand or shoulder may be acceptable to some but not to others. Nurses must consider the client’s personal space and cultural background when determining appropriate touch during labor.

Massage, a form of touch, relaxes muscles and increases blood flow (Brown, Douglas, & Flood, 2001) and enhances the release of endorphins, promoting comfort while decreasing pain (Simkin & Bolding, 2004). Brown et al. found that clients who used pain medication also found the use of massage and acupressure to be more effective than other nonpharmacologic methods of pain relief. Further investigation is needed to determine whether massage alone directly decreases pain during labor.

Ho-Ku Point Pressure. The Ho-Ku point is an acupressure point which when stimulated can increase frequency of contractions without increasing pain. The point is located where the bones of the index finger and thumb join (web of the hand). Apply pressure for 10 to 60 seconds and repeat six times (Simkin, 1997).

Double Hip Squeeze. The double hip squeeze changes the shape of the pelvis and releases tension on the sacroiliac joints. Position the woman on her hands and knees or have her lean over the bed. Standing behind the woman, locate iliac crest and gluteal muscle. Place hands on each side below iliac crest and over gluteal muscle with fingers pointing toward midline. Apply pressure by simultaneously pushing hands toward sacrum throughout the contraction (Simkin & Ancheta, 2005).

Knee Press. Pressure on the knees pushes the femurs toward the hips to relieve strain on sacroiliac joints. Position the woman in a chair with knees a few inches apart and feet flat on the floor. The nurse faces the woman and locks elbows into his or her sides, cupping both knees with the hands. As contraction begins, the nurse uses entire body weight to lean in and apply pressure against knees. The knee press can be used when the woman is in a lateral position. The nurse presses the upper knee toward her back, while the partner applies pressure over sacrum (Simkin & Ancheta, 2005).

Application of Cold and Heat

Pain perception is lowered and muscle spasms decrease when cold and heat are applied to different areas of the body. Temperature of the source should be monitored to protect the woman’s skin from injury. Cold compresses numb an area, slowing transmission of pain and other impulses over sensory neurons, and last longer than heat. If the woman is experiencing intense pain in the lower back, an ice pack placed directly over the sacral area can be helpful. Cold application to the forehead and neck can also provide relief.

Heat application raises the pain threshold, increases circulation, and relaxes muscles. A heat pack can be placed over the lower back, groin, or thighs. Warm water immersion increases relaxation (Benfield, Herman, Katz, Wilson, & Davis, 2001) and promotes labor progress (Simkin & Bolding, 2004). Further investigation is needed to determine whether other forms of cold and heat application decrease pain during labor.

Partner Care

Physical labor support can be exhausting for the partner. To maintain the partner’s energy, nurses can offer respite time and encourage nutritional intake. Making the environment comfortable by offering a pillow or blanket is also helpful.

Emotional LSB

Emotional LSB provide the client with a sense of emotional comfort (see Table 2). Lazarus and Folkman

Table 1: Physical Labor Support

<table>
<thead>
<tr>
<th>Specific Category</th>
<th>Specific Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental control</td>
<td>Control room temperature; control noise; dim lights; control odors; arrange personal items</td>
</tr>
<tr>
<td>Positioning, first stage of labor</td>
<td>Standing; ambulation; abdominal lift; slow dancing; leaning; knee-chest; hand and knees; pelvic rocking; lunge; sitting; dangle; squatting; semi-Fowler’s; Sims’ position</td>
</tr>
<tr>
<td>Positioning, second stage of labor</td>
<td>Knee-chest; hands and knees; squatting; Semi-Fowler’s; Sims’ position</td>
</tr>
<tr>
<td>Touch</td>
<td>Massage; pressure</td>
</tr>
<tr>
<td>Application of cold and heat</td>
<td>Use of ice packs; use of cool washcloths; use of hot packs; use of warm blankets</td>
</tr>
<tr>
<td>Hygiene</td>
<td>Provide bath or shower prn; mouth care; perineal care; change bed linens; change gown</td>
</tr>
<tr>
<td>Hydrotherapy</td>
<td>Use of shower; use of tub</td>
</tr>
<tr>
<td>Urinary elimination</td>
<td>Promote frequent emptying of bladder; encourage ambulation to bathroom</td>
</tr>
<tr>
<td>Nourishment</td>
<td>Provide ice chips; provide popsicles</td>
</tr>
<tr>
<td>Partner care</td>
<td>Respite; nutrition; physical comfort; environmental control</td>
</tr>
</tbody>
</table>
(1984) defined emotional support as contributing to the feeling of being loved or cared about and includes attachment, reassurance, and the ability to rely on and confide in a person. These LSB assist to occupy the client's mind with positive thoughts and diminish or block feelings of fear, dread, and anxiety. Sauls (2004) defined emotional support in labor as the ability to subjectively participate and share in the laboring client's feelings.

