

Running head: EXPERIENCES OF WOMEN IN EARLY LABOUR

EXPERIENCES OF WOMEN IN EARLY LABOUR SENT HOME FOLLOWING  
HOSPITAL ASSESSMENT

by

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## EXPERIENCES OF WOMEN IN EARLY LABOUR

### **Abstract**

Labour and birth is a life event common to many women yet the physical process, in addition to psychological, social, and spiritual experiences, is unique to each woman. A woman under the care of a physician will come to a hospital when she believes she is in labour. If she is in active labour, the woman is admitted to hospital. If in early labour, the woman is often sent to walk within the hospital prior to reassessment as walking can contribute to progress in labour, or she is sent home. There is limited information about the phenomenon when a woman in early labour is sent home until she is admitted in active labour. Combining the elements of early labour and known possible psychosocial outcomes of birth, this qualitative study explored the experiences of women sent home in early labour within the context of one hospital site in Canada, having 4000 births annually. In-depth interviews with 10 postpartum women within 48 hours of birth yielded the data that were analyzed through a qualitative approach using interpretive description defined by Thorne, Reimer-Kirkham and MacDonald-Emes (1997), and using methods of analysis as outlined by Giorgi (2012). Themes resulting from this analysis were: Conflict between knowledge of labour symptoms and women's initial responses; background influences and current pregnancy concerns; impact of the unspoken; experiences of pain and coping; and influence of others. Through literature integration it was concluded that all women experience an overwhelming anxiety that may empower/disempower their self-efficacy, confidence, communication with self/others and their coping. Suggestions for practice include a culture of open access to the assessment area and a focus on communication with women in early labour to better understand their

individual needs and provide support to decrease anxiety and fear, increase confidence and foster empowerment.

*Keywords:* early labour, experiences, women, labour onset, admission, empowerment, qualitative, interpretive description

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## Chapter One: Introduction and Background

This thesis was written to explore the experiences of women who were sent home from hospital in early labour. Currently the healthcare system experiences an increased demand to have balanced budgets; mission statements which promote patient-centred care, family-centred care, and quality improvement; along with staffing shortages, and a more informed consumer. These dominant influences can impact the expectations and care for women giving birth. In Canada, obstetrical care is provided by health professionals who support different philosophies of the birth process. One model in the province of Ontario is the midwifery model. “Midwifery care is based on a respect for pregnancy as a state of health and childbirth as a normal physiologic process and a profound event in a woman's life” (College of Midwives of Ontario, 2011). Midwives partner with women and provide care during the antenatal period, through birth within the home or hospital, and for the woman and neonate during the six-week postpartum period. A second model, the medical model of care for obstetrics, includes providing care for the woman antenally and care within the hospital during labour, birth and the immediate postpartum period. When she believes she is in labour, a woman under the care of a physician will come to the hospital and be assessed to determine her labour status. If she is in active labour, the woman is admitted to hospital. If not in active labour the woman is often sent to walk within the hospital prior to reassessment, or is sent home.

As a nurse with experience working in labour and birth and while pregnant with my first child, I was quite comfortable to stay at home for as long as possible until certain that I was in active labour. I did wonder about some symptoms that I experienced in the 48 hours prior to the birth and did not know whether I should be at work, at home or in hospital as a patient. However, I had the advantage of being able to come to work early

and talk to my obstetrician when he came in to do rounds. Once assessed and reassured, I was fine to carry on my normal activities. Overdue with another child, I remember the anticipation of confirmation of labour as I knew what my body was telling me and felt that I belonged in hospital. However, more recently I have observed pregnant women leaving the birthing unit with their suitcases and support persons, some talking on their phones sharing the news that they are being sent home. What is it that these women experience while at home prior to admission?

Simkin (1991) noted the perceptions of women 15 to 20 years after their first labour and birth experience: “Women reported that their memories were vivid and deeply felt” (Abstract). Thorne, Oliffe, Kim-Sing, Hislop, Stajfuhhar, Harris et al. (2010) explored the impact of receiving a diagnosis of cancer and described it as, “recalled and retold, even decades later, with the vivid colour, texture and sound of an immediate experience ... becomes a memory that can awaken at a moment’s notice...” (p.747). Eleven of thirteen women who were approached to participate in the current research wanted to tell their story. Based on this information and the fact that women and men of all ages, once hearing the research topic, spontaneously had a story to tell, suggests that the experience of being in early labour and sent home following hospital assessment has lasting significance. These experiences need to be communicated so that good practice can be confirmed and recommendations developed for the context in which women labour.

