Nursing Support in Labor: Perceptions of Newly Delivered Mothers

by

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CHAPTER I

Pregnancy is considered a developmental crisis, a time of transition during which numerous physical and psycho-social changes take place. The birth experience is the culmination of this process, and is a highly intense experience. Nurses who come into contact with women during this time can have a great impact on their experience. Nursing behaviors focus on meeting the physical, physiologic, psycho-social, and emotional needs of the woman in labor. All of these behaviors can be seen as specific functions under the more general classification of nursing support.

Providing support has long been an essential component of nursing practice. However, a clear definition of support is lacking and the term is often used loosely and inconsistently. Some studies have attempted to clarify the meaning of nursing support by having nurses identify and/or rate words that refer to, or are synonymous with, support. Frequently mentioned words included understanding, acceptance, empathy, care, and help. (DeYoung & Dickey, 1967; Stockwell & Nishikawa, 1970) Other studies have focused on identifying nursing behaviors considered to be supportive. (Pearlmutter, 1974; Irwin & Meiner, 1973)

Gardner and Wheeler (1981) described eight behaviors reported most frequently as being supportive. They were: 1) assisting patients to cope with feelings, 2) conversing with patients, 3) providing information, i.e. explaining procedures, 4) sitting and spending time with the patient, 5) listening, 6) providing physical comfort measures, 7) touching, and 8) coordinating patient care. All of these studies suggest patient focused nursing is supportive, however none of them investigated support from the patient's perspective.

Evaluation of nursing support from the patient's perspective is especially appropriate for the labor and delivery setting. Improvements in technology and obstetrical knowledge have made birth a relatively safe experience for both mother and baby. As a result, attention has shifted to the quality of the birth experience. With the advent and rapid growth of childbirth education and its philosophy, more and more women are beginning labor possessing knowledge and coping skills, accompanied by trained coaches, and committed to active participation in their birth experience. At the urging of consumers, many hospitals have modified their policies so that a more family centered focus in obstetric care has emerged. Due to all of these factors, nurses need to re-evaluate their role in

providing support for women in labor.

Today, childbirth is viewed as an important life event, often preceded by much planning and preparation. Therefore, the goal of nursing support is not only a safe delivery, but also a positive and satisfying childbirth experience. To achieve this goal, nurses must assess the support needs of women, intervene appropriately based on this assesment, and then evaluate the effectiveness or success of their interventions.

Statement of the Problem

Nurses need to know what behaviors are perceived as helpful by women in labor in order to most effectively provide support. An assumption of this study was that nursing support that meets the needs of individual women contributes to a more positive childbirth experience. A second assumption was that the value women place on maintaining control in labor may influence their perception of the helpfulness of nursing support. The purpose of this study was to identify what support behaviors of nurses are perceived as helpful by women in labor and to explore the relationship between the value placed on control in labor and perception of nursing support. The findings of the study will be of interest to those who plan and provide

maternal-child services. Information gained from this study will have direct implications and special relevance for nurses practicing in labor and delivery units.

Review of the Literature

The problem area of this study involved several related topics. In this section, literature dealing with social support, nursing support and women's perceptions of support during labor, and control issues are reviewed. It is recognized that since these areas are closely related a certain amount of overlap may occur. The review concludes with a synthesis of the literature as related to the purpose of this study.

Social Support

In this section, literature and studies related to the multidimensional construct of social support will be reviewed. Conceptual and theoretical papers will be discussed first followed by a discussion of the empirical research. Only those studies with implications for pregnancy and the childbirth experience will be included.

Before proceeding further, it is necessary to recognize the problems involved in the current study of social support. Thoits (1982) identified a number of conceptual methodological, and theoretical problems with the literature

on social support. The first problem deals with the lack of a clear and precise definition of support, and reliable and valid measures of support. Another problem is the confusion regarding the direct and interactive effects of life changes and social support in studies which use a cross-sectional design. Finally, most studies have focused on the buffering or indirect effect of social support on distress but have not investigated the main or direct effect. These issues should be kept in mind when interpreting and evaluating the social support literature.

Conceptual and Theoretical Papers. A theory paper by Cassel (1974), discussed the relationship between psycho-social processes and disease. Cassel proposed that increased disease susceptibility occurs for those individuals who do not receive adequate feedback regarding the effects of their actions. He stated that this can occur in two situations: when people are unaware of society's cues and expectations or when there is social disorganization. Cassel noticed that some members of a population were less adversely affected by absent or inconsistent feedback than others. He concluded that there were protective factors that served to buffer or cushion the individual from physical or psychological distress, one of which was social support. He further specified that stressful circumstances

must exist before social support assumes its protective function.

Caplan (1974) developed Cassel's theme further. He defined social support systems as ". . . continuing social aggregates that provide individuals with opportunities for feedback about themselves and for validation of their expectations about others" (pp. 4-5). Other needs that are met through these social aggregates include the need for love and affection, for satisfaction of nurturance and dependence, for feeling safe to express oneself freely and unselfconsciously, for confirmation of self-identity and worth, for support in dealing with emotions and controlling impulses, and for help with tasks (Caplan, 1974).

Similar functions of social support were enumerated by Weiss (1969). On the basis of his work with Parents without Partners, he concluded that individuals have a variety of needs and require a range of specialized relationships to meet them. The six functions of social relationships he identified as necessary for well-being were: intimacy, social integration, opportunity for nurturant behavior, reassurance of worth, assistance, and guidance.

Cobb (1976) perceived social support as the provision of information which leads people to believe that: 1) they are cared for and loved, 2) they are valued and esteemed,

and 3) they belong to a network of communication and mutual obligation. Social support achieves its effects by facilitating coping and adaptation. Cobb defined coping as manipulating the environment in the service of self, and adaptation as changing the self to improve person-environment fit. He suggested that esteem support encourages a person to cope and that emotional support as well as the sense of belonging help the individual to adapt by creating an environment that is favorable to changes in self-identity.

The three major types of social support defined by Schaefer, Coyne, and Lazarus (1981) were: emotional, tangible, and informational. Emotional support deals with intimacy and attachment, feelings of being loved and belonging. Tangible aid signifies provision of resources and services. Informational support involves supplying advice and guidance in problem solving. These three categories provide a clear and simple summary of the various definitions of social support reviewed up to this point. In addition, Schaefer et. al. stressed the importance of making a clear distinction between the terms social network and perceived social support. Social networks describe the composition and structure of the relationships of a particular person. It is quantitative in that it looks at

numbers and size whereas perceived social support is the individual's qualitative perception of the supportive value of social interactions.

The importance of social support across the life span is proposed by Kahn and Antonucci (1980). They proposed that social support contributes to well being both directly and indirectly as a moderator of the effects of stress. Kahn and Antonucci introduced the concept of the convoy as the dynamic structure wherein social support is both given and received. Social support itself is defined as ". . . interpersonal transactions that include one or more of the following key elements: affect, affirmation, and aid" (p. 267). Affect denotes expressions of admiration, respect, liking, or love. Affirmation signifies agreement or acknowledgement of the rightness of another person's actions or statements. Aid indicates direct assistance is provided such as money, things, information, or time. The categories of affect and aid are similar to those of Schaefer et. al., but the concept of affirmation is a unique contribution. Kahn and Antonucci also developed an explanatory framework that examines the interaction of personal and situational properties, the structure of the person's convoy, the requirements for and adequacy of social support, and the actual outcome.

Using the framework proposed by Kahn and Antonucci, Norbeck (1981) developed a model to guide research for incorporating social support into nursing practice. Her model also included the four elements of the nursing process: assessment, planning, intervention, and evaluation. Norbeck suggested that situation specific needs for support are especially relevant to health care professionals who come into contact with people experiencing maturational and situational crises. The intensity and duration of support necessary for various situations and stressors will vary. For example, in situations where stress levels are high but the situation is temporary, such as life changes and transitions, more intense support is required, but for a shorter time period.

Empirical Research. Nuckolls, Cassel, and Kaplan (1972) investigated the relationship between psychosocial assets, social stresses, and the prognosis of pregnancy. The final sample consisted of 170 white, primigravid women married to enlisted men, who registered for obstetrical care at a large military hospital prior to 24 weeks gestation. The sample was homogenous in terms of age, social class, educational level, and duration of pregnancy.

Psychosocial assets were defined as social or psychological factors that enhance adaptation to a first

pregnancy. The adaptative potential for pregnancy was measured by a questionnaire (TAPPS) designed to measure subjects' feelings or perceptions regarding herself, her pregnancy, and her life situation. This was completed at the time of registration. The Holmes and Rahe Schedule of Recent Experiences was mailed to subjects at 32 weeks gestation of pregnancy. Two scores were obtained: one for life changes which occurred in the two years prior to the pregnancy, and the second for changes which occurred during the pregnancy. Pregnancy outcome was classified as either normal or complicated based on the review of medical records after delivery and previously established criteria.

There were no significant correlations between either life change scores or psychosocial asset scores and complications of pregnancy. However, when life change scores were high both before and during pregnancy, women with favorable psychosocial assets (high TAPPS scores) had only one third the complication rate of women with low psychosocial assets. In the absence of high life changes, psychosocial assets had no such effect on the complication rate.

These findings suggested a stress-buffering effect for social support. However, methodological weaknesses exist that confound the implications. First, social support was

not measured separately but placed under the construct of psychosocial assets which also included measures of attitudes toward pregnancy and ego strength. Furthermore, as military dependents, subjects may have experienced altered life stress and social support patterns, thus making it difficult to generalize the findings to other populations and settings.

In a similar study, Norbeck and Tilden (1983) investigated the effects of life stress, social support, and the emotional state variables of anxiety, depression, and low self-esteem, on pregnancy outcome. The setting for the study was a large, urban university medical center. The sample consisted of 117 women representing various racial, marital and socioeconomic groups. Subjects were between the ages of 20 to 39, 12 to 20 weeks gestation, and had no pre-existing risk factors.

Subjects were recruited at a routine clinic visit, at which time they completed the following instruments: the Sarason Life Experience Survey (LES), Part II of Cohen and Lazarus' Social Support Questionnaire, the Spielberger State-Trait Anxiety Inventory, the Lubin Depression Adjective Checklist, Form-C, and the Rosenberg Self-Esteem Scale. Investigator developed items that measured tangible aid, loss and presence of a confidant were also included. A

second LES was mailed to subjects at 34 weeks gestation. Complications were scored from a chart review performed after all participants had delivered. Three categories of complications were identified: complications of gestation; labor, delivery, and post-partum complications; and infant-condition complications.

The results indicated that high life stress and low social support (emotional) were significantly related to high emotional disequilibrium. High life stress during the previous year was significantly related to overall and gestation complications, and emotional disequilibrium predicted infant condition complications. Significant interaction effects for life stress during pregnancy and tangible support were found for all three types of complications.

