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Midwives' Verbal Support of Nulliparous Women in Second Stage Labor

Noelle Borders, CNM, MSN [staff certified nurse-midwife],

Department of Obstetrics and Gynecology, University of New Mexico, Albuquerque NM

Claire Wendland, MD, PhD [associate professor],

University of Wisconsin, Madison WI

Emily Haozous, PhD RN [assistant professor],

College of Nursing, University of New Mexico, Albuquerque NM

Lawrence Leeman, MD MPH [professor], and

Department of Family and Community Medicine, University of New Mexico, Albuquerque NM

Rebecca Rogers, MD [professor]

Department of Obstetrics and Gynecology, University of New Mexico, Albuquerque NM

Abstract

Objective—To describe how nurse-midwives verbally support nulliparous women during second stage labor and document specific details of each second stage.

Design—Descriptive qualitative study.

Setting—A university hospital labor and delivery unit in the southwestern United States.

Participants—Nulliparous women (N=14) greater than 18 years of age and their attendant midwives (N=9).

Methods—A single research midwife observed the entire second stage of each woman and used a standardized data collection form to record spontaneous or directed pushing, position changes, open and closed glottis pushing. A digital audio recorder was employed to capture verbal communication between the midwife and laboring woman. The research midwife and two qualitative experts employed content analysis to analyze the audio transcripts and identify categories of verbal support.

Results—Analysis revealed four categories of verbal support: affirmation, information sharing, direction, and baby talk. The vast majority of verbal communication by nurse-midwives consisted of affirmation and information sharing. Nurse-midwives gave direction for specific reasons. Women pushed spontaneously the majority of the time, regardless of epidural use.

Conclusion—Nurse-midwives use a range of verbal support strategies to guide the second stage. Directive support was relatively uncommon. Most verbal support instead affirmed a woman's ability to follow her own body's lead in second stage labor, with or without epidural.

1. Our study provides evidence on how nurse-midwives verbally support nulliparous women while they push.

Corresponding Information: Noelle Borders CNM, MSN, Department of Obstetrics and Gynecology, Midwifery Division, MSC10 5580 1, University of New Mexico, Albuquerque NM 87131, aborders@salud.unm.edu.

Disclosure

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2. Nurse-midwives utilized mostly affirmation and information sharing in their support of women during second stage, regardless of epidural use.
3. Spontaneous pushing and epidural anesthesia are compatible, especially if the woman labors down and feels the urge to push prior to initiating active pushing.

Keywords

Second stage labor; verbal support; spontaneous bearing down efforts; laboring down

In the 2006 Listening to Mothers II Survey, a national survey of 1,573 U.S. women who gave birth in 2005, 56% of new mothers indicated that nursing staff provided supportive care during labor. Only husbands or partners (82%) filled this role more frequently (Declerq, Sakala, Corry, & Applebaum, 2006). Previous researchers found that laboring women appreciate the sense of calm and confidence that nurses provide as well as their assistance with breathing and relaxation (Bryanton, Fraser-Davey, & Sullivan, 1994). Nurses can also enhance women's awareness and control of the events surrounding the birth and help the women's partners provide needed support (Bryanton, Gagnon, Johnston, & Hatem, 2008). Because of the powerful influence that nurses can have during labor, their knowledge and implementation of effective and evidence-based practices and techniques play a crucial role in this milestone event in women's lives (Association of Women's Health, Obstetric and Neonatal Nursing, 2011).

Background and Significance

Verbal support or labor coaching has received increasing attention by researchers during the last 50 years. In a recent meta-analysis of randomized controlled trials comparing spontaneous and Valsalva pushing, the authors concluded that women should routinely be supported in spontaneous pushing efforts; directed pushing should be employed only in the case of compelling maternal (extreme pain or fatigue) or fetal (concerning heart rate patterns) conditions (Prins, Boxem, Lucas, & Hutton, 2011). In 1957, Beynon, a British obstetrician and 1 researcher, asked, "If there is no good reason in theory or in practice for hurrying the second stage of labor, why has the habit been prevalent for so long and why does it still exist?" (p. 819) Beynon had conducted a trial comparing the length of second stage and rate of forceps delivery for primigravidas who were coached to push (n=393) versus those who were entirely uncoached and allowed to push of their own volition (n=100). Although the length of labor between the two groups was similar, the rates of forceps delivery and sutured lacerations were higher in the coached group (Beynon, 1957).