In the specific hospital setting from which the data was collected, women in early labour are given the option of walking for an hour or two prior to being reassessed or going directly home depending upon the cervical dilation. Explanations of coping techniques for early labour and warning signs to prompt a return to the labour unit are on

a written information sheet that is reviewed with the woman and support person prior to going home. It should be noted that on occasion a woman who is not comfortable to leave the hospital labour unit in early labour may stay for some time as an outpatient. There is limited published research about the interim period when a woman is determined to be in early labour until she is later admitted in active labour, yet this phenomenon has earned some international attention.

Barnett, Hundley, Cheyne, and Kane (2008) explored the phenomenon of women who were not in active labour upon arrival at hospital and were sent home, by means of a qualitative study. Barnett et al. (2008) used a rating scale from 1 to 10 to determine women's feelings being sent home: A score of 1 aligned with feeling very upset and 10 indicated feeling very happy. Two of the six women reported the number 1 or feeling very upset, and one women scored 3 (Barnett et al., 2008). Not only were women upset about being sent home but partners, mothers and even a family pet became upset when women were home and in pain, the authors noted. Women also reported feeling anxious and worried about the baby and feeling exhausted (Barnett et al., 2008). Childbirth is expected to be a normal life process yet some women have reported symptoms of psychosis, depression and post-traumatic stress disorder (PTSD), along with positive effects of empowerment as a new parent following the birth of a child (Ayers, Joseph, McKenzie-McHarg, Slade, & Wijma, 2008; Olde, Kleber, van der Hart, & Pop, 2006; Saisto, Salmela-Aro, Nurmi, & Halmesmäki, 2001; Stanton, Lobel, Sears, & DeLuca, 2002).

### **Project Purpose/Rationale**

Early labour "is often neglected as a factor of negative impact on the women's birth experience" reported Stadlmayr, Schneider, Amsler, Bürgin, and Bitzer (2004), who

recommended further research to investigate whether “preventive psychosocial support might be very helpful in avoiding a low intra-natal emotional adaptation and a negative emotional experience in the immediate postpartum” (p.49). Combining the elements of early labour experiences and known psychosocial outcomes of birth, I explored the experiences of women sent home following hospital assessment in early labour. The purpose of this research was to generate knowledge about women's experiences to determine:

1. How women describe their experiences, including psychosocial aspects, of being sent home in early labour following assessment in hospital; and
2. What recommendations can be developed for nurses when assessing women in hospital.

### **Methodology**

The research methodology utilized a qualitative, phenomenological, descriptive and contextual design. Women who were assessed in the labour and birth unit, determined to be in early labour and sent home, were the target population whether having had their first or subsequent birth experience. Chart audits of women admitted on the postpartum unit in one hospital site determined which women met the criteria for this research. Convenience sampling was used. Women who consented to participate in the research were interviewed individually prior to discharge home following birth. Each interview was audiotaped and transcribed verbatim. The data was analyzed following a five-step process outlined by Giorgi (2012). Once the data was integrated with known literature on the research topic, recommendations for nursing practice were developed to facilitate understanding the experiences of women and how to support women in early labour.

### **Definitions of Terms**

Although there is some variation in the definition of active labour, most sources are consistent with the definition that McNiven et al. (1998) reported as “the presence of regular, painful contractions and cervical dilation greater than 3 cm” (p.6) or at a minimum, 4 cm (see also Jackson et al. 2003; Pates, McIntire & Leveno, 2007). Hoh, Cha, Park, Ting Lee and Park (2012) defined the measure of active labour as cervical dilation between four and ten centimetres. McDonald (2010) acknowledged that the latent phase of labour or early labour “is poorly understood and can be hard to define” (p.630). For the purposes of this research the definition of early labour is, uterine contractions with resultant cervical dilation less than 4 cm, as shared by authors Jackson et al. (2003) and Cheyne, et al. (2007). Throughout some of the interviews the women talked about the cervix as being posterior or behind the baby’s head. The significance of the position of the cervix is that it is a marker of progress in labour. The cervix has to become anterior, efface or thin out, and then dilate or open to 10 cm to facilitate a vaginal birth.

Pregnant women as research subjects are sometimes categorized as those who are pregnant and anticipating labour and birth for the first time and those who have given birth previously. It is thought that women anticipating birth for the first time may be more frightened than women who have given birth previously, Nolan and Smith (2010) reported. The term primiparous in this research refers to a woman who gave birth to her first child at the time of the interview and multiparous refers to the woman who gave birth to at least one child previously. The following paragraph will explain the outline of the paper.

**Outline of Paper**

This thesis is comprised of five chapters. In this first chapter, current influences on obstetrical care in the context of medical care in Canada are reviewed to establish the need for this project. In Chapter Two, related literature is reviewed. Chapter Three presents the research design and research methodology. Ethical considerations and scientific quality of this research are discussed to enable the reader to understand the research, its quality and its outcomes. In Chapter Four, highlighted themes from the data analysis are described as they relate to the women within the context of time, culture and location. Concepts which cross the themes are explicated followed by a description of the overall phenomenon and possible outcomes of disempowerment. In Chapter Five, limitations of this research, recommendations for practice in nursing and healthcare based upon the discussed concepts, and suggestions for future research are summarized which concludes the thesis.