**Nursing Presence**
Jackson (2004) defined nursing presence as being with the client rather than performing tasks on the client and as complete physical, emotional, psychological, and spiritual engagement between nurse and client. MacKinnon, McIntyre, and Quance (2005) identified physical presence, developing a trusting relationship and emotional presence as essential components of nursing presence. Nursing presence includes portraying a high level of nursing skill; being open, honest, and nonjudgmental with the client; listening intently to her needs and concerns; understanding the privilege of being part of the client's life; and the client's perception of the meaningfulness of the relationship with the nurse (Hunter, 2002; Jackson).

The optimum staffing for labor and delivery units is one nurse to one client. Although most unit staffing matrices will not allow for continuous presence, choosing when to be at the bedside, demonstrating a caring, effective attitude, and being fully present when in the room are important. Nursing tasks can be clustered to provide longer periods of physical and emotional presence.

**Effective Caring Attitude**
Nurse theorist Leininger (2001) called caring the essence of nursing. In Bowers' (2002) review of 17 studies of perceived labor support, clients described a caring nurse as calm, warm, and open. Supportive nurses bestowed praise and encouragement upon the client, were concerned, respectful, and competent, and provided a constant presence. Hodnett (2002) found that maternal satisfaction with the birth process was not related to relief of pain but more closely related to the attitudes and behaviors of caregivers. Communicating caring, competence, and advocacy early in the nurse-client relationship fosters the development of a trusting relationship through which emotional and physical needs can be met.

**Distraction**

**Focal Point.** Distraction includes providing laboring women with specific activities so that conscious thoughts and anxieties are reduced. During the contraction, the focal point assists the laboring woman to tune out painful stimuli by focusing on visual stimuli. When using an internal focal point such as a thought or visual image, the woman closes her eyes and uses mental images to provide distraction from the pain of labor.

**Guided Imagery.** The effectiveness of guided imagery has not been reported within the nursing literature; however, the usefulness in clinical practice has been frequently reported (Jacobson, 2006). This technique uses the mind to create a pleasant image and enhance relaxation in early labor. It is important to keep the environment free of distractions and the client comfortable. Use a script meaningful to the client. Make a suggestion to picture a scene and engage each of her senses to experience the scene. See Table 3.

**Spirituality**
The laboring woman's spirituality or faith may serve as a source of inner strength and comfort during labor (Breen, Price, & Lake, 2006). To provide effective spiritual care, the nurse must attend to the client's spiritual well-being and detect and address spiritual distress (Jackson, 2004). Questions such as “Tell me about your sources of inner strength” or “In what ways can I assist you to rely on

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**Table 2: Emotional Labor Support**