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More recent studies comparing coached and spontaneous pushing have yielded similar results: no differences in mode of delivery or estimated blood loss, comparable or higher Apgar scores and less perineal trauma in women who pushed spontaneously, and no difference in postpartum urinary incontinence (Chang et al., 2011; Low et al., 2012; Sampselle & Hines, 1999; Schaffer et al., 2005; Sleep, Roberts, & Chalmers, 2000; Thomson, 1993; Yeates & Roberts, 1984; Yildirim & Beji, 2008). Just as important, women express greater satisfaction and experience less fatigue with spontaneous pushing (Yildirim & Beji; Chang et al.; Hansen, Clark, & Foster, 2002). Unfortunately, despite the evidence in support of spontaneous pushing, Beynon's question remains as relevant today as in 1957. The Listening to Mothers II survey revealed that only 21% of women decided for themselves when and how hard to push, 28% said a nurse or provider directed them, and 47% indicated that they used a combination of spontaneous and directed pushing (Declerq et al., 2006).

Both midwives and nurses were rated as giving equally excellent supportive care (68%) by women in the Listening to Mothers II survey (Declercq et al., 2006). Midwives have long held to the philosophy that labor and birth should be woman-directed, rather than directed by the provider or hospital protocols. Thus, encouraging spontaneous pushing in second stage labor seems a natural practice for midwives. In order to determine the specific practices used by midwives to support maternal pushing efforts, Osborne and Hanson (2012) surveyed 375 certified nurse-midwives (CNM) and certified midwives (CM). The majority of the respondents (67%) indicated that they often or almost always supported spontaneous bearing down efforts without giving directions for women without epidural anesthesia; for women with an epidural, they were more likely to provide direction (Osborne & Hanson, 2012). Evidence about actual (rather than self-reported) second stage practices of nurse-midwives is scant.

Although other studies have detailed how midwives physically support the perineum during second stage, there has been a gap in the literature related to how nurse midwives provide verbal support to women during second stage labor and birth (Albers, Sedler, Bedrick, Teaf, & Peralta, 2005; Hastings-Tolsma, Vincent, Emeis, & Francisco, 2007; Trochez, Waterfield, & Freeman, 2011). The details of the second stages and births are integrally entwined with the verbal support; both elements must be described in order to understand the context in which these women labored and gave birth. The purpose of this study was to describe how nurse-midwives verbally support nulliparous women during second stage labor and to document spontaneous and directed pushing efforts, open and closed glottis breathing, position changes, and birth outcomes. We have chosen to use the term “verbal support,” rather than “coaching” because “coaching” implies giving direction, whereas “verbal support” can encompass a wider range of communication.

Methods

Design—We used a descriptive qualitative design (Sandelowski, 2000) in which the researcher keeps the interpretation *data-near* in order to describe the reality of the phenomenon of interest. The goal of a descriptive qualitative study is to describe the phenomenon of interest rather than develop a theory or larger conceptual framework or model (Sandelowski, 2010). For this study data were collected by a single research midwife using an audio recorder and data collection form designed specifically for this study. In vivo observation and data collection helped ensure validity (Richards & Morse, 2007). The research midwife is a practicing clinician and part of the CNM group that was observed.

Participants—The setting was a university hospital in the southwestern United States. The participants were nulliparous women greater than 18 years of age and nurse-midwives, part of a single practice group of 12 CNMs. Both the nulliparous women and CNMs were participating in a larger study on pelvic floor changes. The parent study was observational in nature; nulliparous women cared for by midwives were approached to give data regarding pelvic floor changes during and following pregnancy, specifically whether pelvic floor changes were associated with the occurrence of genital tract trauma. For this descriptive qualitative study, the CNMs discussed the nature of the study and agreed to participate prior to applying to the institutional review board (IRB). We obtained IRB approval prior to recruitment. Women were eligible to be approached in the third trimester of pregnancy and gave written consent for participation in the antenatal midwifery clinics. Because epidural anesthesia profoundly changes the second stage of labor and, presumably, the way midwives support these women (Enkin et al., 2000, Chapter 34), we considered excluding women using epidurals. However, because the majority of laboring women in the United States use epidural anesthesia, we included these women to increase the applicability of our findings.