## **Chapter Two: Literature Review**

In Chapter Two, a review of literature outlines relevant knowledge to give context to the current research. Strategies for literature search and literature integration are described as they relate to the topic of the experiences of women in early labour sent home following hospital assessment.

### **Literature Search Strategies**

There is debate as to how much literature should be reviewed prior to undertaking a qualitative study. Speziale and Carpenter (2007) explained that the review of literature generally follows data analysis in order to, “achieve a pure description of the phenomenon under investigation” (p. 97). Polit and Beck (2008) concluded that whether the literature search was done prior to or following the research, a relatively small number of results are typically found. Speziale and Carpenter (2007) advocated for an initial review to determine the need for the study and a more in-depth review following the analysis of data to locate the findings within what is known. A preliminary literature search was done to determine a gap in current knowledge and throughout the research while a more comprehensive search was performed following the data collection to ensure understanding of current knowledge in analysis and recommendation.

Literature was reviewed to determine background information on the sub-topics: current trends in labour assessment and admission criteria; history and mystery of labour; the psychology of labour and birth; philosophies of care and to explore published works on the topic of interest. Databases accessed included Academic Search Premier, Biomedical Reference Collection: Comprehension, Medline, CINAHL, E-Journal, Evidence Based Medicine Reviews (Cochrane database of Systematic Reviews), Embase, Psycinfo, and PsychArticles. Using advanced methods, publication types such as

article, clinical trial, patient handout, and systematic reviews were searched. Keywords used in the literature search were: labour, early labour, latent phase of labour, onset of labour, labour onset, outpatient, active labour, hospital admission, experience, perception, pregnancy, triage, childbirth, intrapartum care, hospital birth, psychology, discharge, and the word “labour” substituted with the spelling “labor” for all combinations noted above. Of the 24 articles which made reference to early labour, one study focused on women who had gone to hospital and were sent home not far along enough in labour to be admitted; four other articles mentioned women being sent home from hospital. See Appendix C for the comprehensive literature search strategy. The medical subject headings (MeSH), part of Pubmed, were used as follows: Labor, Obstetric, Onset of Labor, Labor, and First Stage. I located 129 articles published in the past 20 years which were screened by title and abstract when combined as follows: Labor, Obstretic OR Onset of Labor AND Labor, First Stage. Other filters which were applied to the search were English, Humans, and Female. Of the 129 articles which were written about early labour, no new articles were found as compared with searches on all the other databases.

In addition, major national medical websites such as The Society of Obstetricians and Gynaecologists of Canada, The College of Midwives of Ontario, The Royal College of Midwives, and the American Congress of Obstetricians and Gynecologists were searched for clinical guidelines and patient educational information. Reading through the Government of Canada websites such as National Research Council of Canada and public health department websites enabled a broader historical and timely perspective on the issues which were foundational to this research but which yielded no new data.

Articles were read and references were used as another means of literature search as were forward citations. In total, 60 publications including research articles, one poster

presentation and commentaries which had some reference to early labour, were sourced between 1982 and 2012. The majority of these were written from the perspective of midwifery care; many had little relevance to the research phenomenon and one study of women sent home in early labour, by Barnett and colleagues (2008), was located along with a response to this study by Reid (2008).

### **Current Trends in Labour Assessment and Admission Criteria**

Since the mid-1980s, evidence has linked early labour admissions with increased medical interventions throughout labour and birth. Hemminki and Simukka (1986) considered the relationship between the timing of hospital admission, progress in labour and rates of Caesarean births. The authors found that, “too early admission to the hospital may negatively affect the progress of labour,” and concluded that clinical trials were needed (Abstract). Jackson, Lang, Ecker, Swartz, and Heeren (2003) studied more than 2000 women with low-risk pregnancies and concluded that a combination of factors contributed to the outcomes of birth interventions. These authors reported that, “Later admission in labor (at 4 cm or greater cervical dilation) and management of perinatal care by certified nurse midwives in collaboration with obstetricians increased the rate of spontaneous vaginal delivery in low-risk women who were admitted early in labour” (2003, p.147).

McNiven, Williams, Hodnett, Kaufman, and Hannah (1998) conducted a study of 209 women following the trial of a labour assessment program to delay labour admission to hospital (as cited in Lauzon & Hodnett, 2001). Lauzon and Hodnett summarized that women who were assessed and not admitted in early labour were, “less likely to receive intrapartum oxytocics than women who received standard care and analgesia,” but there was, “insufficient evidence to assess effects on rate of caesarean section” (p.1). They

concluded that, “Labour assessment programs, which aim to delay hospital admission until active labour, may benefit women with term pregnancies” (Lauzon & Hodnett, 2009, p.1).