The findings of Norbeck and Tilden are consistent with those of Nuckolls et. al. in relation to the stress buffering effect of social support. A weakness of the study is that social support was measured in early pregnancy, but not again at the end of pregnancy. The level of support available to the women may have changed by the time of the second LES, thus influencing the results. Acknowledging this limitation, the authors suggest that future studies use a longitudinal design.

An experimental study by Sosa, Kennel, Klaus, Robertson, and Urrutia (1980) examined the effects of a supportive companion on the length of labor and mother-infant interaction after delivery. The study took place at a social security hospital in Guatemala which averaged 60 deliveries per day. Hospital policy did not allow for the presence of family, friends, or a continuous caregiver. The sample consisted of 40 primigravid women. To be included in the study, subjects had to be in early labor (cervix dilated 1-2 cm) with no evidence of pre-eclampsia or other medical problems. Women were removed from the study for false or prolonged labor; if fetal distress necessitated medical intervention; or if the infant demonstrated any sign of illness, was stillborn, premature, malformed, meconium stained, depressed, or asphyxiated.

Subjects were randomly assigned to a control or experimental group, with 20 in each group. The control group received routine hospital care which consisted of auscultation of fetal heart tones, occasional vaginal exams, and assistance during delivery. In addition to this routine care, the experimental group received support from an untrained lay woman from admission to delivery. She supplied physical contact, conversation, and the presence of a friendly companion, previously unknown to the mother.

Mothers in both groups remained in the delivery room for up to one hour after the baby was delivered, then both groups were allowed 45 minutes of skin to skin contact with their infants in a private room. A time sampling method of observation was used to record maternal state and behavior during the first 22.5 minutes. Agreement obtained between two observers ranged from 0.88 to 0.98 for items included in the analysis.

Three separate findings emerged from the study. The first, and unexpected finding had to do with the development of complications. In order to obtain the final sample of 20 women in each group with uncomplicated labor and normal vaginal deliveries, 103 women were admitted to the control group and 33 to the experimental group. After excluding 9 women (8 in the control group and 1 in the experimental group) for false labor, premature delivery, and one with severe anxiety, a chi square analysis was used to compare the two groups. An association was found between the presence of a supportive companion and a decrease in the incidence of labor, delivery, or infant problems used as exclusion criteria.

Length of labor, as measured from time of admission to the hospital until delivery, was dramatically decreased for the experimental group. Mean length of labor for the

control group was 19.3 hours compared to 8.7 hours for the experimental group.

The final group of findings dealt with maternal behavior. Mothers in the experimental group were observed to stroke, talk, and smile at their infants more than did mothers in the control group. No significant difference was found in simple touching or in the proportion of time spent touching or stroking the infant. The amount of time spent in body to body contact, en face, looking at the baby, or nursing were also the same.

When evaluating the implications of the findings, the authors acknowledged that the effects of the supportive companion may have been exaggerated due to a possible increase in maternal anxiety related to the crowded and unfamiliar hospital environment and lack of prenatal class preparation. However, they proposed that their findings were especially relevant for the population of low-income, single teenage mothers who may not receive support or preparation for childbirth. The findings of this study suggest that the presence of a supportive companion can decrease intrapartum complications, shorten labor, and perhaps enhance the early maternal-infant relationship. The nurse as the primary caretaker for women in labor can encourage the participation of the woman's family and

friends as well as offer her own support. Further studies in this area are needed to confirm these findings.

In summary, social support has been conceptualized in a variety of ways by numerous theorists. However, all authors define social support as interpersonal transactions which address the individual's emotional, informational, and tangible needs. Although conceptual and measurement problems still need to be resolved, the current literature suggests that social support may play a role in the prevention of disease and promotion of health. The exact mechanism of action, whether direct, indirect, or both, is not yet known. Social support has both expressive and instrumental functions, and is given and received within a social network or system. The labor room nurse, although not part of the woman's pre-existing support system, can function as a situation specific resource for support.

The Labor Experience: Nursing Support and Women's Perceptions

Literature relevant to nursing support of the woman in labor is presented in this section. Studies which approach support from both the nurse's and the patient's perspectives are included.

Anderson (1976) formulated an operational definition of

support specific to the labor and delivery setting based on the nursing process. According to Anderson, the goal of support is to enhance the woman's participation in the labor process and enable her to maintain control. The nurse assesses the resources which are available to the woman and her need for support, adjusting the degree and the type of support provided accordingly. Nursing interventions identified by Anderson include: 1) promoting the woman's dignity by providing privacy, comfort measures, and hygiene; 2) helping her to feel safe by giving her some control over the environment, assisting her to control bodily functions, and offering encouragement and reassurance, and 3) promoting active participation of the woman in the labor process.

The findings from two related studies conducted between 1962 and 1964 were reported by Bender (1967). Both studies investigated the impact of supportive nursing care on distress experienced in labor. Vomiting was the operational definition of the dependent variable of distress. The independent variable was the type of nursing care given: control nursing was task oriented while experimental nursing focused on the women's behaviors, thoughts, and feelings. No clearer definition of either type of nursing care was given by the author. Bender hypothesized that there would be a decreased incidence of vomiting for women who received

terms of cervical dilation was recorded, as well as the use of any medications.

The results of the first study found that the distress rating was slightly greater for the control group of patients than for the experimental patients. Vomiting, retching, and nausea occurred only in the control group, with three (50%) women experiencing vomiting or retching. Control nurses did not spend as much time in the room with their patients. However, even in two cases where the nurse was with the patient 60% or more of the observed time, retching, nausea, and vomiting still occurred, suggesting that the amount of time itself was not the critical difference. In terms of verbal interaction, control nurses were observed to give more commands and statements of information while experimental nurses used more noncommital and structured statements.

In the second study, Bender and a research associate alternated as care givers and observers for the experimental group. The control group was cared for by the staff, with the researchers alternating as observers. For the experimental group, the nurse researcher to be the observer obtained the informed consent, so that the women were unaware that the nurse providing care was involved in the study. Scoring of verbal interactions was eliminated due to

the difficulty in developing high reliability among observers and was replaced with a checklist of comfort measures. The observers recorded how and when the measures were initiated: whether requested by the patient or offered or commanded by the nurse. All other procedures were the same as those carried out in the first study.

Analysis of the data from this second experiment showed a decreased incidence of vomiting in the experimental group: 1 out of 15 women as compared to 8 out of 15 in the control group. In terms of distress ratings, 27% of the experimental group compared to 67% of the control group were scored in the highest category. In the experimental group, the nurse was in the room 83% of the observed time compared to 40% for the control group.

To obtain women's evaluation of nursing support, a third group of subjects were matched to the experimental group for race, parity, and type of service, but were neither observed nor cared for by the research nurse during labor. All 45 women (15 experimental, 15 control, 15 matched) were interviewed within 11 to 48 hours of delivery. Interviewers were blind to which groups the subjects were assigned to, and the women were not aware that the interview was related to the study.

The data gathered from these postpartum interviews

indicated that women in the experimental group perceived the nurse as more helpful with comfort measures and more concerned about them as individuals as compared to the control group. When questioned as to what was most helpful, 8 (53%) of the women in the experimental group replied "the nurse" compared to 2 (13%) in each of the other two groups. Specific answers as to how the nurse was helpful centered around perceptions of udnerstanding and caring, safety, and helping the woman to cope with contractions. In describing the overall birth experience, the women in the experimental group showed a slightly increased use of positive descriptors, 67% compared to 53% in the combined control and matched group. Further, only 1 (6%) woman in the experimental group as opposed to 7 (23%) in the combined groups described the experience as painful.

Several limitations to this study exist. A major weakness is the lack of a clear operational definition for experimental nursing care. Control and experimental nursing were differentiated after the fact, based on the findings of the study. In the second study, a bias was introduced by having the research nurses act as observers. In both studies, women were aware that they were being observed, which could have affected their behavior. No clear explanation of how distress ratings were arrived at was

given, so it is difficult to interpret their meaning. Finally, the small sample makes it difficult to generalize the findings. In spite of these limitations, the results of these studies suggested that nurses can assist women to have more satisfying and less distressful labor experiences.

A similar study by Tyron (1966), who was the co-investigator in the second experiment above, focused on specific comfort measures performed by nurses in support of the laboring woman. Thirty women were included in the sample, 22 multipara and 8 primipara. Women who developed complications during their labor were not eligible for the study. Patients were alternately assigned to either the control or experimental group. Routine nursing care was provided for the control group, while the women in the experimental group were cared for by the investigators. Experimental nursing differed primarily in that the focus was on the behaviors, thoughts, and feelings of the women, which they were encouraged to express. Seven comfort measures were chosen to be evaluated as part of nursing support: breathing control, positioning, back care, elimination, oral care, oral fluids, and linen changes. Patient behaviors were observed every 30 minutes during and immediately following a contraction, with a minimum of two observations made on each patient. Observed behaviors were

classified into three categories: vocal activity, body activity, and breathing.

The author stated that data analysis was difficult due to the infrequent use of comfort measures in the control group. She also acknowledged the limitation caused by having the investigators also act as observers. However, there were significant differences between the responses to labor in the two groups. The experimental group was found to exhibit lower responses in the three categories of behavior, e.g. less moaning. The experimental nursing probably contributed to this finding, but other factors, such as the mere presence of someone in the room, may also have played a role. The author also stated that the absence of an observable behavior indicating a certain comfort measure is helpful, does not mean that it is not perceived as helpful by the patient. Tyron suggested that further study needs to focus on what the woman perceives as being helpful.

A different approach to evaluating the effectiveness of nursing support during labor was provided by Allen (1964). She participated in a two-year study of 130 women undergoing continuous internal monitoring of fetal heart rate and uterine contractility. Of the total group, 70% were induced, with the remainder being evenly divided between

spontaneous or augmented labor. The setting was a high risk obstetrical unit, and 78% of the subjects experienced labors complicated by pre-eclampsia, diabetes, anemia, polyhydramnios, pylonephritis, or Rh incompatability.

The author found that tense and anxious women had monitor strips characterized by uterine irritability. When pain medication was given, for example Demerol, there was a decrease in abdominal muscle spasm and uterine irritability and increased uterine relaxation between contractions. Based on her own experience in providing care for women in labor, Allen concluded that nursing care characterized by individualized attention, explanations, encouragement and reinforcement of breathing and relaxation, achieved the same results as the mdeication. Records of uterine contractility and fetal heart rate patterns were presented as evidence to support her proposition that the supportive presence of the nurse promoted a more relaxed and effective labor.

Much information was missing regarding the purpose and design of the study in which Allen participated, and the sample was not adequately described. However, she does raise an interesting point by relating psychosocial factors (nursing support) to physicophysiologic factors (uterine irritability) and in suggesting an alternative to medication for relief of pain and tension.