<table>
<thead>
<tr>
<th>Specific Category</th>
<th>Type of Behavior</th>
<th>Specific Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distraction</td>
<td>Visual focal point;</td>
<td>Guided imagery; visualization; hypnosis; encourage client rituals; engage in social</td>
</tr>
<tr>
<td></td>
<td></td>
<td>conversation</td>
</tr>
<tr>
<td>Effective caring attitude</td>
<td>Verbal expression</td>
<td>Affirming words or phrases; soft tone; calm voice; confident voice; encouraging</td>
</tr>
<tr>
<td></td>
<td></td>
<td>words; reassuring praise</td>
</tr>
<tr>
<td></td>
<td>Nonverbal expression</td>
<td>Undivided attention; eye contact; flexible, noninterfering, unobtrusive care; pleasant facial expression</td>
</tr>
<tr>
<td>Nursing presence</td>
<td>Physical presence;</td>
<td>emotional presence; cluster tasks; establish trusting relationship early; convey</td>
</tr>
<tr>
<td></td>
<td></td>
<td>expertise</td>
</tr>
<tr>
<td>Therapeutic use of humor</td>
<td>Assist client to focus</td>
<td>on the comic elements of labor; ensure humor is used appropriately</td>
</tr>
<tr>
<td>Refocusing</td>
<td>Sinikin's (2002)</td>
<td>Take charge routine; refame negative thoughts into positive</td>
</tr>
<tr>
<td>Spirituality</td>
<td>Acknowledge spirituality</td>
<td>prayer; meditation; chanting; quoting scripture</td>
</tr>
<tr>
<td>Partner care</td>
<td>Encouragement;</td>
<td>praise; reassurance; presence</td>
</tr>
</tbody>
</table>
your faith? are useful in assessing the client's reliance upon this source of strength. Nurses also must critically assess their own comfort with providing spiritual care. If a spiritual need is identified that the assigned nurse is unable to meet, a reassignment may be necessary.

Labor support behaviors that incorporate spirituality include prayer, meditation, chanting, reading or reciting from scriptures, and the use of rituals or sacraments. Prayer or meditation can be facilitated by a quiet and respectful environment. Nurses can read scripture or prayers on request of the client. Spiritual rituals or sacraments are typically administered by clergy.

**Partner Care**
Nurses must be aware of the emotional status of the laboring woman’s partner and provide the partner with encouragement, praise, reassurance, and nursing presence. Relieving the emotional stress of the partner can in turn alleviate maternal stress.

**Instructional/Informational LSB**
Instruction and information on all aspects of labor and birth provide clients with an opportunity to be a part of the decision-making process, which fosters a positive birth experience for all (see Table 4). Effective verbal and nonverbal communication is vital when delivering instructional and informational support to clients. Verbal and nonverbal communication is delivered simultaneously, and the message is stronger when these are congruent (Adams & Bianchi, 2005). Verbal communication must be culturally sensitive, taking into consideration how instruction or information is understood by the woman. When an interpreter is used, the nurse should face the woman and direct questions to her instead of the interpreter (Trivasse, 2006).

**Instruction for Relaxation**
The ideal time to provide instruction for relaxation is prior to labor. At the time of labor admission, the intrapartum nurse should assess knowledge and comfort with relaxation techniques. When instructions are provided during labor, a demonstration may be necessary. Instruction presented to the laboring woman should also be directed to the partner. The nurse can encourage relaxation by offering instructions on progressive relaxation and touch relaxation (see Table 5).

**Instruction for Breathing**
Breathing patterns are a learned technique of controlling the depth and rate of respiration to match the intensity

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**Table 3: Supportive Distraction Through Guided Imagery: Beach Scene**

| Preparation | Assist the client to a comfortable position; remove distractions from the room; ask the client to close her eyes and practice abdominal breathing. |
|  |  |
| Read this script in a calm, quiet voice | “You have arrived at the beach. It is early in the day and there are no people in sight. You are alone. With your eyes closed, raise your head toward the sun. Feel how warm the sun feels against your skin. You slowly move toward the edge of the sand. With bare feet you feel the sand and it is soft and warm against your toes. You stand for a moment, to experience your surroundings. The day is fair and bright. There is a light, warm breeze that moves in little swirls around your body. It moves your hair and you feel free. You can smell the seashore and you hear the seagulls a short distance away. Listen to the gentle waves as they move along the edge of the sand. You can see them roll in and out. There is a rhythm to the waves and it matches your breathing. You move closer and feel the coolness of the water around your legs. As you float in the coolness of the water, match your breathing with the waves and let it relax you. You are totally relaxed. The sun rays feel warm upon your face. The water is refreshing and you feel peaceful.” |

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**Table 4: Instructional/Informational Labor Support**