In 2006, Rahnama, Ziaei, and Faghihzadeh conducted a study in Iran and compared 466 low-risk women with first pregnancies who were admitted to hospital early in labour with 329 women who had previously given birth and who were admitted in the active phase of labour. The researchers aimed to determine, “the rate of and reasons for caesarean section and the rate of labor augmentation” (p.217). The authors concluded that by admitting women later in the labour process the, “rate of spontaneous vaginal delivery in low risk nulliparous women,” would be increased (p.217).

Holmes, Oppenheimer, and Wen (2001), in a retrospective cohort study of 3220 women in Ottawa, Canada, explored the “relationship between the cervical dilatation at which women present in labour and the subsequent likelihood of caesarean section” (p.1120). The authors wanted to measure the rate of caesarean section in addition to the following secondary outcomes: “operative vaginal delivery, fetal weight, cord pH, five minute Apgar score, length of labour, labour augmentation with oxytocin and epidural analgesia.” This study concluded that for all women, those who had not given birth and those who had previously given birth, caesarean section rates were higher when women came to the hospital early in labour (having cervical dilatation of 3 cm or less) (Holmes, et al.). For women who had not previously given birth, the caesarean section rates were reported as 10.3% if a woman arrived in early labour and 4.2% if a woman arrived at hospital in active labour (Holmes, et al.). Also, for women who arrived at hospital in early labour, the frequencies of oxytocin and epidural analgesia use were significantly higher than for women who arrived at hospital in active labour (Holmes, et al.). For

future research Holmes, et al. affirmed that, “the factors which cause women to seek early admission are an important area for further study.”

Kwast, Poovan, Vera, and Kohls (2008), in a descriptive retrospective study of 226 women in Ethiopia, reported significant differences between women who presented to hospital in early labour and those who presented to hospital in active labour. The caesarean section rate for the former group of women was 46.7% compared with 17.9% for latter group of women (Kwast, et al.). The authors noted that the sample sizes in this study were not equal. There were 32 women who presented to hospital in early labour and 194 women who presented to hospital in active labour. Kwast, et al. concluded that, “women with <4 cm dilatation on admission are more likely to end up with complicated deliveries” (p.532).

Greulich and Tarrant (2007) researched about the latent phase of labour and its significance. The authors stated that, “the mistaken diagnosis of active labour may result in unnecessary interventions, such as the administration of oxytocics or operative birth” (p.191). Greulich and Tarrant reviewed numerous studies such as those referred to previously in this paper by Jackson, et al., Holmes, et al. (2001); McNiven, et al. (1998); and Lauzon and Hodnett (2001). Recommendations made by Greulich and Tarrant included, “healthy pregnant women should be encouraged to spend latent phase at home,” and, “women should be counseled about the risks associated with early admission (<4 cm cervical dilatation)” (p.196). The authors summarized that early admission in labour has repeatedly been linked to, “increased risks of operative birth and obstetric procedures” (Greulich & Tarrant, p.196).

### **History and Mystery of Labour**

Historically, the understanding of labour and birth was solely from the perspective of the physical body. An example of this is the contribution of Friedman which remains a gold standard in determining normal patterns for women in labour. The labour process may have typical patterns of cervical dilation and fetal descent through the pelvis, Friedman reported in 1954, however, this process can also be unique and divergent. A number of researchers have questioned the normal labour curve proposed by Friedman with respect to length of time in each phase and stage of labour, and interventions for slower than normal progress (Cesario, 2004a, 2004b; Suzuki, Horiuchi, & Ohtsu, 2010; Zhang, Troendle, & Yancey, 2002). Neither health professionals nor pregnant women can predict and define labour onset or labour pattern for an individual and this fact contributes to the complexity and mystery of labour and birth. It should be noted that the determination of labour necessitates a physical examination and therefore, telephone triage is not adequate. Some women who have experienced contractions will go to the hospital and have their suspicion confirmed that they are in active labour. However, other women will go to the hospital after experiencing contractions for many hours and be informed that they are in early labour and do not meet admission criteria (Greulich & Tarrant, 2007; Lauzon & Hodnett, 2009). While these studies demonstrated divergent physical experiences of labour, more recent writings focused also, on the psychological aspects of labour. Based on limited publications, how women in early labour experience being sent home following hospital assessment is relatively unknown; a mystery.

### **Psychology of Labour and Birth**

Beck (2004) discussed the topic of birth trauma not so much as a physical experience but as a psychological experience even for what is deemed routine medical

practice and procedures. Greulich and Tarrant (2007) reported that women can experience fatigue, dehydration and fear through this early labour yet, early labour, “is rarely addressed antenatally, and is usually managed by the laboring family without professional support” (p.190). Lauzon and Hodnett (2009) concluded that, “formal approaches to labour assessment,” may have negative effects psychologically for women who are very anxious or in a lot of pain and are sent home (p.2).