A study by Klein, Gist, Nicholson, and Standley (1983) specifically examined the kind and amount of support received by women in labor as well as their perception of the helpfulness of the support. The subjects consisted of 40 primiparous, married, middle-class, caucasian women. All had attended childbirth classes with their husbands who were present for their labor and delivery. The women experienced uncomplicated pregnancies and gave birth to healthy, full-term infants. Data were collected at three separate intervals: 1) in a home interview approximately two weeks before the due date, 2) in a one hour observation period of the couple during labor when the woman was 4-5 cm dilated, and 3) at a home interview one week post-partum. A time sampling method of observation was used during labor to record supportive behaviors, medical events, aspects of the women's physical state, and the content of conversations. Supportive behaviors provided by the husband and nurse that were studied included physical presence, talking, touching, coaching breathing, and the use of comfort measures. Information regarding the women's perceptions and evaluations of support was obtained in the postpartum interview. Interobserver agreement of 95% or greater was achieved among six staff members with each coding category. Interrater reliability of 95% was also obtained between the

two interviewers.

The findings of Klein et. al. revealed that husbands were not only physically present during almost the entire hour observed, but that they provided more support than did the nurse in all of the other four categories. Husbands were five times more likely to touch their wives as nurses were. Talking was the one behavior in which nurses and husbnads spent an equal amount of time (56% to 62%). In the mother's postpartum evaluation of what behaviors were most helpful, the husband's contribution was more important in all areas with the exception of talking. The husband was perceived as most supportive by just being there, while the nurse was seen as most supportive when conversing with the woman. Nurses rated as most helpful were those who were in the room more frequently than the nurses rated as less helpful. The final analysis omitted 11 cases due to incomplete data.

The study is limited due to the select nature and small number of the subjects. However, it is one of the few studies that is based on direct observation of what a companion does that is specifically supportive for the woman in labor. The finding that nurses were seen as most helpful by talking to the women and by being present in the room more often, lends credence to his/her role as a support

person. Unfortunately, the study did not indicate what content of conversation was most helpful such as social, instructional, and/or reinforcing conversation. Another area which could be clarified is what the increased time spent in the room signified in terms of supportive behavior. Was there an actual increase in supportive behaviors or was physical presence itself interpreted as supportive by the women? Finally, the findings related to the importance of the husband in providing support suggested that the nurse could indirectly support the woman in labor by supporting her husband. All of these areas need to be explored further.

According to Butani and Hodnett (1980), nursing support of the woman in labor should be guided by the individual needs of women. They interviewed 50 women in an effort to learn about the perceptions, concerns, and evaluations they had regarding their labor experience. Suggestions for interventions which could have contributed to a more positive experience were also sought. The subjects were 29 primiparas and 21 multiparas who had delivered at a large, urban, teaching hospital. Forty-five women were married, four women were single, and one woman was separated. The mean age was 26, with a range from 16 to 40 years. To be included in the study, subjects had to be fluent in English,

had to have delivered a single, healthy infant within the past 48 hours with no complications, and have received no narcotics within the past 12 hours. Birth experiences included 29 spontaneous vaginal deliveries, 20 forceps assisted, and one primary cesarean section. Each woman was interviewed in her room and her responses recorded verbatim. The questions covered five major content areas: 1) past experience, 2) support during labor, 3) feelings and perceptions of time during labor, 4) whether expectations had been met, and 5) overall evaluation of their labor. Only the findings with implications for the support role of the nurse will be discussed.

"Pain" and "loss of control" emerged as the most unpleasant aspects of the labor experience. All of the 16 women who expressed regrets about their behavior in labor attributed it to loss of control, such as screaming or groaning. Women with higher levels of education tended to view control as more important to them. The women who felt they maintained control identified encouragement from others, breathing techniques, and medications as beneficial. Two multiparas identified inadequate support from the nurse or doctor as one of the reasons contributing to their loss of control. Prenatal classes did not have a positive effect on perceptions of labor, other than to

increase knowledge about the process. The authors suggested that a number of factors can affect women's perceptions of labor, one of these being the philosophy of nursing care.

> If the nurse fails to be support-oriented, e.g. by failing to assess each woman's expectations, by not providing comfort measures, by relying solely on the significant other to supply psychological support, it seems that no single factor such as prenatal education, had a significant positive effect on the women's perceptions of her experience (Butani & Hodnett, 1980, p. 80).

In regard to the presence of a significant other, 43 women reported having someone remain with them in labor, and six mentioned student or staff nurses as being supportive. When giving their overall evaluation of the experience, 21 identified the care and concern of others as being very gratifying to them. Suggestions by the women as to what would help them relax or rest included more respect for their modesty, position changes, presence of a radio or television, and more attention paid to the person instead of the machine. One third of both the primiparas and multiparas expressed objections to the fetal monitor. They reported discomfort and decreased mobility, as well as the feeling that the monitor was more important than they were. The above findings indicate that the nurse can be instrumental in meeting the support needs of women.

According to Roberts (1983), nursing care begins by

assesing the woman's need for assistance in coping with pain during labor. The nurse then intervenes to support the mother and reduce the distress caused by pain, thus helping her to achieve a more positive birth experience. The actual degree of distress perceived from a painful stimulus may be altered by a variety of factors. "The distress associated with pain during labor seems to be caused not only by the pain, but also by the feelings of helplessness and lack of control stemming from repeated, painful contractions" (Roberts, 1983, p. 63). Nurses can assist women cope with the pain of contractions by encouraging active involvement in their labor. Relaxation and breathing techniques are coping skills that decrease distress by enabling the individual to maintain control and thereby, indirectly, decrease pain. Distress due to pain in labor can also be reduced by acknowledging the woman's discomfort and by eliminating environmental factors that are distressing or unpleasant, i.e. restrictions on movements.

In contrast to the pain model just discussed is the psychoanalytic approach to care of women in labor proposed by Rich. Her research examined how women in labor feel about themselves (1971, 1983). The setting for the study was the labor and delivery unit of a university teaching and research hospital. Nineteen primarily caucasian women whose

ages ranged from 22 to 40 comprised the sample of convenience. All women were married multigravidas in early labor, without major medical or obstetrical complications, and had received care from a private physician.

A clinical-observational method was used to observe women's verbal and nonverbal behaviors. The nurse researcher provided some nursing care, but was not fully responsible. Observations were made from early labor through delivery and the data recorded within 24 hours after the time of observation. In evaluating the content of women's verbalizations, 67% focused on giving and seeking of information about the self. Seventy-five percent of the verbal interaction was with the nurse researcher, even though 15 out of 19 husbands were present. Based on these findings, Rich suggests that women use the nurse for ego orientation as well as a source for ego strength during the temporary crisis of labor. It is also possible that the nurse researcher's interventions altered the women's behavior, and hence, the data.

According to Rich, the laboring woman experiences the loss of a familiar environment, self-identity, decreased mobility, and the presence of significant others. She also experiences the internal and overwhelming forces of labor, over which she has minimal control. All these factors

contribute to a disrupted ego structure and increased vulnerability.

Ego orientation can be provided by the nurse when she informs the woman about the physiologic process of labor and hospital procedures. Nurses can also provide ego strength by conveying caring willingness to assist women with the mental and physical tasks of labor. Rich emphasized that the focus should be on the patient and her needs, as opposed to the nurse's perception of those needs.

The findings of this study reinforce previous studies that suggest the important role of the nurse in providing information about labor. The nurse is recognized as an important support person for the woman in labor. However, the data regarding verbal interaction leads one to wonder whether husbands were intimidated by the nurse researcher. An alternate explanation is that the men chose not to be active participants which could have been consistent with currently held attitudes and expectations for fathers during childbirth.

Two consumer surveys found that the support of staff was a top priority. Scaer and Korte (1978) interviewed 645 women over the telephone, asking them to rate 54 items related to labor, delivery and postpartum options. The help and support of staff rated as second in importance, with the

presence of the father in labor and delivery receiving highest importance. Similar results were found when Pridham and Schutz (1983) surveyed 91 families regarding their labor and delivery experience. Staff behavior was one of the three major factors identified by parents as important in contributing to a more pleasant and satisfying experience. Specific suggestions included the importance of a cheerful demeanor, allowing for maternal sleep in labor, and making decisions based on family interests rather than clinician needs. Parents clearly wanted to be informed of their options.

Value Placed on Control in Labor

The issue of control as it relates to the childbirth experience appears frequently in the literature. Helping the woman in labor to maintain control has been proposed both as a way of providing nursing support as well as a goal of the support itself. Further, assisting women in their efforts to maintain some control over their labor should decrease their distress and increase their self-esteem (Anderson, 1976; Butani & Hodnett, 1980; Roberts, 1983). In this section, literature which explores the meaning and role of control as it applies to childbirth will be reviewed. The broader construct of locus of control is also introduced

and briefly discussed.

Willmuth (1975) retrospectively reviewed 145 women's written evaluations of their birth experience. All of the women had attended childbirth classes and were accompanied by their husbands or another individual who was to be their coach in labor. The major factor associated with a positive outcome was the woman's perception that she had been able to maintain control.

Willmuth did not define control as a single entity but stated that "to maintain control" meant different things to different women. Three different types of control were reported in their evaluations as being important: 1) control of pain perception, i.e. via breathing and/or relaxation techniques; 2) control over emotions and actions, or "self-control"; and 3) control over interpresonal relationships, i.e. to continue to influence decisions made during labor and delivery. The majority of women preferred being active participants rather than passive recipients of care, ". . . to lose control was to become helpless and useless to a staff which then took over" (Willmuth, 1975, p. 39). The final type of control was reported most frequently and found to be most closely related to satisfaction with the birth experience. Reduction of pain, increasing physical comfort, and breathing-relaxation methods were also

identified as being helpful, but were of major importance for only a minority of the women.

The major limitation of this study is that the sample was drawn from prenatal classes. By their commitment to attending classes to prepare for childbirth, subjects may have self-selected for the variables of control and involvement. The author acknowledged that the women were not representative of the general population as they came from relatively higher educational and social levels, which also may have predisposed them to value control in labor more highly. Nonetheless, the definition of control given by Willmuth allows for a range of behaviors, with active involvement being the key element.

A similar view is held by Humenick. Based on her review of the literature, (1981) she proposed mastery as being the key factor affecting satisfaction with the birth experience. Humenick views childbirth as a developmental task where successful accomplishment leads to satisfaction. She identified a number of potential supports: 1) knowledge of the process with realistic goals, 2) skills for active coping, 3) influence in decision making, 4) support from others, including health professionals, and 5) a back up system of intervention if necessary. This model depicts an actively involved woman who collaborates with health care

providers. In this approach to childbirth, pain is but one of several potential stressors which also include fatigue, fear, aloneness, sense of helplessness, loss of dignity, and threats to the health of mother or infant. Successful mobilization of resources results in ability to cope with the stressors and mastery of the task of childbirth. This, in turn, leads to satisfaction and improved self-esteem.