<table>
<thead>
<tr>
<th>Specific Category</th>
<th>Type of Behavior</th>
<th>Specific Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective communication techniques</td>
<td>Verbal</td>
<td>Reflecting; reframing; choosing appropriate words and phrases; choosing culturally sensitive words; using interpreter</td>
</tr>
<tr>
<td></td>
<td>Nonverbal</td>
<td>Gestures; body language; eye contact; culturally sensitive behaviors</td>
</tr>
<tr>
<td>Instructional</td>
<td>Breathing patterns</td>
<td>Cleansing breath; abdominal breathing; patterned breathing; breathing levels</td>
</tr>
<tr>
<td></td>
<td>Relaxation techniques</td>
<td>Progressive; physiological; passive; touch; selective relaxation</td>
</tr>
<tr>
<td></td>
<td>Pushing techniques</td>
<td>Open glottis; closed glottis</td>
</tr>
<tr>
<td>Informational</td>
<td>Routines</td>
<td>Familiarize with surroundings; plan of care; interpret medical jargon; labor and birth process</td>
</tr>
<tr>
<td></td>
<td>Procedures</td>
<td>Nonpharmacologic pain relief; pharmacologic pain relief; routine hospital procedures; electronic fetal monitoring</td>
</tr>
<tr>
<td>Partner care</td>
<td>Explain procedures; update on client progress; role model support behaviors</td>
<td></td>
</tr>
</tbody>
</table>
of the contraction. Breathing awareness and use of different breathing levels can increase a laboring woman’s confidence and ability to cope with contractions and reduce discomfort. Breathing patterns are most effective when learned and practiced before labor begins (Adams & Bianchi, 2005). Antepartum nurses have an opportunity to increase the confidence of pregnant women and their ability to learn breathing and relaxation skills before labor begins, and they can encourage clients to attend childbirth classes that incorporate breathing and relaxation.

Breathing awareness and breathing patterns enable a woman to better control her response to labor. When the woman becomes aware of her breathing rhythm and depth as she inhales and exhales, she is better able to adjust her breathing levels as labor progresses. (See Table 6.) As labor becomes more difficult, a woman may state that she feels overwhelmed by the contractions. When the laboring woman is unable to maintain her concentration, the intrapartum nurse can suggest switching to the next breathing level, one that has a faster pace and requires more concentration (Adams & Bianchi, 2005).

Instruction During Pushing

During the second stage, the nurse can support the woman to use open-glottis pushing and follow her own

Table 5: Instructions for Relaxation

<table>
<thead>
<tr>
<th>Type</th>
<th>Purpose</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| Progressive relaxation| Allows the woman to differentiate between tense muscles and relaxed muscles. Once this distinction is made, the woman will be more aware of tension and able to consciously relax muscles. | Instruct laboring woman  
1. Progressively contract each of the following sets of muscle groups beginning with face and neck; shoulders, arms, and hands; chest, back, and buttocks; ending with the legs, feet, and toes.  
2. Become aware of how it feels when all muscle groups are contracted.  
3. Progressively release tension in each muscle group in reverse order: toes, feet, and legs; buttocks, back, and chest; hands, arms, and shoulders; neck and face.  
4. Pay attention to how it feels when all muscle groups are relaxed. |
| Touch relaxation       | Touch brings awareness of tense muscles and signals the woman to release tension. Touch can be applied to the forehead, back of neck, shoulders, arms, hands, back, legs, or feet. | Nursing actions  
1. Determine whether woman prefers a light touch or a firm touch.  
2. Place hand flat over the muscle group or if possible, wrap hand around the muscle.  
3. Apply a light touch or firm touch over muscle.  
4. Instruct the woman to release tension into the touch.  
5. Continue to apply touch until the muscle is relaxed. |