Having to rely on a physical examination to determine onset of labour can be problematic for a woman as it is difficult to understand just what is happening within her changing body. She already has had to adjust to pregnancy’s increasing physical discomforts; lack of uninterrupted sleep; excitement and nervousness about the expected labour and birth along with unsolicited advice and questions from well-meaning individuals as she waits for labour to begin. Being told that she is not in active labour or that she is in false labour can confuse and contribute to feelings of inadequacy for a woman. Eri, Blystad, Gjengedal, and Blaaka (2010) studied women in early labour and found that these women experienced vulnerability. Going to hospital may involve much preparation for women if there is a lack of support available to them or if there are young children at home. Saisto, Ylikorkala, and Halmesmaki reported that, “experiencing a complicated labour may result in anxiety and a strong fear of having another child,” (as cited in Stålhammar & Boström, 2008, p.259) or this may result in a request for a caesarean section according to Dencker, Taft, Bergqvist, Lilja, and Berg (2010). In summary, Greulich and Tarrant (2007) reported that it is a challenge to help women navigate through the early or latent phase of labour. Healthcare professionals need to consider this challenge, to meet the varied needs of pregnant women, by focusing more closely on the patient in all aspects of her wellbeing.

### **Philosophies of Care**

Patient-centred care has been a prevalent trend within healthcare for over 25 years. Hospitals throughout North America have engaged external partners to survey patients with respect to satisfaction with their care. In the target hospital, as in other Canadian hospitals, National Research Corporation Picker (NRC Picker) conducts patient surveys (<http://www.nrcpicker.com/about/>). National Research Corporation Picker (NRC Picker) surveys have yielded very low return rates in the obstetrical areas within the target hospital (K. Moore, personal communication, March 27, 2012). In fact, when the survey data was reviewed the resulting information related to overall care; not to aspects of early labour experiences.

The Public Health Agency of Canada collaborated with Statistics Canada to develop and implement the Maternity Experiences Survey which was used to survey women in Canada between 2006 and 2007. The intent of this survey was to explore, “the determinants and outcomes of maternal, fetal and infant health,” but the survey had no questions which pertained to early labour, nor to the care of women prior to admission in labour, nor to those sent home not in active labour (Public Health Agency of Canada, 2006). Nolan and Smith (2010) reported that women who are sent home in early labour believe that they are obligated to go home and may not feel comfortable being at home as compared to being in hospital. It is evident that there is a lack of research and knowledge about women’s experiences of being sent home in early labour.

### **Early Labour Experience**

From the literature review, there is a gap in the knowledge base especially for women cared for under the medical model as compared with the midwifery model. Writers from this latter group have begun to ask questions and conduct research about the

early labour experience prior to admission in active labour (Barnett, et al., 2008; Carlsson, Hallberg, & Odberg Pettersson, 2009; Baxter, 2007; Walsh, 2009; Nolan & Smith, 2010). In reference to the article by Barnett, et al., Dr Helen Cheyne wrote,

It is an interesting topic and although a few trials and innovations such as triage have been used I feel that we have not yet succeeded (*sic*) in improving care for these women. The journal Midwifery is currently planning a special series on the topic of early labour. (personal communication, February 27, 2012)

The Royal College of Midwifery Practice Guidelines (2008) are of significance for explicating the latent phase of labour, otherwise known as early labour. Although a few studies about early labour were published, only two were located within the Canadian context of obstetric care. Simpson (2008) wrote about support of women in labour and included findings on aspects of early labour in her research. It seemed that all women were given the choice to stay in hospital or go home if both the fetus and mother met criteria for discharge (Simpson, 2008). Following birth, three of the women reported that they “went to hospital prematurely” related to anxiety and anticipation of labour pain (Simpson, 2008, p.120). One of the women wondered if what she was feeling was labour and what actions she should take which Simpson described as a dilemma that “can cause women to go to hospital sooner than necessary” (p.59). “The anticipation of more pain than they had already experienced made them feel that for their safety and the safety of the baby, the hospital was the best place to be,” Simpson reported (2008, p.59). While some women liked being in hospital, one woman using hypnotherapy wanted to go home but was unable to leave hospital because of medical considerations, Simpson noted. Of the studies located, only the study by Barnett et al. (2008) specifically considered the

experiences of women in early labour who had been sent home after assessment in hospital.