The contruct of locus of control has its origin in the work of Rotter (1966) who examined the role that reward or reinforcement plays in determining behavior. Social learning theory provided the conceptual framework for his research. According to social learning theory, ". . . a reinforcement acts to strengthen an expectancy that a particular behavior or event will be followed by that reinforcement in the future" (Rotter, 1966, p. 2). Rotter stated that the effect of a reinforcement following a behavior depends upon whether or not the individual believes that a causal relationship exists between their own behavior and the reward. When an individual perceives reinforcements as being controlled by forces outside of himself, such as chance, fate, or powerful others, he is exhibiting a belief in external control. If an individual perceives that reinforcement is contingent upon his own behavior or attributes, he is exhibiting a belief in internal control.

Rotter developed a scale to measure these individual differences in expectancies regarding reinforcement (I-E Scale, 1966). Based on data gathered from a series of studies using this scale he hypothesized that an individual who strongly believes in internal control is more likely to: 1) be alert to environmental aspects which provide useful information for future behavior, 2) try to improve his environmental condition, 3) value skill or achievement reinforcements more highly and be more concerned with ability, and 4) be more sensitive to subtle influences.

Rotter (1966) reported that in several studies where the I-E scale was used, significant correlations were found between internality and outcome measures indicative of attempts to control the environment such as petition signing, smoking behavior, union membership, etc. However, most were low, with a decreased predictive value. He attributed this to the possible existence of specific attitudes and behaviors which were not measured by the more general I-E Scale.

The need for specific measures for locus of control was addressed by Wallston, Wallston, Kaplan and Maides (1976). They suggested that the prediction of behavior in specific situations would improve if more specific expectancy measures were available. Based on this assumption they

developed a situation specific scale for measuring health related locus of control (Health Locus of Control Scale). Individuals who score high on the HLC scale are "health externals"; health is determined by factors over which they have no control. Those with low scores are "health internals"; health status is determined by their own behavior.

Data were gathered in two separate studies to provide preliminary construct validity for the HLC scale. In both studies, the classification of subjects as internals or externals based on their HLC scores led to results that were in the expected direction and more consistent with their hypothesis than if they had only used Rotter's I-E scale for classification.

The strength of Wallston, Wallston, Kaplan and Maides' scale is that it specifically examines the relationship between locus of control and health related behavior. However the authors recognized that it was still a more generalized measure of expectancy and did not tap beliefs about specific conditions (diabetes, hypertension) and/or specific behaviors (medication taking, information seeking).

A new scale to measure health locus of control was developed by Wallston, Wallston and DeVellis (1978) to

explore the multidimensionality of the concept (MHLC). In the new scale, three different dimensions of health locus of control are tapped: 1) internal locus of control, IHLC; 2) powerful others locus of control, PHLC; and 3) chance health locus of control, CHLC. A distinction was made between belief in external control due to chance or fate and that due to powerful others. According to the authors, since the MHLC scale evaluates three separate dimensions of health locus of control, there should be an increase in our understanding and ability to predict health behaviors. However, Wallston, Wallston and DeVellis stressed that HLC belief is only one of many factors which interact to explain health behaviors.

Summary

A recurring theme in the literature was the importance of women's active participation and involvement in their labors in contributing to and maintaining a sense of control and self-esteem. This, in turn, appears to lead to a more positive childbirth experience. The support of other people, whether it be husband, friend, or nurse was found to be important in achieving this control. Specifically, nurses were seen as supportive when they spent time with women, focused on their concerns and needs as individuals,

and provided them with needed information as well as comfort measures.

The nurse is a situation specific source of social support for the woman in labor. Nursing behaviors providing emotional, informational, and tangible support could be discerned in the literature. Nursing support which focuses on meeting the needs of the woman in labor, including the need to maintain some sense of control, may contribute to maintenance of self-esteem and satisfaction with childbirth.

The importance attributed to maintaining control in labor may result from a cultural bias as all the studies reviewed have occurred in the United States. Furthermore, samples were described as being primarily caucasian and middle-class. Therefore, the assumption that maintenance of control is related to the promotion of self-esteem and childbirth satisfaction applies only to those individuals from similar cultural backgrounds.

Conceptual Framework

The focus of this study was to evaluate nursing support from the perspective of women who recently experienced labor. Two concepts were explored: perceived helpfulness of nursing support and control. In addition, this study sought

to determine whether a relationship existed between women's beliefs about control and their perception of nursing support.

Social Support and Nursing Behaviors

Social support was the conceptual framework used to explore women's perceptions of nursing support in labor. Although nursing support is not equivalent to social support, many nursing behaviors can be perceived as providing various aspects of support. Women in labor often have their naturally occurring social support system restricted to one or two individuals, primarily due to hospital policies, as well as practical or geographic constraints. As suggested by Norbeck (1981), the nurse can function as a situation specific source of support.

Kahn and Antonucci's definition of social support was used to evaluate how labor room nurses provide support for women in labor. They defined social support as ". . . interpersonal transactions that include one or more of the following key ingredients: affect, affirmation, and aid" (Kahn & Antonucci, 1980, p. 267). Affect denotes expressions of admiration, respect, liking, or love. Affirmation signifies agreement or acknowledgement of the rightness of another person's actions or statements. Aid

indicates direct assistance, such as money, things, information, or time.

This definition was chosen because it taps an aspect of support which is particularly relevant to the labor and delivery setting -- affirmation. As childbirth is a significant life event, it is important for nurses to accept and acknowledge women's goals and behavior during labor. An increasing number of women desire and expect to participate actively in their labors. This requires a shift in focus from nurses "caring for" women in labor, to "working with" women in labor. An example of affirmative support in labor would be providing feedback about the woman's ability to use learned breathing and relaxation techniques. Nurses affirm a woman's self-worth not only by recognizing her right to be actively involved in her labor, but also by reinforcing her efforts to do so.

Nurses also provide affective support for women in labor. Because of the intensity of the childbirth experience, and the role of the nurse as the primary caregiver, a strong and close relationship often develops between the woman and the nurse. Nurses can convey liking and respect to the woman as an individual by spending time in the room apart from that necessary to perform tasks, and by protecting her privacy.

Many nursing behaviors provide aid support, such as giving a back rub or administering pain medication. A specific aspect of aid support, providing information, comprises an especially important nursing function. As an "expert" in the situation, nurses explain procedures and interventions, and interpret fetal monitor recordings. One way of evaluating support nurses provide is to solicit the laboring woman's perception of the helpfulness of nursing behaviors.

Control

The value placed on control in labor emerged from the literature as an important variable which affects the childbirth experience. It is possible that a desire to maintain control can influence a woman's perception of the helpfulness of nursing support in labor. The three dimensions of health locus of control identified by Wallston, Wallston and DeVellis (1978) were used to operationally define women's value for, or orientation to, control in labor. Based on this construct of health locus of control, women were characterized as believing that what happens to them is controlled or determined by: 1) themselves (internal health locus of control); 2) powerful others, such as the nurse and/or physician

(powerful others health locus of control); or 3) fate or chance (chance health locus of control). These various beliefs in health locus of control may affect women's perceptions of the helpfulness of nursing support. For example, if a woman believes that control rests with powerful others, she may desire more direct aid from the nurse. On the other hand, a woman who has an internal locus of control may prefer more affirmation.

Research Questions

An assumption of this study was that nursing support that meets the individual needs of women will enhance the birth experience and increase satisfaction. A second assumption was that the value placed on maintaining control in labor may be related to the type and amount of support desired. The purpose of this study then, was to answer the following questions:

1. How helpful are selected supportive behaviors of nurses as perceived by women during labor?
2. Is there a difference between the perceived helpfulness of nursing behaviors that provide affective, affirmative, or aid support?
3. Do women who have different health locus of control beliefs have any differences in their perception of the

helpfulness of nursing support behaviors?

4. Do women who have different health locus of control beliefs have any differences in their perceptions of the helpfulness of nursing behaviors that provide affective, affirmative, or aid support?

CHAPTER II

METHODS

In this chapter, the setting and sample, variables studied, data collection instruments used, and the design and procedures of the study are described. In conclusion, analysis of the data are discussed.

Setting and Subjects

This study was conducted on the postpartum unit of a metropolitan hospital that serves members of a large health maintenance organization. The labor and delivery unit consists of several labor rooms, delivery rooms, and a recovery room. Primary nursing care with a family centered approach is provided. The hospital averages over 300 births each month.

The sample of 78 women was one of convenience. For the purpose of this study, a homogenous sample with similar pregnancy and labor experiences was sought in order to control for those conditions that can alter or influence perceptions of labor. Therefore, to have been eligible for the study, women must have experienced an uncomplicated prenatal and intrapartal course and delivered a healthy infant of 37 or more weeks gestation. Women experiencing

cesarean births were excluded from the study as they experience greater discomfort in the immediate postpartum period that may influence their perception of labor. For many of these women their labors may have been more difficult while others may have had no labor at all, factors which also can affect perceptions of labor (Marut, 1978; Marut & Mercer, 1979; Tilden & Lipson, 1981). Women with pre-existing disease or a diagnosed major complication of pregnancy, i.e. premature labor, placenta previa or abruptio, pre-eclampsia, were also excluded. Finally, the length of time a woman in labor spends in the hospital can influence the type and amount of nursing care she receives. Therefore, to be included in the study, women must have been admitted at least two hours prior to delivery. Subjects who correctly completed the supplied set of instruments were included in the final sample.

Variables and Data Collection Instruments

Two variables were measured in this study: women's perceptions of nursing support in labor, and the value women place on control in labor. Three data collection instruments were used: a demographic questionnaire and two tools which measured the study variables. Each of these will be described below.

Demographic Questionnaire

The first tool was a demographic questionnaire (DQ) that sought descriptive information regarding age, marital and partnered status, educational level, and occupation. Three questions dealing with attendance at childbirth classes and the presence of a companion in labor were included. (see Appendix A)

Nursing Support in Labor Questionnaire

The second data collection instrument measured the perceived helpfulness of nursing support in labor (NSILQ). Because no instrument could be found that measures nursing care of the woman in labor from a social support framework, it was necessary to design a new instrument to measure nursing support. The initial draft of the instrument was based on the investigator's review of the literature and clinical experience as a labor and delivery nurse over the past five years. An attempt was made to select items that were representative of the purposes and functions of the contemporary obstetrical nurse and also were congruent with the conceptual framework of support.