Procedure—When a consented woman presented to the hospital for term delivery, the admitting midwife confirmed her willingness to be observed and notified the research midwife of her admission. The research midwife was called again as the women neared second stage. Upon the researcher's arrival in the woman's room, the research midwife introduced herself and confirmed the woman's willingness to be observed. The research midwife placed the audio recorder near the head of the bed, switched it on, and stood in the back of the room, repositioning herself as necessary to have full view of the woman. She was present for the entire duration of the second stage and played no role in provision of clinical care or as labor support for these women. The research midwife used a data collection form created specifically for this study to record the details of each second stage. A data form was piloted for the first four observations. The format of the form was then revised to ease data collection; the data collected remained the same. The final version was utilized for all subsequent observations. The quantitative data collected included the time that each contraction started. In addition, for each push, maternal position, whether the mother used open or closed glottis pushing or both, whether she vocalized during the push, and whether the push was directed or spontaneous was recorded.

Data management and analysis—Analysis began immediately after each observation when the research midwife recorded general impressions of each labor. The audio recordings were transcribed verbatim by the research midwife or a private transcription service. Next, the transcripts were compared to the recordings and de-identified. The research team conducted analysis through an iterative process of coding, recontextualizing, discussion, and immersion in the data. Coding of the transcripts was done by hand. The research midwife and one of the qualitative experts (EH) concurrently did preliminary coding of the first transcript while the other qualitative expert (CW) coded the transcript separately, identifying dominant categories and subcategories. The research midwife then compared the two and developed the first coding dictionary. She then coded the 2nd transcript, fine-tuning specific codes during the process. With each iteration, she discussed the changes with EH and CW, comparing categories and subcategories until they reached consensus. All three researchers then coded the 3rd transcript separately; these codes were compared line-by-line by the research midwife who discussed discrepancies with both EH and CW. The coding dictionary was then finalized and applied to the remaining transcripts. This process was done in order to ensure dependability and reliability (Richards & Morse, 2007; Graneheim & Lundman, 2004). All quantitative data from the data collection forms (described in the previous paragraph) were entered into a RedCap database by the research midwife and were summarized using Excel and SAS. Descriptive statistics including mean, standard deviation, range, and percentiles were used.

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Results

Description of study sample—Between November, 2010 and July, 2011, 49 women gave consent for the study and 14 were able to be observed. Nine different nurse-midwives attended the women; some nurse-midwives were observed more than once. Table 1 presents demographic characteristics of the CNM participants. The midwives had a mean age of 42 years and had been in practice for a mean of 12 years; all except one had a master's degree in nursing. Two students (a student nurse midwife and a family medicine intern) were present for three of the births and participated to varying degrees with the CNM as the mentor. Because the CNMs work 12 hour shifts, a woman was attended by a mean of 2.5 midwives (range 1-4; SD 1) during her labor. The CNM who attended the woman during second stage was with her for a mean of 4.3 hours (range .5-10 hours; SD 3.4) of her entire

labor. Because second stage labors ranged from 16-226 minutes, the woman and CNM often had time to establish a rapport prior to second stage.

Table 2 presents the demographic and labor characteristics of the patient participants. The laboring women had a mean age of 24 years, were largely non-Hispanic white, and had some college education. All the women but one had a spontaneous vaginal birth; one woman pushed for approximately 3 hours, had an attempted vacuum extraction and subsequent cesarean section. Half of the women had epidural anesthesia and 4 received intravenous oxytocin for labor augmentation. No episiotomies were performed, and six women had sutured lacerations.