A number of scholars attempted to determine the best type of care for women in early labour within the last ten years. The Early Labour Support and Assessment (ELSA) Trial centred in Britain looked at the care of women in early labour in the home (Spiby, Crawshaw, & Fyle, 2006; Spiby et al., 2008). Nolan and Smith (2010) reviewed the report and stated that

While home visits evaluated positively and there was some evidence of an improvement in women's experience of labour in the intervention group, there were no significant differences for instrumental vaginal birth or caesarean section between the women allocated to receive home visits and those in the control group. (p.286)

The Structured Early Labour Assessment and Care by Nurses (SELAN) Trial investigated the type of care for women in hospital early labour units to determine contributors to spontaneous birth rates and also, patient satisfaction at sites in Canada, the United States, and the United Kingdom (Hodnett et al., 2008). Hodnett et al. (2008) generated new knowledge and recommended that:

A formalized approach to care in a hospital labour assessment unit improves women's views of their care and may increase the likelihood of spontaneous vaginal birth; and Labour assessment units may want to consider standardising the care provided to include assessment and interventions for maternal psychological state, pain, and positioning. (p.8)

The OPAL (OPtions for Assessment in early Labour) study in England and Wales reviewed service provision especially telephone assessment and advice, using a clinical

pathway for normal labour, to assess efficacy as alternate methods of care for women in early labour in the home (Spiby, Green, Hucknall, Foster & Andrews, 2006). Some of the findings from interviews with 46 women noted by Spiby et al. (2006) were: the significance of communication between labouring women and their caregivers as a vital role in the overall experience of labour; women who are sent home are more dissatisfied; and women whose anxieties were not addressed by phone conversation experienced “greater upset, fears, anxiety and misconceptions” (p.140). Spiby and colleagues (2006) reported that “not feeling treated as an individual and with respect ... was the variable most strongly related to satisfaction” (p.127).

Janssen and colleagues (2006) conducted a study of 1459 women in British Columbia assessing women in early labour with support in the home (ELASH) or support by telephone in an effort to reduce caesarean section rates. Janssen et al. (2006) reported that while home assessment did reduce “the number of visits to hospital in latent phase labor” it did not “impact cesarean delivery rates among healthy nulliparous women” (p.1463). In 2009, a Roundtable discussion was held with authors and researchers from diverse professions on the topic of early labour. Green and Spiby (as cited in Spiby, Green, Janssen, Nolan, Gross, Cheyne, et al., 2009) prefaced the report: “We might reasonably hypothesize that a woman’s experience of early labor sets the scene for what follows, and it is clear that this is an area worthy of considerable further research” (p.332).

### **Summary**

In Chapter Two, a review of literature gave background information for the current research and strategies for literature search and literature integration were described. While there have been studies published about early labour in the last decade,

from the literature review there is a gap in the knowledge base about the experiences of women in early labour sent home following hospital assessment.

### **Chapter Three: Research Design and Methodology**

In Chapter Three, the research design and rationale, and research methodology are described. Ethical considerations and scientific quality are also discussed in this chapter as a prelude to chapter four in which the findings from the interviews are explicated within a framework of current literature on the subject of women in early labour sent home following hospital assessment.

#### **Research Design and Rationale**

A qualitative, phenomenological, descriptive and contextual research design was used for this study. While quantitative research has many benefits it is limited in generating data about a phenomenon as quantitative research has an objective focus of one reality that is reductionist in its analysis yielding measurable data (Speziale & Carpenter, 2007). Speziale and Carpenter (2007) noted that the development of qualitative research originated because some phenomena could not be adequately quantified by traditional science or had unsatisfactory measurement results: “Aspects of human values, culture and relationships were unable to be described fully,” by quantitative methods alone (p.2). This was further supported by Thorne (as cited in Speziale & Carpenter, 2007) who concluded that, “nurses and other healthcare professionals clearly want to grasp the lived experience of their clients, to enter into the world their clients inhabit, and to understand the basic social processes that illuminate human health and illness events” (p.2).

The use of qualitative methods to study human phenomena is rooted in the social sciences with current research methods known as phenomenology, ethnography, grounded theory, historical research and action research, reported Speziale and Carpenter (2007). Giorgi (2012) explained that

the phenomenological method is generic enough to be applied to any human or social science – sociology, anthropology, pedagogy, etc. The only difference is that one assumes the attitude of the discipline within which one is working: pedagogical if it is pedagogy, sociological if sociology, etc., instead of a psychological attitude. One would then have a pedagogical or sociological phenomenological method. (p.11)

Qualitative research methods focus on discovery of multiple realities of a human phenomenon and are context based; participants are not objectively measured but give rich insight into the phenomenon in question and therefore qualitative methods are more aligned with the research participants (Speziale & Carpenter, 2007). Reeves, Albert, Kuper, and Hodges (2008) explained that phenomenology was, “originally developed by Edmund Husserl to explain how individuals give meanings to social phenomena in their everyday lives” (p.631). Of these five qualitative approaches to research, phenomenology rooted in the psychological perspective, is best matched to this research phenomenon in many ways yet more than psychology must be investigated to understand the experience of women in early labour sent home following hospital assessment.