Content validity was established by the following procedures. Interviews with women who had delivered within the previous 48 hours were conducted to ascertain their

perceptions of nursing support. The opinions and practices of labor and delivery nurses regarding their care of women in labor and input from nurse educators who teach maternal-child nursing were also obtained. A content analysis of all responses was performed and the categories that appeared were used to revise the questionnaire. Behaviors consistently reported as being helpful were retained and all others were omitted. This revised version was then submitted to a panel of individuals knowledgeable about the concept of social support who rated items as demonstrating affective, affirmative, or aid support. Items where there was less than 80% agreement among raters were omitted from the final questionnaire.

Internal consistency for the NSILQ was measured by Cronbach's alpha. Since this analysis is based on inter-item correlation, all items must be answered. However, the nature of the NSILQ is such that subjects did not experience every behavior and thus could not rate all 20 items. This reduced the sample size for which reliabilities could be computed. Several different ways of treating the data were undertaken in an attempt to circumvent this problem. The alpha's which will be reported here were obtained by substituting the mean score of the subject whenever an item received a code of 7 for a behavior not experienced. This

approach was deemed the soundest conceptually and resulted in the closest approximation to the values obtained during the original analysis prior to any recoding.

The alpha reliability derived for the 6 item subscale of affect was 0.84 (n=71). Affirmation, which also had 6 items, received an aplha of 0.82 (n=73). The 8 item subscale of aid had an alpha reliability of 0.84 (n=71). For the whole 20 item scale, an alpha of 0.93 (n=68) was obtained.

In order to determine the technical clarity and comprehensibility of the instrument, subjects who returned the first 10 packets were questioned regarding their impressions of the NSILQ. All respondents reported that they found it easy to understand and not at all confusing. Their responses on the questionnaire were examined for consistency and completeness to further confirm this. Based on this information, no further revisions were made in the instrument and these 10 subjects were included in the final sample.

The NSILQ consists of 20 items that describe various supportive nursing behaviors. For each item, subjects were directed to circle "yes" if they had experienced the behavior and "no" if they had not. Women who circled "yes" were then asked to rate the behavior on a 5-point Likert

scale from not at all helpful (1) to very helpful (5). When "no" was circled, the item received a code of 7, for not applicable. There was a possible range of total scores from 0-100. Eight items measured aid support (1, 4, 5, 12, 14, 16, 18, and 20); six items measured affect support (2, 7, 9, 10, 11, and 13); and six items measured affirmation support (3, 6, 8, 15, 17, and 19). Following these 20 items, there were two open-ended questions that gave respondants the opportunity to identify personal opinions and concerns. These answers also provide a basis for future revisions of the instrument. (see Appendix B)

Multidimensional Health Locus of Control (MHLC) Scale

The third data collection tool was developed by Wallston, Wallston, and DeVellis (1978) as a measure of health locus of control. The MHLC scale consists of three scales: 1) internal health locus of control (IHLC); 2) powerful others health locus of control (PHLC); and 3) chance health locus of control (CHLC). Each of these scales is composed of 6 items that are rated on a 6-point Likert scale from strongly agree (score of 6) to strongly disagree (score of 1). Two forms (A and B) are available; they are parallel and equivalent. Form A was arbitrarily used for this study.

In the scale development study, the alpha reliabilities for form A ranged from 0.67 for PHLC to 0.78 for IHLC; no value was reported for CHLC (Wallston, Wallston, and DeVellis, 1978, p. 165). Slightly lower reliabilities were reported for two more recent studies by Wallston and Wallston (1981, p. 205).

In order to establish concurrent and discriminant validity the MHLC scales were correlated with Levenson's Internal, Powerful Other and Chance Scales. Although these scales do not include items specific to expectations about health, they were the first to identify and attempt to measure three distinct dimensions of locus of control. Each MHLC scale correlated most highly with the corresponding Levenson scale.

In examining intercorrelations, the IHLC and PHLC scales are statistically independent; the PHLC and CHLC are positively correlated while the CHLC and IHLC are negatively correlated. A preliminary indication of predictive validity was obtained during the initial study by computing correlations between health status (as identified by subject response) and MHLC scores. A positive correlation was found between health status and IHLC ($r=.40$, $p<.001$), a negative correlation between health status and CHLC ($r=-.28$, $p<.01$), and no correlation between health status and PHLC ($r=-.06$).

(see Appendix C)

For this study sample, the alpha reliabilities obtained were 0.76 for IHLC, 0.75 for PHLC, and 0.72 for CHLC. These are slightly higher overall than those reported by Wallston and Wallston. A higher correlation was found between CHLC and PHLC (0.33 vs. 0.20) and for PHLC and IHLC (0.20 vs. 0.12). There was no correlation between IHLC and CHLC.

Design and Procedure

A descriptive retrospective survey design was used. The study sample was drawn from the postpartum unit of a metropolitan hospital in the following manner. The investigator visited the hospital on alternate days from December 30, 1983 to January 30, 1984. The Kardex was reviewed to initially screen for eligible subjects. Individual charts were then examined to confirm eligibility, identify parity, and document length of time nursing care was received during labor.

Women who met the criteria for inclusion in the sample were then approached by the investigator who introduced herself and briefly explained the study. All women were informed that participation was voluntary, and asked to replace the blank instruments in the packet if they chose not to participate. The packet containing a cover letter

and the data collection instruments was then left with each potential subject. The cover letter described the purpose of the study, how the information was to be handled, and what was required of subjects (Appendix D). The cooperation of the nursing staff was solicited in picking up these packets for the investigator. By the end of the month, 78 useable sets of questionnaires were obtained.

Analysis

Analysis of data involved both descriptive and inferential statistics. Description of the sample included deriving a mean and standard deviation for interval and ratio data, and frequencies and percentages for nominal and ordinal data. Analysis by research question required inferential as well as descriptive statistics, and will be described in the next chapter.

CHAPTER III

RESULTS AND DISCUSSION

The first part of this chapter will present the findings of this study. A discussion of the results will follow.

Description of the Sample

During the month of data collection, questionnaire packets were distributed to 118 eligible subjects. Of these, 94 were returned for a response rate of 80%. Non-respondents were similar to the sample in terms of parity and length of labor during which nursing care was received. After eliminating questionnaires that were unuseable due to incomplete or confusing responses, the final sample size was 78.

Selected demographic characteristics of the study sample are presented in Table 1. Subjects ages ranged from 18 to 40, the mean age was 26.14, and 74% of the sample were between 20 and 29 years old. A majority of respondents were married (83.3%) and 93.5% identified themselves as partnered.

The sample was primarily caucasian (85.9%) with a low, but diverse, minority representation. In comparison to Multnomah County and the State of Oregon, the percentage of

TABLE 1
Selected Demographic Characteristics of Subjects

Characteristic	n[a]	Value[b]
Age	78	
mean		26.14
S.D.		4.95
range		18-40
Marital Status	74	
single		14.1
married		83.3
divorced/separated		2.6
Partner Status	77	
partnered		93.5
not partnered		6.5
Ethnic Identification	78	
White		85.9
Asian		5.1
Hispanic		3.9
Black		2.6
Native American		2.6
Educational Level	78	
mean		13.7
S.D.		1.95
range		9-16+
Occupation	74	
housewife		33.8
clerical/sales		25.7
professional/technical		13.5
service		9.5
managerial		6.8
other		10.9

[a] n = number of subjects responding to the item.

[b] With the exception of age and education level, all values represent percentages.

white respondents in the study sample was slightly higher than for the county but lower than for the state (82.7% and 88.5% respectively, State Health Division, 1982). This slight underrepresentation may be partially due to the requirement that study participants be able to read and understand English. It may also reflect a cultural bias in that the white, middle class population tends to respond more frequently to surveys and questionnaires.

Overall, subjects were well educated. The modal grade level attained was 12; 87.2% of the sample had completed high school. Of these 30.8% had completed 1 to 3 years of college, 11.3% had completed college, and 11.3% had some postgraduate education. Only 12.8% of the study sample reported less than a high school education (9 to 11 years).

The majority of the sample were employed; 33.8% identified themselves as housewives while 25.7 reported holding clerical or sales position and 20.3% were in professional, technical, or management positions. Since the above information was obtained by an open-ended question, this may not be an accurate depiction of subjects' actual occupational and professional experience. Respondents could have perceived that only their current occupational status was being requested. With the birth of a first child, or subsequent children, there may be a change in employment

status. Women who up until now have been in the work force may be interrupting jobs and careers either temporarily or indefinitely. This could have increased the number of women who reported their occupation as being a housewife while simultaneously decreasing the number of women who reported other occupations. Four subjects left the question unanswered.

Variables which may have influenced subjects recent childbirth experience can be found in Table 2.

The total length of labor was not reported since the time spent in labor prior to coming to the hospital was not measured. Subjects were divided fairly evenly between multiparas and primiparas, although there were slightly more multiparous women. Slightly over half of the subjects did not attend childbirth classes. All but two subjects reported having a non-nurse companion present during labor, with the majority (n=50) identifying their husband or partner as the companion.

Research Questions

The study asked four research questions regarding perceived nursing support in labor. The findings relevant to each of these will be presented. Nursing support was conceptualized as providing affect, affirmation, or aid. Affect support is the expression of admiration, respect,

TABLE 2
Selected Childbirth Characteristics of Subjects

Characteristic	n[a]	Value[b]
Hours of nursing care during labor	59	
mean		8.58
S.D.		4.50
range		2-18
Parity	77	
primiparous		45.5
multiparous		54.5
Childbirth Class Attendance	78	
attended		43.6
did not attend		56.4
Presence of companion during labor	78	
present		97.4
not present		2.6
Identification of companion	72	
husband/partner		69.4
mother		6.9
sister		4.2
friend		2.8
other		3.8
combination		12.5

[a]The number of hours of nursing care during labor was not collected for the first 19 subjects.

[b]With the exception of hours of nursing care, all values represent percentages.

liking or love. Affirmation signifies agreement or acknowledgement of the rightness of another person's actions or statements. Aid indicates the provision of money, things, information, or time. Women's orientation to control in labor was based on the construct of health locus of control. Accordingly, subjects were characterized as believing that what happens to them is controlled or determined by: 1) themselves (internal health locus of control, IHLC); 2) powerful others (powerful others health locus of control, PHLC); or 3) fate or chance (chance health locus of control, CHLC).

Research Question 1

The first research question asked how helpful selected supportive behaviors of nurses were as perceived by women during labor. Overall, the study sample perceived the 20 nursing support behaviors evaluated as being helpful.

Behaviors were rated on a scale of 1 to 5 with 1 being not at all helpful and 5 being very helpful. Descriptive statistics were used to analyze the helpfulness of the 20 nursing behaviors evaluated by the Nursing Support in Labor Questionnaire (NSILQ). These are presented in Table 3. The number of respondents rating each item varied from 63 to 78 as only those subjects who reported a behavior as occurring

were eligible to rate it. The range of individual raw scores was 1 to 5 for the majority of items. The range of mean scores for the items was very small: the lowest mean score was 3.94 (item #1) while the highest mean score was 4.73 (item #20). Furthermore, the mode for all 20 items was five, with 50% or more of the sample rating 16 of the 20 items as very helpful (5).