Table 6: Instructions for Breathing

<table>
<thead>
<tr>
<th>Breathing Technique</th>
<th>Purpose</th>
<th>Instructions to Laboring Woman</th>
</tr>
</thead>
</table>
| Breathing awareness         | Allows client to identify normal breathing pattern | 1. Sit up, place one hand palm down over abdomen, and the other hand on top of the first hand.  
2. Breathe in and out normally, paying attention to how the abdomen rises and falls, like having a balloon in your abdomen. Each time a breath is taken in, the abdomen expands. Each time a breath is let out, the abdomen collapses. |
| Cleansing breath at start and end of contraction | Serves as a signal to begin the contraction, initiate breathing patterns, and end the contraction | 1. Take an exaggerated inhalation of air through the nose and exhale through the mouth.  
2. Breathe in and out slowly at a rate that is half your normal respiratory rate.  
3. Breathe in and out at a rate slightly faster than normal. |
| Level 1 breathing           | Promotes relaxation                                | 1. Place hands over lower abdomen and inhale until lower abdomen expands.  
2. Breathe in and out slowly at a rate that is half your normal respiratory rate. |
| Level 2 breathing           | Promotes relaxation                                | 1. Place hands on waist and inhale until waist expands.  
2. Breathe in and out at a rate slightly faster than normal. |
| Level 3 breathing           | Promotes concentration                             | 1. Place hands above the breast area at the level of shoulder blades and inhale until that area expands.  
2. Breathe in and out at a rate that is double your normal rate. |
| Level 4 breathing           | Promotes maximum concentration during transition   | 1. Place hands at the level of the clavicle and inhale to that level.  
2. Breathe in and out in a shallow fashion, as in a pant.  
3. Alternation: Take three short breaths in and out, then blow out quickly, and inhale quickly again, in a three-inhale to one-exhale pattern. |
In Focus

Approach to Labor Support

In Focus

Approach to Labor Support

urges to push, reminding the woman and her partner that her body will respond appropriately. The closed-glottis method of pushing has been linked to negative effects on the fetus, such as fetal heart decelerations associated with prolonged second stage (Thomson, 1993). Despite this evidence, rising rates of epidural anesthesia have contributed to the continuation of the closed-glottis method (Simpson & James, 2005).

Information Regarding Patient Care

Informing women of the plan of care and interpreting medical jargon can ease anxiety. As labor progresses, the woman must be updated on fetal status and cervical change. Allow time for information to be assimilated. The laboring woman and her partner may want time alone to discuss health care decisions. The nurse should follow up to make sure they understand the information that has been provided.

Partner Care

Nurses can ease the partner’s anxiety and provide support by offering information concerning the woman’s labor progress. Taking time to demonstrate and explain supportive measures allows the partner to effectively participate in labor support.

Advocacy LSB

Advocacy includes protecting the client, attending to needs, and assisting in making choices related to health care; this requires the establishment of a therapeutic relationship (Foley, Minick, & Kee, 2002). Advocacy may require being the client’s voice when she is vulnerable or unable to speak for herself. In being an advocate for the client, the nurse empowers the client to give birth with dignity (see Table 7).

Conveying Respect

Conveying respect to the laboring woman means ensuring privacy, protecting modesty, providing nonjudgmental care, and protecting client rights. Nurses ensure privacy and protect modesty by keeping unnecessary people from the room, securing the door during procedures, providing gowns that adequately cover her while ambulating, and covering her with drapes when appropriate. Lothian (2004) noted that feeling respected allows women to “tap into inner wisdom and dig deep to find the strength needed to give birth” (p. 6). Nonjudgmental care includes putting self aside and providing competent care in all situations. Being an advocate means providing the same quality of care to the client at 28 weeks in preterm labor who refuses tocolytic therapy as to the previously infertile couple pregnant with their first child.

Acknowledgment of Mothers’ Expectations

Simkin (2002) suggested that when laboring women are distressed, nurses can ask, “What’s going through your mind?” (p. 729). Wutchik, Bakal, and Lipshitz (1989) found that distressing thoughts in latent labor increased the likelihood of prolonged labor, fetal distress, and medical intervention. Nurses can help relieve distress by determining the woman’s concerns and giving accurate information.

Birth Planning

A motto promoted by the American College of Nurse-Midwives is “listen to women” (Kathryn, 1993). Listening enables the nurse to hear the woman’s intuitive wisdom on her needs and desires for labor, birth, and the postpartum period. Constructing a carefully executed birth plan requires a thorough assessment of the client’s needs and desires. Clients’ needs and desires may require the nurse to negotiate with members of the health care team or her family, or both. Negotiation requires clear delineation of the client’s desires, appropriate timing, and respectful communication skills.