Nurses relate to their patients in diverse perspectives, social, psychological, physical and spiritual, therefore a method better suited to the realm of nursing is required to understand the research phenomenon. As the foundation of nursing does not mirror that of social science, Thorne et al. (1997) believed that, “nurses can use an interpretive descriptive approach to develop knowledge about human health and illness experience phenomena without sacrificing the theoretical or methodological integrity that the traditional qualitative approaches provide” (p.169).

The qualitative, phenomenological, descriptive and contextual elements of this design are explained in relation to research in general, to nursing research and to this specific research. Thorne et al. (1997) explicated interpretive description as a “noncategorical qualitative research approach.” Interpretive description was used to understand the phenomena of women in early labour sent home following hospital assessment. Analysis was guided by recent writings of Giorgi (2006; 2012), a proponent of phenomenology whose steps in analysis align with interpretive description, as reported by Thorne et al. (2007). Both of these foundations are clarified in this chapter.

Description is a required step of phenomenological analysis reported by Spiegelberg (as cited in Speziale & Carpenter, 2007) yet Thorne et al. (1997) explained that qualitative description differs from quantitative description where tallies of scores and correlations are often reported. Thorne et al. (1997) further noted that, “a qualitative descriptive approach would assume that while patterns within human behavior might be explicable using one or another theoretical proposition, recognition that they might occur was more important than explanation in the clinical application domain” (p.172). In this research, I focus upon the presence of patterns and significant realities reported by the women as initial descriptions of the findings. Giorgi and Giorgi (2003) noted the use of description in qualitative research,

The scientific phenomenological method also partakes of description, essential determination, and the use of a phenomenological reduction, but with differences with respect to each criterion. The scientific method is descriptive because its point of departure consists of concrete descriptions of experienced events from the perspective of everyday life by participants, and then the end result is a

second-order description of the psychological essence or structure of the phenomenon by the scientific researcher. (p. 251)

Formulating descriptions at different stages of the analysis leads to understanding the phenomenon in question.

Understanding a described phenomenon also depends upon the context of the data. Giorgi (2012), “wanted to study the whole person and not fragmented psychological processes,” and, “desired a non-reductionistic method for studying humans” (p.3). Giorgi (2006) was adamant that the phenomenological methods of investigating psychology be reviewed as a number of writers seemed to have proposed a mixed method of data analysis which can be contradictory to the theoretical underpinnings of phenomenology. As an example, Colaizzi, in 1973 and 1978 (as cited in Giorgi, 2006), had proposed extracting data *from* the whole research and that method, Giorgi claimed, would take the content out of context: “This procedure of extraction fails to account for all of the data and also decontextualizes the statements that are kept” (p.308). Maintaining all meaning units intact is beneficial in that “seemingly irrelevant statements end up providing nuanced, but important, senses to the major significant statements,” Giorgi wrote (2006, p.308).

The research setting was one hospital site in Mississauga, Ontario having a population of over 713,000 people. The city, with Toronto immediately to the east, is the sixth largest city in Canada and reports a greater percentage increase in population than that of Ontario or Canada, much of which is attributed to immigration (City of Mississauga website). The hospital provides obstetrical care to women 32 weeks gestation and greater with obstetricians, midwives and family physicians as care providers. The birthing suite has 12 rooms for labour, birth and recovery, two operating

rooms for caesarean births, and four outpatient induction beds. On average, 4000 births occur annually with a caesarean section rate just under 25%. As the research setting was this specific unit alone, a contextual research design was validated.

It was my intent to utilize inductive reasoning by reflecting on the experiences of women sent home following assessment in early labour with a focus on psychosocial concepts or essences. Following this research, I integrated literature that could add understanding of the phenomenon. Liehr and Smith (2002) explicated this as a process where knowledge broadens to a more general understanding of the phenomenon (as cited in Speziale & Carpenter, 2007). It is well known that the qualitative study of a phenomenon can highlight an area which needs further investigation and it was my desire to explore and describe the phenomenon in question for these purposes. Speziale and Carpenter (2007) concluded that human science and methods of inquiry offer, “an opportunity to study and create meaning that enriches and informs human life” (p.9). Based on these findings, it would be safe to conclude that interpretive description is a most suitable element of this research design. What follows is an explanation of the research methods used in sampling participants for the experiences of some women in early labour sent home following hospital assessment.