TABLE 3
Subjects' Ratings of the Helpfulness
of Selected Nursing Support Behaviors

NSILQ Item[a]	n	range	mean	S.D.	% very helpful rating	rank
1	72	2-5	3.94	1.07	43.1	19
2	63	2-5	4.37	0.77	52.4	9
3	72	2-5	4.24	0.93	54.2	14
4	64	2-5	4.25	1.00	56.3	13
5	77	2-5	4.36	0.90	59.7	10
6	77	2-5	4.46	0.80	63.6	7
7	77	2-5	4.49	0.82	66.2	5
8	75	2-5	4.59	0.72	70.7	3
9	78	1-5	4.46	0.82	62.8	6
10	78	3-5	4.62	0.65	70.5	2
11	62	2-5	4.05	1.03	43.5	17
12	73	1-5	4.18	1.05	52.1	15
13	77	2-5	4.51	0.79	64.9	4
14	59	1-5	4.02	1.15	47.5	18
15	69	1-5	4.09	1.07	47.8	16
16	76	2-5	4.40	0.88	63.2	8
17	78	2-5	4.62	0.79	76.9	2
18	74	2-5	4.31	0.98	59.5	11
19	64	2-5	4.27	0.93	53.1	12
20	75	3-5	4.73	0.553	78.7	1

[a]See Appendix B for corresponding nursing support behavior.

Items were rank ordered from least to most helpful based on the sample mean of each item. Because all of the NSILQ items were rated as helpful, only the least and most helpful will be identified here. Six behaviors were ranked from 1 to 5, with two items sharing a rank of 2. The six most helpful nursing behaviors in descending order were: coaching, praising the woman's efforts, providing friendly and personal care, accepting the woman's behavior, treating the woman with respect, and making the woman feel cared about as an individual. All four of the items where less then 50% of the sample rated the behavior as very helpful were also the four items with the lowest mean score. These four least helpful nursing support behaviors in descending order were: supporting the woman working with her coach, spending time in the room apart from tasks, providing for the needs of the coach, and familiarizing the woman with her surroundings.

Research Question 2

The second research question asked whether there was a difference between the perceived helpfulness of nursing behaviors that provide affective, affirmative, or aid support. No significant differences were found.

The mean and standard deviation for each of the three

NSILQ subscales of support can be seen in Table 4. The mean score for each subscale was high which was predictable with the high mean scores obtained for the individual items. The three subscales of support were ranked based on their mean scores. Affect had the highest ranking, followed by affirmation and then aid. The means for all three subscales were very similar, however. In examining the six nursing behaviors receiving the highest helpfulness rating, three of these were from the affect subscale, two were from the affirmation subscale, and only one was from the aid subscale.

TABLE 4
Subjects' Ratings of the Helpfulness
of Affect, Affirmation, and Aid Support

Support	n	mean	S.D	rank
Affect	78	4.42	0.63	1
Affirmation	76	4.38	0.68	2
Aid	76	4.30	0.63	3

All three subscales were highly correlated as can be seen by the correlation matrix presented in Table 5. The lowest correlation was betwen aid and affect while the highest was for aid with affirmation. However, there was

very little difference in the correlations.

TABLE 5
Correlation Matrix for the Three Subscales of Support*

	Affect	Affirmation	Aid
Affect	1.00	0.76 (n=76)	0.69 (n=75)
Affirmation		1.00	0.80 (n=73)
Aid			1.00

*p=.001

Research Question 3

The third research question asked whether women who have different locus of control beliefs have any differences in their perception of the helpfulness of nursing support behaviors. No significant differences were found.

In the first analysis, the sample was dichotomized into groups with high and low scores on each of the Multidimensional Health Locus of Control (MHLC) scales using a median split. Table 6 presents the mean, standard deviation, and t-value for the NSILQ total scores for each of the groups thus obtained. No significant differences were found between the mean total scores for any of the categories based on the t-test analysis of means between two

groups.

TABLE 6
Relationship of Mean NSILQ Total Scores to Health Locus of Control Groups Split at Medians Using a t-test Analysis

Health Locus of control	n	NSILQ Total Score mean	S.D.	t-value*
Internality				
below	37	4.29	0.55	
above	39	4.39	0.62	-1.31
Powerful Other				
below	38	4.27	0.65	
above	38	4.40	0.51	-0.95
Chance				
below	41	4.29	0.55	
above	35	4.39	0.62	-0.79

*All obtained values were non-significant

The study sample was also divided into three separate locus of control groups and a one-way ANOVA performed. The first group consisted of "true" internals: subjects who scored above the median on IHLC and below the median on PHLC and CHLC. Group two consisted of "true" externals: subjects who scored below the median on IHLC and above the median on PHLC and CHLC. The third, and largest group consisted of all subjects with any other combination of MHLC scores. Table 7 presents the mean, standard deviation, and F-value for the NSILQ total score for the three groups. Using the

one-way ANOVA, no significant differences between groups for total NSILQ scores were found.

TABLE 7
Relationship of Mean NSILQ Total Scores to Health Locus of Control Groups using a one-way ANOVA

Health Locus of control Group[a]	n	NSILQ Total Score mean	S.D.	F-value
Internals	5	4.38	0.50	0.03
Externals	6	4.36	0.55	
Mixed	63	4.33	0.60	

[a]Internals = above the median on Internal Health Locus of Control, below the median on Powerful Other and Chance Health Locus of Control
Externals = below the median on Internal Health Locus of Control, above the median on Powerful Other and Chance Health Locus of Control
Mixed = any other combination of Health Locus of Control Scores

Research Question 4

The fourth research question asked whether women with different health locus of control beliefs have any differences in their perceptions of the helpfulness of nursing behaviors that provide affective, affirmative, or aid support. No significant differences were found.

As described for research question 3, the sample was first dichotomized into groups with high and low scores on each of the MHLC scales using a median split. Tables 8, 9,

and 10 present the mean, standard deviation, and t-value for the subscale scores of each of the groups. A significant difference between NSILQ subscale means was found only in one cross classification. High internals had a significantly higher mean score on the aid subscale than did the low internals. When the study sample was divided into "true" internals, "true" externals, and a "mixed" locus of control classification, no significant differences were found for any of the groups using the one-way ANOVA. Table 11 presents the mean, standard deviation, and F-values for the NSILQ subscale scores for these three groups.

Discussion

Research Question 1

The uniformly high ratings for all 20 nursing support behaviors identified by the NSILQ have several possible explanations. One of these could be that subjects tended to rate the person rather than the behavior. Subjects who liked their nurse and/or had a positive and satisfying birth experience may have thus tended to rate every behavior highly. In addition, subjects could have perceived that the information they provided reflected on the performance of individual nurses rather than the behaviors of nurses in general. Their ratings may have been influenced by a desire

TABLE 8
Relationship of Mean Affect Scores According To Health Locus of Control Groups Split at Medians

Health Locus of Control	n	mean	S.D.	t-value*
Internality				
below	37	4.38	0.60	
above	39	4.44	0.62	0.10
Powerful Other				
below	38	4.46	0.65	
above	38	4.35	0.56	0.83
Chance				
below	41	4.38	0.60	
above	35	4.35	0.62	-0.39

*All obtained values were non-significant.

TABLE 9
Relationship of Mean Affirmation Scores According To Health Locus of Control Groups Split at Medians

Health Locus of Control	n	mean	S.D.	t-value*
Internality				
below	35	4.36	0.63	
above	39	4.37	0.75	-1.45
Powerful Other				
below	38	4.26	0.71	
above	36	4.47	0.65	-1.32
Chance				
below	40	4.36	0.63	
above	34	4.37	0.75	-0.08

*All obtained values were non-significant.

TABLE 10
Relationship of Mean Aid Scores According To
Health Locus of Control Groups Split at Medians

Health Locus of Control	n	mean	S.D.	t-value
Internality				
below	36	4.17	0.64	
above	37	4.42	0.59	-1.97*
Powerful Other				
below	37	4.17	0.71	
above	36	4.41	0.51	-1.71
Chance				
below	39	4.17	0.64	
above	34	4.41	0.59	1.69

*p = .05

TABLE 11
Relationship of NSILQ Subscale Scores to Health
Locus of Control Groups Using a one-way ANOVA

Health Locus of Control Group	Support Subscale	n	mean	S.D.	F-value
Internals	Affect	5	4.30	0.76	
Externals		8	4.38	0.67	
Mixed		63	4.42	0.60	0.09
Internals	Affirmation	5	4.45	0.48	
Externals		7	4.38	0.70	
Mixed		62	4.36	0.70	0.04
Internals	Aid	5	4.39	0.39	
Externals		8	4.37	0.45	
Mixed		60	4.27	0.66	0.16

to help the nurse, or at least not get her into trouble.

The manner in which the NSILQ was designed offers a second possible explanation. All items on the questionnaire were obtained by asking newly delivered mothers and experienced labor and delivery nurses to identify what nurses do that is helpful. Only those behaviors consistently reported as being helpful were retained. Therefore, the high scores could be validating these "expert" opinions. Finally, subjects who agreed to participate may have done so because they were satisfied with their birth experience. Women who did not return questionnaires or whose questionnaires were omitted because too many behaviors were reported as not experienced, may have responded differently and provided more variation in rating.

For those behaviors rated most highly by subjects, five of the six had to do with interpersonal dynamics. Women in this study rated nursing support characterized by praise, respect, friendliness, caring, and acceptance as being very helpful. This is consistent with the findings of other studies. Women interviewed postpartum in the hospital by Bender (1967) and Butani and Hodnett (1980) perceived nurses as being helpful when they were understanding, caring, and concerned about them as individuals. In a study by Klein

et. al. (1980), women interviewed at home one week postpartum identified the nursing support behavior of talking as most helpful. In addition, those nurses rated as most helpful were observed to have been in the room more frequently than those nurses rated as less helpful. Although not specified in their study it is reasonable to suggest that these two behaviors provided nursing support characterized by the interpersonal behaviors identified in the present study.

Coaching of women in labor by nurses received the highest rating by the study sample. It should be noted however, that all behaviors were rated highly, with only small differences among their means. This finding suggests the importance of the role of the labor and delivery nurse as a source of expert knowledge and experience. Although 76 of 78 subjects reported having a non-nurse companion who helped them during labor, the nurse still made an important contribution. The literature is not as clear regarding the value of this support behavior. Bender's study (1967) reported assistance in coping with contractions as being helpful. However, in a more recent study by Klein et. al. (1980), coaching breathing had the second lowest mean helpfulness rating out of the five support behaviors they evaluated. These differences in findings could be due to

changing attitudes and the advent of prepared childbirth, as both influence the nurse's role and what women may want or need from the nurse.