Details of the second stages by presence or absence of epidural are presented in Table 3. Women without epidurals had second stage labors of less than half the time of women with epidurals. Active pushing ranged from a mean of 60 minutes without epidural to 95 minutes with an epidural. Laboring down is the practice of delaying active pushing for women with an epidural until the woman has the urge to push or the fetal head is seen at the introitus. Four of the 7 women with epidurals labored down for a mean of 101 minutes prior to active pushing. Women without and with epidurals pushed spontaneously 96% and 83% of the time, respectively. Vocalization was defined as any noise other than expulsion of breath. The majority of women made no noise while pushing except exhalation of breath. The vast majority of pushing was closed glottis, but the pushes were between 3 to 6 seconds long; no woman voluntarily held her breath for 10 seconds. Only 2 women were encouraged to push to the count of 10 and this was by the resident obstetrician who was asked by the attendant CNM to evaluate progress after greater than 2½ hours of active pushing. As the head emerged, 12 of the 13 women who gave vaginal birth were directed by the CNM to “grunt the baby out” or otherwise push using very short, gentle pushes. One CNM provided only encouragement and reinforcement of the mother’s efforts as the head emerged. Women assumed a mean of 3 to 4 positions and changed positions a mean 4 to 6 times, depending on presence of epidural. The most common positions assumed for second stage were semi-Fowler’s and right and left lateral. The hands and knees position was assumed by only two women (one of whom had an epidural); however, they remained in this position for the duration of the second stage. Another woman who did not have an epidural remained in the right lateral position for her entire second stage.

Verbal support by midwives—Four central categories of verbal support of midwives with several subcategories emerged from analysis of the transcripts: affirmation, with subcategories of simple affirmation, reassurance, and reinforcement; information sharing; direction, with subcategories of specific direction and mantras; and baby talk. Any given statement by the midwife might contain one, two, or several of these types of verbal support; thus, percentages presented in the following paragraphs do not add to 100%.

Affirmation: The overwhelming majority of verbal support provided to laboring women by midwives was affirmative in nature: 57% and 48% of statements made to women without and with epidurals, respectively, were affirmative. Affirmation was subdivided into simple affirmation, reassurance, and reinforcement; many affirmative statements combined all three subcategories. While the midwife provided affirmation both during and between pushing efforts, the balance of affirmative statements were made during pushing efforts. Sometimes the woman would ask if her pushes were effective; sometimes the midwife would notice that her energy was waning. In either case, the midwife affirmed her efforts and buoyed her spirits. In almost all cases, partners, family members and friends in the room would mimic the midwife’s statements, surrounding the woman with positive statements.

Simple affirmation: Roughly half of affirmative statements were straightforward affirmation, which focused on a woman's strength and natural ability. "You're perfect. You're great. Your body is doing everything it needs to do to get this baby delivered. You're really strong. It's gone really well." "Beautiful. Perfect, perfect! Just like that. Beautiful, beautiful, beautiful. You are really good at this." While midwives occasionally used diminutives (honey, sweetie), they usually addressed women using their names, which helps establish a connection with that woman and demonstrate care for her as an individual.

Reassurance: The midwife provided reassurance when the woman expressed doubt in her ability to continue, pain, fear, or worry about progress or the baby. Statements providing reassurance comprised a quarter of affirmative statements. The midwife would stress the normality of what a woman was experiencing and underscore her confidence in the woman's ability to birth her baby: "You're okay. You can trust it. It's okay, a lot of stretching, but it's okay." "Everything's been perfect. You don't have a long time. This is the last little bit, okay?" "That's it. She's going to stay this time. Hang on. It's all right. Trust it." "Are you worried about him? He's okay. [His heart rate] goes right back up when the contractions are over."

Reinforcement: When the woman was pushing effectively or taking an opportunity to rest between contractions, the midwife would praise and reinforce this behavior: "You just keep doing what you're doing." "All right. Thatta girl. That's it, that's it, that's it, good, good, good." "That's right, just sink into the bed. Let everything relax." In the latter statement, the midwife is reinforcing the woman's attempt to relax between contractions. Affirmative statements providing reinforcement made up approximately one quarter of all affirmative statements.