Development of a standard birth plan form can diminish duplication of effort and promote continuity among health care providers. The birth plan form should be developed by an interdisciplinary team. Consent forms

Table 7: Advocacy Labor Support

<table>
<thead>
<tr>
<th>Specific Category</th>
<th>Type of Behavior</th>
<th>Specific Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conveying respect</td>
<td>Ensure privacy; protect modesty; provide complete information; provide nonjudgmental care; protect patient rights; respect existing relationships</td>
<td></td>
</tr>
<tr>
<td>Ensuring security</td>
<td>Support client to express both positive and negative emotions; provide physical safety/security; provide emotional safety/security</td>
<td></td>
</tr>
<tr>
<td>Acknowledging mother’s expectations for labor and birth</td>
<td>Listening to her wishes</td>
<td>Encourage woman to verbalize her needs, fears, anxiety; convey that she has the right to choose; give her time to consider choices</td>
</tr>
<tr>
<td></td>
<td>Assisting with making informed choices</td>
<td>Explain risks and benefits; periodically offer reevaluation and reflection</td>
</tr>
<tr>
<td></td>
<td>Birth planning</td>
<td>Support her wishes with words and actions; negotiate with health care team on her behalf; communicate birth plan to others</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>Encourage problem-solving behavior; intervenes if others interfere</td>
<td></td>
</tr>
<tr>
<td>Partner care</td>
<td>Determine partner’s expectations; convey respect; encourage partner to be an advocate for the client</td>
<td></td>
</tr>
</tbody>
</table>

Lothian (2004) noted that feeling respected allows women to “tap into inner wisdom and dig deep to find the strength needed to give birth” (p. 6). Nonjudgmental care includes putting self aside and providing competent care in all situations. Being an advocate means providing the same quality of care to the client at 28 weeks in preterm labor who refuses tocolytic therapy as to the previously infertile couple pregnant with their first child.

Acknowledgment of Mothers’ Expectations

Simkin (2002) suggested that when laboring women are distressed, nurses can ask, “What’s going through your mind?” (p. 729). Wutchik, Bakal, and Lipshitz (1989) found that distressing thoughts in latent labor increased the likelihood of prolonged labor, fetal distress, and medical intervention. Nurses can help relieve distress by determining the woman’s concerns and giving accurate information.

Birth Planning

A motto promoted by the American College of Nurse-Midwives is “listen to women” (Kathryn, 1993). Listening enables the nurse to hear the woman’s intuitive wisdom on her needs and desires for labor, birth, and the postpartum period. Constructing a carefully executed birth plan requires a thorough assessment of the client’s needs and desires. Clients’ needs and desires may require the nurse to negotiate with members of the health care team or her family, or both. Negotiation requires clear delineation of the client’s desires, appropriate timing, and respectful communication skills.

Development of a standard birth plan form can diminish duplication of effort and promote continuity among health care providers. The birth plan form should be developed by an interdisciplinary team. Consent forms
and waivers are necessary when families make requests that are outside the usual care provided at the facility. Many facilities require the birth plan form to be signed by each physician or certified nurse-midwife in the practice. This formality may assist in ensuring that the laboring woman’s needs are met.

In a Swedish study (Lundgren, Berg, & Lindmark, 2003), midwives assisted one group of women in development of a birth plan, while the control group did not use a birth plan. There was no improvement in the birth plan mothers’ relationship to caregivers, fear and pain related to childbirth, perceived control over childbirth, or concerns for the unborn child, and their relationship with the caregivers was less satisfying. Lothian (2006) suggested that birth plans may increase tension when clients and providers hold conflicting views of birth: as a normal natural process that could occur safely without intervention or as full of risk, requiring interventions to avoid negative outcomes. For clients or providers who hold the second view, birth plans represent a request to remove the safeguards put in place to avoid risk.