One of the two examples given for this NSILQ item may help explain the high rating for this behavior. The example "told you how to push" could have strongly influenced subjects' responses. Assistance with pushing was identified as being very helpful both verbally by women interviewed during questionnaire design and from written comments on the actual questionnaire.

In interpreting the findings related to the four lowest rated behaviors, it is important to keep in mind that none of these were rated as not being at all helpful, they just were not as helpful as the other support behaviors. These behaviors can be compared to the "extra's", and may be those likely to be omitted or not offered as consistently when busy and difficult conditions prevail in the labor and delivery suite. For example, several subjects who circled "no" that they did not experience, or gave a low rating to, the behavior of time spent in the room apart from task performance, wrote down the explanation that it was very busy and the nurse did the best she could.

Research Question 2

The ranking of the subscales of support reflect the responses to individual items. The subscales of affect and affirmation deal with the interpersonal, psychosocial aspects of social support, and five of the top six behaviors belong to these two subscales. However, the highest rated behavior was from the aid subscale, which had the lowest scale mean score. A possible interpretation again relates to the example given for the behavior, "assisting with pushing." It is during this stage of labor that nurses usually spend the most time in the room and assume a more active role and when women are most likely to rely on the expertise and reassurance that the nurse provides. In coaching pushing, nurses also can be expressing affective and affirmative support as well as aid support--showing concern for the woman by being there with her and reinforcing and praising her efforts.

The high correlations among each of the subscales is not surprising since all items have been identified as providing nursing support. Furthermore, when designating items as belonging to one subscale or another, there was often disagreement among panel members. Several behaviors could be interpreted as being congruent with the definition of more than one subscale of social support. What was

surprising was the high correlation between aid and affirmation. A possible explanation could be that high scores on affect most closely reflect whether women liked their nurse or vice versa. High scores on the aid and affirmation subscales however, can result when the nurse is perceived as competent and conscientious even when no such rapport occurs. Although labor room nurses can and should strive for competence in technical skills and verbal instruction and reinforcement, no one can be expected to "click" with every woman and/or couple they meet. The lower correlation between affect and aid would be consistent with this explanation.

Research Questions 3 & 4

In analyzing questions 3 and 4, certain difficulties were encountered in trying to establish comparison groups based on health locus of control beliefs. Wallston and Wallston (1981) themselves state they have had little success in developing clear cut typologies using the three dimensions of IHLC, CHLC, and PHLC. For that reason, several different groupings and analyses were performed. In the first analysis, a median split was used to dichotomize the sample into low-high for each of the three subscales of health locus of control. The only significant finding was

that high internals scored higher on the NSILQ subscale of aid than did the low internals, a relationship opposite in direction to that expected. An explanation could lie in the overlapping nature of these categorizations. A person above the median on internal health locus of control can also be above the median on one or both of the other dimensions. Therefore, high internals who were also high on powerful other health locus of control could have valued and rated highly aid support behaviors provided by the nurse, who is indeed a powerful other during labor. Also, since the MHLC scales include only positively worded items, "yea saying" by individuals who agree with any item regardless of content could have produced a bias in the data.

The second analysis attempted to look at "pure" internals and externals compared to those of mixed typology. Again, no significant findings resulted. The major problem is due to unequal numbers in groups. As can be seen from Table 9, there were only 5 subjects in the internal group, 7-8 in the external group, and an overwhelming majority in the mixed group. This finding reflects the difficulty of establishing a clear typology for the MHLC scale due to the multidimensional and overlapping nature of the health locus of control construct.

For this study, the health locus of control construct

is not ideal. First of all, it deals with general health beliefs and is not designed for the specific situation of labor. Furthermore, it is possible that an individual's identified health locus of control can change in the special circumstances of labor. For example, a woman who possesses internal locus of control may demonstrate behavior consistent with a high belief in powerful other locus of control when surrounded by medical personnel in the hospital. Women who have recently delivered a newborn are in a state of transition and disequilibrium. During the postpartum period, they are coping with the addition of a new family member while simultaneously being in a semi-dependent state as a patient in a hospital setting. This factor could also have influenced the study sample's responses to the MHLC scale. Finally, Wallston and Wallston (1981) have emphasized that the locus of control will not be predictive of health behaviors unless combined with an instrument that measures the value individuals place on health. In this study, no measure of health value was administered. All of the above factors could be responsible for the lack of expected findings to research questions 3 and 4.

CHAPTER IV

CONCLUSION

Summary

The childbirth experience is a significant life event. The goal of nursing support is not only a safe delivery, but a positive and satisfying childbirth experience. The purpose of this study was to identify what support behaviors of nurses are perceived as helpful by women in labor and to explore the relationship between value placed on control in labor and perception of nursing support.

Social support was the conceptual framework used to explore women's perceptions of nursing support in labor. The definition by Kahn and Antonucci (1980) was used to identify specific behaviors as providing affective, affirmative, or aid support. Woman's value for, or orientation to control in labor, was based on the three dimensions of health locus of control identified by Wallston, Wallston, and DeVellis (1978): internal locus of control, powerful other locus of control, and chance locus of control.

Four research questions were formulated: 1) How helpful are selected supportive behaviors of nurses as perceived by women during labor? 2) Is there a difference between the

perceived helpfulness of nursing behaviors that provide affective, affirmative, or aid support? 3) Do women who have different health locus of control beliefs have any differences in their perception of the helpfulness of nursing support behaviors? and 4) Do women who have different health locus of control beliefs have any differences in their perception of the helpfulness of nursing behaviors that provide affective, affirmative, or aid support?

The sample consisted of 78 women who had experienced an uncomplicated prenatal and intrapartal course. The sample was primarily young, caucasian, married, well-educated, and employed. Subjects were fairly evenly divided between primiparas and multiparas, and those who had and had not attended childbirth classes. Almost all were accompanied by a companion other than the nurse during their labor.

Three data collection instruments were used: a demographic questionnaire, the Nursing Support in Labor Questionnaire (NSILQ) and the Multidimensional Health Locus of Control (MHLC) Scales. All 20 of the behaviors appearing on the NSILQ were perceived as helpful by the study sample. No major differences were found between the perceived helpfulness of affective, affirmative, or aid support for the total sample. Women with different health locus of

control beliefs did not demonstrate any significant differences in their overall perception of nursing support. In addition, no meaningful differences were found for their perceptions of any of the subscales of support.

Limitations

There are several limitations of the study that could have influenced the findings. The major limitation relates to measurement issues. Since the data collected were based on subject recall, a discrepancy may exist between the actual, and reported, incidence and helpfulness of the various nursing support behaviors. Subjects who reported that a behavior did not occur may have experienced the behavior, but either did not value it as important or find it to be helpful, so forgot it in retrospect.

Another limitation relates to subjects rating the person and not the behavior. In examining the findings it is unclear whether a behavior's rating reflected its actual helpfulness or the manner in which the nurse carried it out. Ratings could have been inflated because subjects liked their nurse and wanted to give her a good evaluation.

The issue of non-participation is a third limitation. There was no data other than parity and length of labor for those individuals who did not return packets or left them

blank. Their ratings may have differed from those who completed the questionnaires. For those subjects who were included in the sample, the majority reported not experiencing one or several nursing behaviors and thus could not rate them. It could be that the behavior was offered but not needed. On the other hand, a woman may have desired to experience the behavior, but it was never offered by the nurse. Due to the design of the instrument and the study it remains unclear whether not experiencing a behavior was voluntary or involuntary.

The construct of health locus of control may be inadequate conceptually to explain the phenomena of desire for control in labor. No clear categorizations emerged which were predictive of women's responses on the NSILQ. This was not entirely unexpected, since the MHLC scales were designed to measure generalized health beliefs and are not specific to the childbirth experience. Furthermore, desire to maintain control and the belief or expectancy that health can be determined by personal efforts are two separate entities. Finally, since the MHLC scales were administered during the postpartum period when there is disequilibrium due to numerous physiological and psychosocial changes, the validity of the findings is further weakened.

In addition to these conceptual limitations there are

measurement limitations. As stated in the previous chapter, the authors of the MHLC scales acknowledge that clear typologies have yet to be developed and that most individuals fail to fit into pure types anyway. In addition, Wallston and Wallston (1981) propose that there is less evidence for validity when the construct is used as a predictor of behavior, as was the case in this study. Finally, they suggest that the lack of significant findings with the MHLC scales may be due to inappropriate analysis strategies, and propose the use of a multiple regression model.

Implications for Nursing Practice

The contribution of this study to nursing practice results from the finding that all 20 nursing support behaviors evaluated were highly rated in terms of their helpfulness. As nurses, we often act based on "gut" feelings or "tradition." This study provides more objective confirmation of the helpfulness of selected nursing support behaviors for women in labor.

One implication for nursing practice is the use of these 20 behaviors as a teaching tool, both for student nurses and practicing nurses. These behaviors can provide a focus for discussing nursing support in labor and encourage

the exchange of ideas. Items on the NSILQ can be used as a primary or supplemental tool for performance evaluation of labor and delivery nurses. It could also be used to solicit feedback from patients. As consumerism and competition for clients continue to be issues, health care providers need to be aware of and responsive to the needs and desires of those served.

Finally, the ratings for the three types of support--affect, affirmation, and aid--suggest that interpersonal skills are at least as important as technical skills, if not more so. Nursing has always emphasized the integration of psychosocial and physical care. Nurses working in labor and delivery share in a very special and important experience. It is not enough to be competent. We must show women the concern, respect, and acceptance they deserve as we assist them during this significant life event.

Recommendations for Research

Recommendations for further study include replicating this study in different settings with different samples. Another area of study needed is the investigation of discrepancies between reported and actual occurrence of support behaviors. The 20 nursing support behaviors on the

NSILQ could be used as a checklist to document occurrence of these behaviors by observation during labor. Postpartum, the NSILQ could be administered and a comparison made between those behaviors women reported as experiencing and those behaviors observed to have occurred.

In order to avoid the problem of the "halo effect" the NSILQ could be used as an interview schedule. In this way, the investigator would be able to clarify and explain that it was only the behavior that was being rated. Information regarding why a behavior did not occur could also be obtained in an interview setting.

Differences between professional and consumer values could be examined by administering a modified NSILQ to nurses and postpartum patients and comparing the findings. To investigate whether the experience of labor itself affects women's perceptions of what is helpful, a pre- and post-test design could be used. A modified NSILQ could be given to subjects during childbirth classes and then repeated after delivery.

To test the effect of the birth and postpartum experience on health locus of control beliefs, the MHLC scales could also be administered prior to and immediately after childbith, with a final administration two to three months later. The two forms of the scale could be

alternated and then combined for the third administration. Finally, the development of a tool that measures specific expectancies of control related to childbirth would provide a better instrument for evaluating the impact that individual women's beliefs have on the type and amount of nursing support they desire in labor.