Information sharing: Women need timely, thorough, truthful information in order to be full participants in their care. Women, their partners, family, and friends would solicit information from the midwives with questions such as, "Why is this taking so long?" or "Can you see the head yet?" Such questions were asked and answers provided by the midwives primarily between contractions when the woman was able to concentrate more readily on the content of the conversation. Midwives shared information equally with women regardless of presence of epidural; 21% of midwives' statements to women involved information sharing.

The midwives tended to give women information in lieu of direction when they were uncomfortable or expressed the need for a change: "You can push if you want or you can take the contraction wherever you want to go and that's okay, too. Just do whatever you want to do." The midwives shared options about position changes, giving women information about what positions might aid them or relieve their discomfort:

You can use the squat bar just to support yourself. You can kneel and lean over, or you can put all your body weight on it. It's pretty strong, so you can just scoot your butt forward and lean over it, or you can just use it like that. Whatever works.

The midwives also provided women with information about what they would feel, implying that the sensations were normal and expected: "Lots of pressure. Lots and lots of pressure is totally normal, okay? I'm sure you're feeling all kinds of new sensations, and it's all very normal. The baby's really, really low." Midwives talked with women about the mechanics of pushing:

When you push, the baby's head moves down and it stays down while you push. When you let go, it goes back up. That's normal. That's all that birthing dance.

That's why we have you push a few times to hold it down. That way when you stop, it doesn't go back as much as it was when it started. It's all very normal.

When the midwife needed to involve the physicians in the woman's care, she explained the rationale and what would happen: "I'm going to go chat with the physicians because once you've been pushing for 2 hours, we have them do a quick evaluation. We have them check you and make sure that everything seems like it's going like it should."

As the birth neared, the midwife often gave the woman very specific anticipatory guidance about what she would feel and how the midwife would direct her as the head was born:

So at some point, I'm probably going to tell you not to push. It's going to be when you really want to push. Okay? But I'm either going to have you not push or give tiny little huffs [demonstrates panting]. Breathe out the baby. OK? Trying to protect your skin.

"I'd say the head's staying on the perineum now, so we're going to crown. The next couple of contractions, it's just going to get more and more intense, more stretching, okay?"

Direction: Midwives provided direction depending on the needs of the woman or fetus and perceived progress. Women were directed on position changes, pushing efforts, and relaxation between contractions; women were also encouraged to stay hydrated. For women without epidurals, midwives provided very little direction—13% of all statements to women without epidurals were directive. Midwives directed women with epidurals more often but still relatively little—23% of CNM statements to women with epidurals were directive. Direction was equally divided into specific direction and mantras (a word or phrase that is recited repeatedly). Some women required no direction whatsoever so the percentages given should be interpreted with that caveat in mind.

Specific direction: For women with and without epidurals, midwives usually observed spontaneous pushing efforts and only provided direction if the woman asked for it or expressed pain, discouragement, or fear. Often, midwives provided information about why they were directing the woman to do something specific. Some women with epidurals needed much guidance in how to push, even after they felt the urge: "Can you do one more just like that one? That moves him beautifully, perfect. Could you feel that difference? That's what you want to do with each one right from the beginning." Once the woman was pushing effectively, the midwife provided reinforcement rather than continuing with specific direction. Other women, both with and without epidurals, pushed more intuitively and effectively, in which case the midwife was more likely to provide reinforcement.

Regardless of epidural use, midwives would direct the woman to change position if she was having trouble coping with pain or seemed acutely discouraged or if the fetal heart rate looked worrisome: "As soon as this contraction is over, I think we're going to need to try hands and knees, okay? You've been a great trooper on trying all these positions, but I think that might be what's going to help you." The midwife was also more likely to suggest frequent position changes if she suspected malposition, such as occiput posterior position: "Let's put the head flat and we'll turn you on your side, because if we can help baby to move out from that position, it'll be a lot easier." Women also were directed to relax between contractions to sustain their energy: "Deep breaths, close your eyes, relax your forehead. Just rest." In 13 of the 14 observations, the midwife specifically directed the woman in how to push the head out as it emerged, asking the woman to give little pushes or breathe the baby out, in order to protect the perineum: "That's it. Little pushes—just like that. You're going to ease out this head. Little pushes." "She's on her way, she's right here, she's right here. You did it. Almost, one more little push, one more little push." In only 2

cases was sustained pushing encouraged with providers counting to 10; both women had been pushing for over 2 hours and the obstetricians were personally involved in their care. In both of these cases, providers used sustained pushing as an intervention.