The intrapartum nurse must be aware of personal views in order to set them aside to support a client’s decisions. Once a woman makes an informed health care decision, the nurse has a responsibility to support the decision rather than adhering only to the nurse’s personal belief structure. For example, a nurse’s approach to alleviating pain in labor may be a reflection of a personal philosophy of pain in labor. If the nurse believes that pain in labor is pathologic, a pharmacologic approach to pain relief may be the first line of defense. However, nurses who believe that pain in labor is normal or physiological may offer a variety of nonpharmacologic LSB (Lowe, 2002).

Conflict Resolution

Labor rooms are not conflict-free zones. The stress of labor can promote conflict that may have negative effects on labor progress. The intrapartum nurse must step in quickly when the client’s needs, desires, or safety is compromised and promote problem-solving behaviors. Steps of problem solving include defining the problem, looking for potential causes, identifying alternative solutions, choosing the best approach, and carefully implementing that approach.

For instance, if the client’s father voices concern that his daughter’s pain is not managed appropriately, the nurse can step in quickly and address this issue, sparing the client the distress of trying to manage her father’s anxiety. The nurse can ask for a clearer understanding of the father’s concern, provide an explanation of comfort measures that have been implemented, describe the stages and phases of labor, and with the client’s permission, outline the client’s plan of action regarding pain management.

Partner Care

While the laboring woman’s wishes and needs must have priority, it is appropriate for the intrapartum nurse to determine the partner’s expectations related to labor and birth. If these are not in conflict with the client’s wishes, every attempt should be made to honor them.

Implementing LSB in Practice

As obstetric nursing content in nursing school curricula decreases (AWHONN, 2006a), there is less emphasis on LSB and less value placed on this type of hands-on nursing care. Therefore, in addition to training in electronic fetal monitoring, neonatal resuscitation, and surgical scrub techniques, extensive hands-on training in LSB should be a required element of labor and delivery orientation. When intrapartum nurses have knowledge and confidence in their LSB skill, they more effectively provide this care (Kardong-Edgren, 2001).

Mentoring is an effective means to pass on the skill of labor support. One way to implement this is to designate a day of the month as Labor Support Day. The LSB expert is not assigned a client but rotates between labor rooms and provides hands-on instruction and support in LSB to the labor and delivery staff.

Intrapartum nurses need time to develop into expert caregivers. It takes time, most likely more than 5 years, in a consistent setting to develop expertise (Benner, 2001). Experts should be studied closely. What characteristics or traits does this nurse exhibit? If these traits could be identified, nurse managers could more easily identify prospective staff members.

All nurses must have access to current nursing literature to develop evidence-based practice (Romano & Lothian, 2004). Hanson (1998) found that nurse-midwives who spent time reading professional journals used the most effective positions for second stage labor. Maintaining subscriptions to professional journals and attending regular continuing education activities on current research will assist the intrapartum nurse to maintain practice that is supported by science.

Labor support behaviors must be faithfully documented, even if a narrative note is required. Consistent terminology for LSB will increase their value and better define the practice of intrapartum nursing. Specific LSB can be added
to the preprogrammed list of annotations of electronic monitoring systems. This may make charting easier and assist in data collection for future research related to LSB.

Improving LSB Definition and Developing Certification

While many researchers have studied labor support, there is no “acceptable or agreed upon definition (that) exists for professional labor support and its underlying components and attributes” (Saules, 2006, p. 38). Concepts, definitions, components, and attributes need to be developed by a consortium of nursing leaders who have proven to be knowledgeable in the field of labor support. This work can produce standards, policies and procedures, competencies, and plans for a comprehensive certification program. Credentialing lends authority to any discipline. Designing and implementing a certification program in labor support would lend importance and credibility to this discipline. Kardong-Edgren (2001) stated that this type of certification should be required just as certification in electronic fetal monitoring is required. For the program to be comprehensive, it should include a workshop with opportunities for hands-on practice of each LSB, a training manual, and an exit examination.

Conclusion

Intrapartum nurses can use a multitude of nonpharmacologic pain relief methods to assist laboring women. Labor support behaviors can be enhanced when the intrapartum nurse taps into more than one labor support category at a time. The nurse who is committed to labor support will positively affect birth experiences (Adams et al., 2006). Every effort should be made to position a nurse who is skilled and committed to labor support at the bedside of all laboring women.

REFERENCES