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APPENDICES

APPENDIX A

Demographic Questionnaire

Demographic Questionnaire

1. Age _____

2. Partner Status

   _____ This pregnancy was a solo experience and I plan to be a single parent for this child.

   _____ This pregnancy was a joint experience with my partner who plans to be a parent with me for this child.

3. Legal Marital Status

   _____ Single, never married

   _____ Married

   _____ Divorced or separated

   _____ Widowed

4. Ethnic or Racial Identification

   _____ White (Caucasian)

   _____ Black

   _____ Mexican-American

   _____ Asian

   _____ American Indian

   _____ Other (please identify) _____

5. Highest Grade of School Completed (circle number)

   1 2 3 4 5 6 7 8 9 10 11 12

   College 13 14 15 16

   above 16

6. Occupation or Profession _____

7. Did you attend childbirth classes during this pregnancy?

_____ yes

_____ no

8. Did you have a non-nurse companion to help you when you were in labor?

_____ yes ____

_____ no

9. Please identify _____

APPENDIX B

Nursing Support in Labor Questionnaire

Nursing Support in Labor Questionnaire

Directions: Nurses carry out a number of actions to assist women in their labors. Some of these behaviors are listed below. Circle "yes" for those behaviors you experienced, circle "no" for those you did not. For those behaviors you experienced, please indicate how helpful each of these were to you by circling the number which best represents your answer, with 1 being not at all helpful and 5 being very helpful.

1. Did the nurse help you to become familiar with your surroundings? For example, showed you where things were.

	not at all helpful				very helpful
yes	1	2	3	4	5
no					

2. Did the nurse touch you? For example, held your hand.

	not at all helpful				very helpful
yes	1	2	3	4	5
no					

3. Did the nurse include you in the decision-making during your labor? For example, informed you of alternatives and gave you a choice.

	not at all helpful				very helpful
yes	1	2	3	4	5
no					

4. Did the nurse instruct you in breathing and relaxation methods?

	not at all helpful				very helpful
yes	1	2	3	4	5
no					

5. Did the nurse provide information about what happens in labor and keep you informed about how your labor was going? For example, explained what dilation meant, told you how dilated your cervix was.

	not at all helpful				very helpful
yes	1	2	3	4	5

no

6. Did the nurse try to carry out as many of your wishes and desires for your labor and delivery as possible?

	not at all helpful				very helpful
yes	1	2	3	4	5

no

7. Did the nurse make you feel cared about as an individual?

	not at all helpful				very helpful
yes	1	2	3	4	5

no

8. Did the nurse accept what you said and did in labor without judging you? For example, didn't criticize you or leave you alone if you were loud or crying, but stayed and tried to help.

	not at all helpful				very helpful
yes	1	2	3	4	5

no

9. Did the nurse provide a sense of security? For example, checked up on you frequently, answered your call light quickly.

	not at all helpful				very helpful
yes	1	2	3	4	5

no

10. Did the nurse provide friendly and personal care? For example, called you by name, made you feel welcome.

	not at all helpful				very helpful
yes	1	2	3	4	5

no

11. Did the nurse spend time in the room with you, even when she didn't have a specific job to do?

	not at all helpful				very helpful
yes	1	2	3	4	5

no

12. Did the nurse help to make you physically comfortable? For example, provide a cool washcloth, help with positioning.

	not at all helpful				very helpful
yes	1	2	3	4	5

no

13. Did the nurse treat you with respect? For example, introduced herself, allowed you to have some privacy.

	not at all helpful				very helpful
yes	1	2	3	4	5

no

14. Did the nurse provide for the needs of your coach? For example, relieved for breaks, offered coffee.

	not at all helpful				very helpful
yes	1	2	3	4	5

no

15. Did the nurse support and reinforce the way you and your coach worked together?

	not at all helpful				very helpful
yes	1	2	3	4	5

no

16. Did the nurse explain hospital routines and procedures: what was going to be done and why? For example, fetal monitoring, vaginal exams.

	not at all helpful				very helpful
yes	1	2	3	4	5

no

17. Did the nurse praise you and tell you that you were doing a good job?

	not at all helpful				very helpful
yes	1	2	3	4	5

no

18. Did the nurse communicate your needs and wishes to the doctor and other hospital workers?

	not at all helpful				very helpful
yes	1	2	3	4	5

no

19. Did the nurse indicate that she understood and supported your birth plan?

	not at all helpful				very helpful
yes	1	2	3	4	5

no

20. Did the nurse coach you in labor? For example, told you how to push, reminded you to relax.

	not at all helpful				very helpful
yes	1	2	3	4	5

no

21. What other nursing behaviors, not identified above, were helpful?

22. Please feel free to write any additional comments. Thank you for your participation.

APPENDIX C

Multidimensional Health Locus of Control Scales (Form A)

This is a questionnaire designed to determine the way in which different people view certain important health-related issues. Each item is a belief statement with which you may agree or disagree. Beside each statement is a scale which ranges from strongly disagree (1) to strongly agree (6). For each item we would like you to circle the number that represents the extent to which you disagree or agree with the statement. The more strongly you agree with a statement, then the higher will be the number you circle. The more strongly you disagree with a statement, then the lower will be the number you circle. Please make sure that you answer every item and that you circle only one number per item. This is a measure of your personal beliefs; obviously, there are no right or wrong answers.

Please answer these items carefully, but do not spend too much time on any one item. As much as you can, try to respond to each item independently. When making your choice, do not be influenced by your previous choices. It is important that you respond according to your actual beliefs and not according to how you feel you should believe or how you think we want you to believe.

		Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
1.	If I get sick, it is my own behavior which determines how soon I get well again.	1	2	3	4	5	6
2.	No matter what I do, if I am going to get sick, I will get sick.	1	2	3	4	5	6
3.	Having regular contact with my physician is the best way for me to avoid illness.	1	2	3	4	5	6
4.	Most things that affect my health happen to me by accident.	1	2	3	4	5	6

		Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
5.	Whenever I don't feel well, I should consult a medically trained professional.	1	2	3	4	5	6
6.	I am in control of my health.	1	2	3	4	5	6
7.	My family has a lot to do with my becoming sick or staying healthy.	1	2	3	4	5	6
8.	When I get sick I am to blame.	1	2	3	4	5	6
9.	Luck plays a big part in determining how soon I will recover from an illness.	1	2	3	4	5	6
10.	Health professionals control my health.	1	2	3	4	5	6
11.	My good health is largely a matter of good fortune.	1	2	3	4	5	6
12.	The main thing which affects my health is what I myself do.	1	2	3	4	5	6
13.	If I take care of myself, I can avoid illness.	1	2	3	4	5	6
14.	When I recover from an illness, it's usually because other people (for example, doctors, nurses, family, friends) have been taking good care of me.	1	2	3	4	5	6
15.	No matter what I do, I'm likely to get sick.	1	2	3	4	5	6
16.	If it's meant to be, I will stay healthy.	1	2	3	4	5	6

	Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
17. If I take the right actions, I can stay healthy.	1	2	3	4	5	6
18. Regarding my health, I can do only what my doctor tells me to do.	1	2	3	4	5	6

APPENDIX D

Cover Letter

Your help is being requested in a study that I am conducting under the direction of Dr. Mary Ann Curry as part of the requirements for the masters of nursing degree at the Oregon Health Sciences University. I am asking women who have delivered babies within the last 48 hours to fill out three questionnaires. Your answers will provide descriptive information about yourself, information regarding your evaluation of the helpfulness of nursing support in labor, and information about your health beliefs. All of the information you supply will be handled confidentially. Your name will not appear on any of the records.

Your participation in this study will help increase our knowledge about how nurses can best assist women in labor. Although there will be no direct benefit to you at this time, the information you provide may help you and other women in the future.

Participation is completely voluntary. If you choose to participate, please answer all or as many of the questions as you can. It will take approximately 20 minutes to complete the questionnaires. If you choose not to participate, please place the questionnaires back in the envelope. All of the envelopes will be picked up in 30 minutes, and nothing further will be required of you. If you have any questions, please feel free to call me at 289-9187 between 7-9 PM. Thank you for your cooperation.

Diane Kintz

AN ABSTRACT OF THE THESIS OF

Diane Lindo Kintz

For the MASTER OF NURSING

Date of Receiving this Degree: June 8, 1984

Title: NURSING SUPPORT IN LABOR: PERCEPTIONS OF NEWLY DELIVERED MOTHERS

Approved: [redacted]

Mary Ann Curry, R.N., D.N.Sc., Thesis Adviser

The childbirth experience is a significant life event. The goal of nursing support is not only a safe delivery, but a positive and satisfying childbirth experience. The purpose of this study was to identify what support behaviors of nurses are perceived as helpful by women in labor and to explore the relationship between value placed on control in labor and perception of nursing support.

Four research questions were formulated: 1) How helpful are selected supportive behaviors of nurses as perceived by women during labor? 2) Is there a difference between the perceived helpfulness of nursing behaviors that provide affective, affirmative, or aid support? 3) Do women who have different health locus of control beliefs have any differences in their perception of the helpfulness of

nursing support behaviors? and 4) Do women who have different health locus of control beliefs have any differences in their perceptions of the helpfulness of nursing behaviors that provide affective, affirmative, or aid support?

The sample consisted of 78 women who had experienced an uncomplicated prenatal and intrapartal course. The sample was primarily young, caucasian, married, well-educated, and employed. Subjects were fairly evenly divided between primaparas and multiparas, and those who had and had not attended childbirth classes. Almost all were accompanied by a companion other than the nurse during their labor.

Three data collection instruments were used: A demographic questionnaire, the Nursing Support in Labor Questionnaire (NSILQ) and the Multidimensional Health Locus of Control (MHLC) Scales. All 20 of the behaviors appearing on the NSILQ were perceived as helpful by the study sample. No major differences were found between the perceived helpfulness of affective, affirmative, or aid support for the total sample. Women with different health locus of control beliefs did not demonstrate any significant differences in their overall perception of nursing support. In addition, no meaningful differences were found for their perceptions of any of the subscales of support.

There were several limitations to the study. The findings may have been influenced by the retrospective design of the study, by the possibility that subjects rated the person and not the behavior, and by the lack of information from non-participants. The construct of health locus of control proved inadequate both conceptually and in terms of its measurement properties.

The major contribution of this study is the objective confirmation of the helpfulness of selected nursing support behaviors for women in labor. Implications for nursing practice include the use of the 20 behaviors as a teaching and evaluation tool for students and practicing nurses in the maternal-child area. Finally, the NSILQ could also be used to solicit feedback from patients, and thus promote responsiveness of health care providers to consumer needs.