Mantras: The midwife would sometimes employ use of a mantra, repetition of a word or phrase, during pushing efforts. While the specific words used were directive in nature, the tone and use were encouraging and reinforcing: “Really strong, really strong. That’s it, that’s it. Go, go, go, go.” “Hold him down, down, down, down, down, down. Beautiful.” “Keep him coming, keep him coming, keep him coming.” Nurses, partners, and other support persons would mimic these mantras in their verbal support of the woman.

Baby talk: Midwives, women, nurses, and support persons frequently spoke to and about the fetus and newborn, acknowledging its central role in the second stage. Because everyone involved in the births exclusively used the word *baby* to refer to the fetus before birth and the newborn afterward, we have characterized this type of communication as *baby talk*. Statements about the fetus comprised approximately 5% of all statements by the midwife. The midwife talked to and about the fetus: “Come on, baby girl. We want to meet you.” The midwife often gave evidence of the child’s well-being: “I think the baby likes this side a little bit better.” “She hasn’t been struggling; she’s been doing fine. She can tolerate this.” Heralded by the midwife, the first glimpse of the fetus’s hair often provided the woman with a new surge of energy and hope: “Look at that, yeah. A lot of baby hair.” “Yeah, here’s his head. He’s got dark hair. Sorry, no blondy here.” The midwife also talked about the fetus as though it had preferences and displayed initiative: “I’m just going to touch your baby’s head. He likes having his head tickled.” “She’s wiggling. She’s like, ‘How am I going to fit through here?’ She’s definitely trying to find her way.” In speaking about the fetus in this manner, the midwife recognizes that she is not just a passenger but an active participant in the birth. One midwife gave voice to the fetus’s passage as a journey from one state of being to another: “There’s a lot more head. He’s in between worlds.”

Discussion

Based on the findings of this study, the verbal support by these nurse-midwives for nulliparous women in second stage labor included affirmation, information sharing, direction, and baby talk. The women were supported in spontaneous pushing the majority of the time, regardless of epidural anesthesia. Women also changed positions frequently. When comparing the proportion of spontaneous pushing in women with epidurals (83%) to women without epidurals (96%), what is remarkable is not that women with epidurals pushed less spontaneously than women without epidurals, but that they pushed spontaneously most of the time. Sampselle, Miller, Luecha, Fischer, and Rosten, (2005) had a similar finding in their study of 20 primigravidas: women without an epidural (n=14) pushed spontaneously 62% of the time whereas women with an epidural (n=6) pushed spontaneously 52%. They discovered that women attended by providers who were supportive of spontaneous pushing were more likely to push accordingly, regardless of epidural anesthesia. Sampselle et al. (2005) conducted a secondary data analysis of audio tracks from video tapes for their study; our study involved first person observation and a prospective design, which garnered richer data. The women in our study pushed for 3-6 seconds duration, similar to what Roberts, Goldstein, Gruener, Maggio, and Mendez-Bauer (1987) reported in their observational study of 31 nulliparous women who were supported to push spontaneously during second stage. Unlike our study, none of the women in the study by Roberts et al. (1987) had epidurals. Again, our study demonstrates that women with epidurals may push similarly to women without epidurals if providers wait for the woman to feel the urge to push and support women to follow their bodies’ inclinations.

Nurse-midwives, obstetrician/gynecologists, and family medicine physicians at this hospital commonly encourage a woman with an epidural to labor down. Laboring down is an integral part of the institutional practices surrounding second stage, and second stage labor is approached with a great deal of patience as long as the fetus's heart rate pattern remains reassuring. In a randomized controlled trial Mayberry, Hammer, Kelly, True-Driver, & De (1999) compared length of second stage labor in women with epidural anesthesia (n=153) who were randomized to labor down for one hour after confirmation of full cervical dilatation or initiate pushing immediately. Women in the delayed pushing group could begin pushing if they felt pressure and an urge to bear down. The researchers discovered only a 13.68 minute difference in length of second stage between the two groups, which was not statistically significant; Apgar scores did not differ between the groups (Mayberry et al., 1999). While Mayberry et al. (1999) did not address spontaneous pushing per se, their study does support patience with second stage labor and working with a woman's body. Our study provides further evidence that spontaneous pushing and epidural anesthesia are not mutually exclusive, especially if the woman labors down and is able to feel the urge to push prior to initiating active pushing.

Figure 1 illustrates how the laboring woman is nested in verbal support. The nest is constructed mostly of affirmation, with information sharing as the next most common building material, followed by direction and baby talk. The categories overlap significantly, as human communication can seldom be divided into purely distinct classifications. Midwives used affirmative communication the vast majority of all the second stages which communicated to women that they trusted in the women's ability to birth their babies. Information sharing constituted a major part of the verbal support of midwives in this study as well.

In a qualitative analysis of women's responses to the care they received in second stage labor, McKay & Smith (1993) discovered that women want information about pain and fear and how to mitigate both, explanations about the instruments and processes involved in birth, and positive communication. The midwives in this study fulfilled those communication criteria. The amount and type of information sharing, including explanations about the process of birth, reports about descent of the fetus's head, and soliciting information about the woman's well-being, did not vary depending on how directive the midwife was of other aspects of the second stage. In their study of birth talk in second stage labor, Bergstrom et al. (2009) had a similar finding: caregivers of women in second stage labor provided explanations and feedback and solicited information equally whether or not caregivers were more or less directive during pushing. Our study provides evidence that information sharing can be used in lieu of direction, especially when women are coping well. When women have more information about what is happening to and around them and are given options about position changes and timing of pushing, they can take control of the birth. Rather than directing women, providers motivate them by providing the information they need to navigate labor. The message is no longer, "Do what I say and all will be well," but "Here are your options; you decide. You are capable and strong, and I trust that you will make the best decision for you and your baby."

While the nurse-midwives were not often directive, they provided specific direction in response to extreme maternal pain, distress, and worry about progress and for fetal indications (heart rate concerns or occiput posterior position). In these cases, direction provided the woman with an anchor, something to cling to in moments of pain and distress. This finding is very similar to that of Roberts, Pittman Gonzalez, & Sampselle (2007) who specifically studied why birth attendants who are normally supportive become directive during second stage. All of the midwives in our study used some direction during second stage, whether it was for position changes or birth of the head. The midwives were more

likely to be directive when the woman had an epidural and was not able to tap easily into her body's natural urge to push. When the head was emerging, almost all the midwives directed the woman to use short, gentle pushes or breathe the infant out. This type of direction is in keeping with evidence from a randomized controlled trial comparing midwifery measures to reduce genital tract trauma at birth (Albers et al., 2005). In the latter study, nurse-midwives used warm compresses, perineal massage with gel, or kept their hands off the perineum until the head was crowning. None of the interventions made any difference in rates of genital tract trauma; what did make a difference in trauma was slow, controlled delivery of the head between contractions (Albers et al., 2005).

CALLOUT 3

Limitations

Because of its qualitative design, the study is not intended to be generalized to a larger population. However, the intent of this study was not to generalize but rather to iterate how midwives in a busy hospital practice support women in second stage labor. Our hope is that these examples might inspire providers who care for women in labor to examine their own practice and, if needed, make changes to encourage laboring down and spontaneous pushing. The midwives in this group enjoy an excellent collaborative relationship with the physicians and nurses with whom they work, and spontaneous pushing and laboring down are norms in this setting. It may be more difficult for nurses and midwives working in a different institutional environment to support women in the same manner as did this group of nurse-midwives. By the same token, the fact that women with and without epidurals are being supported to push and change positions spontaneously in a large hospital setting provides evidence that these practices can be adopted in other institutions.

The research midwife's membership in the group of nurse-midwives being observed presented both challenges and advantages. Her preexisting relationships with colleagues could in theory have altered their behavior or her observations of that behavior. Her familiarity with the setting, however, made her access to the births seamless and may have allowed her to slip into the background more effectively. Several of the nurse-midwives who were observed did say that they were aware of the research midwife's presence, but they did not think her presence had a major impact on their practice. For content analysis, the research midwife recognized that her membership in the group would color her analysis of the transcripts. Thus, two qualitative experts, one a qualitative nurse researcher and one a medical anthropologist and obstetrician, participated in data analysis, which helped to ensure trustworthiness. Despite these limitations, this study adds to the body of literature on how nurse-midwives verbally support women during second stage labor, especially because it focused on all of second stage and took place in a natural setting without any intervention except the research midwife's presence.

Implications for nursing practice and future research

Based on the findings of this study, nurse-midwives can and do provide support for spontaneous pushing in second stage labor the majority of the time regardless of presence of epidural anesthesia, which is in keeping with the results of the survey of CNMs and CMs done by Osborne & Hanson (2012) cited earlier. Further research into how nurses and other obstetric providers verbally support women in second stage labor is warranted to assess and improve generalizability of this study, and to link categories of verbal support with outcomes. Because nurses provide the vast majority of labor support for women in the United States, their confidence and trust in a woman's ability to follow her body's lead in second stage is essential if they are to support spontaneous pushing. Laboring down requires patience which is richly rewarded when a woman with an epidural can follow her body's

lead and push spontaneously. By providing overwhelming affirmation, giving and soliciting information, and offering well-timed directives, nurses can provide women with the support they need to birth their children using their own ample power, imbuing them with much needed confidence as they begin their journeys as mothers.

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Figure 1.
The laboring woman is nested in verbal support.

Table 1Demographic Characteristics of Certified Nurse Midwives (*N*=9)

Characteristic	<i>N</i>	<i>M(SD)</i>	Range
Age (years)		42(7.7)	31-56
Race			
Asian	1		
Hispanic	1		
Non-Hispanic White	7		
Education (degree)			
Bachelor of Arts	1		
Master of Science in Nursing	8		
Years in Practice as Certified Nurse-Midwife		12(7.6)	1-30

Table 2Demographic and Labor Characteristics of Laboring Women (*N*=14)

Characteristic	<i>N</i>	<i>M(SD)</i>	Range
Maternal Age (years)		24(3.1)	20-31
Race			
Native American	2		
Hispanic	3		
Non-Hispanic White	9		
Education (years)		14(2.5)	12-20
Mode of Birth			
Cesarean	1		
Spontaneous Vaginal	13		
Epidural Anesthesia Use	7		
Oxytocin Use	4		
Sutured Lacerations	6		
2 nd Degree Perineal	3		
Labial	2		
Vaginal	1		
Episiotomy	0		
Birth weight of infant (grams)		3513(424.0)	2863-4195
Apgar scores at 5 minutes ^a		9(.3)	8-9

Note.

^aBecause the study location is situated at over 5000 feet above sea level, peripheral cyanosis in newborns is common; thus, Apgar scores rarely reach 10.

Table 3Second Stage Variables by Presence or Absence of Epidural Anesthesia (*N*=14)

Variable	Without Epidural (<i>N</i> =7)		With Epidural (<i>N</i> =7)	
	<i>M</i> (SD)	Range	<i>M</i> (SD)	Range
Length of second stage (minutes)	64 (54.2)	16-178	153 (65.9)	47-226
Active pushing (minutes)	60 (53.4)	24-178	95 (63.2)	30-220
Laboring down (minutes) ^a	--		101 (50.2)	27-138
Positions assumed (number)	3 (2.1)	1-7	4 (2.5)	1-8
Position changes (number)	4 (3.8)	1-12	6 (3.8)	1-12
Type of pushing (percentage)				
Directed	4 (6.7)	0-18	17 (11.8)	8-39
Spontaneous	96 (6.7)	82-100	83 (11.8)	61-91

Note.

^aFour women labored down in the study group. Mean, standard deviation, and range for laboring down refer to these 4 women only.