### **Research Methodology**

**Sampling.** Interviews were conducted with ten women in the first 48 hours following birth. These women were under the care of a physician as opposed to a registered midwife due to a different level of support and flexibility of providing in-home assessments for midwifery patients within the province of Ontario, Canada (Hanna, 2007). It was estimated that between eight and ten participants would be needed to ensure adequate data and saturation of the concepts and themes but saturation, however,

is a debatable concept. Morse as cited in Speziale and Carpenter (2007) stated that, “saturation is a myth,” and that, “another group of informants on the same subject at another time,” would bring different information to light (p.95). Convenience sampling was used in that health records were screened by criteria and each woman who qualified for the research was contacted to determine interest in participating. The screening was at a time convenient for research to be gathered on any day of the week, but not at night.

**Sampling Criteria.** Criteria for inclusion were English-speaking women over the age of 18 who were patients on the postpartum unit, considered low obstetrical risk with a healthy full term newborn admitted in the same hospital, and who had presented to the Birthing Suite and were subsequently sent home in early labour. Eleven women participated in interviews but data for one woman was excluded as although she presented to hospital with contractions, she left prior to being examined to determine if she was in early labour. Women selected the interview location as either their hospital room or a private office on the unit: Nine women chose to be interviewed in their hospital room and one chose the office as it was quieter than the hospital room where her other children and spouse were.

The women who participated in the research shared some similarities with respect to demographic data but also, represented diversity in background information and in their pregnancy histories. Represented here were primiparous women and multiparous women; women who had had previous vaginal births, one who had had a previous Caesarean birth and two who had had at least one pregnancy loss. See Table 1 for comparisons of demographic and pregnancy information of the participating women. All had a spouse or partner living with them and each woman had completed a minimum level of high school education; most had completed some or all of a postsecondary

program. Two of the women identified that they had had a positive culture for Group Beta Strep (GBS) bacteria; they were “GBS positive”, and would require prophylactic antibiotics in labour.

Table 1

*Sociodemographic and Pregnancy Characteristics as a Percentage of the Sample*

Characteristic	n = 10 (%)
Support: Marital status	
Partner	10 (100)
Highest Education	
High school diploma	1 (10)
Some postsecondary/degree	9 (90)
Employed	
Unemployed	3 (30)
Employed	6 (60)
Sick leave	1 (10)
Years in Canada	
Since birth	4 (40)
6-8	5 (50)
21	1 (10)
Primary languages spoken by woman at home <sup>a</sup>	
English	5 (50)
Spanish	2 (20)
Polish	2 (20)
Punjabi	2 (20)
Urdu	2 (20)
Mandarin	1 (10)
Primiparous women	6 (60)
Multiparous women	4 (40)
Previous children <sup>b</sup>	
1	2 (50)
2	2 (50)
Previous vaginal birth <sup>b</sup>	
Previous caesarean section <sup>b</sup>	3 (75)
	1 (25)
Number of Pregnancy losses	
1	1 (10)
2	1 (10)
Positive GBS status	2 (20)

Note. Data was by self-report. <sup>a</sup>Some women selected more than one language: percentages will not add to 100. <sup>b</sup>Percentage of women is based on n=4. Of all women interviewed, n=10, 20% had one child, 20% had two children at home; 30% had a previous vaginal birth, 10% had a previous caesarean section.

**Sampling Procedures.** Women were identified as meeting criteria for the research through a scan of the electronic records of women admitted on the postpartum unit. Nurses were then notified when a woman met criteria for the research and the introductory script was reviewed with the staff member. Potential participants were individually approached by a nurse who followed the introductory script and explained that research was being conducted on the unit and that verbal consent was required for the researcher to speak with the woman.

Following verbal consent I met with each woman individually and gave an overview of the research. Each woman was given an opportunity to choose to receive further explanation of the research at a time convenient for her prior to discharge. The participant consent form was left with each woman (see Appendix A) and if a woman agreed to participate, forms were signed and a copy given to the woman. While four women chose to learn more about the research at a time closer to discharge from hospital, six women wanted to be interviewed immediately following initial discussion of the research. Only two women declined to hear the research overview and one woman who had consented to meet, later declined. It appeared that fatigue was a factor in her decision to leave hospital prior to the interview.

**Data Collection.** The mode of data collection was through an in-depth interview with each woman. A digital audio recorder was used to capture each complete interview which described the experience of women in early labour sent home following hospital assessment. The duration of time spent at home varied between less than three hours to eight days and the interviews lasted between 15 and 40 minutes. Interviews were designed to be open-ended with one central question asked: “Tell me about your experience when you were sent home – when you were not far along enough in labour to

be admitted to the hospital.” Several prompting questions were scripted prior to the interview and were used as needed to guide the woman to describe her experience in detail. The prompting questions also served to clarify the chronology of events and experiences during the interview and assisted in keeping each woman’s experience in focus during the actual interview. Brief handwritten notes were taken during the interview to report details such as the woman’s emotions and non-verbal behaviour, nature of disruptions if any, and others present during the interview. Interviews were friendly, yet professional, relaxed, and focused upon the woman and her experience.

It is important to report that while the focus was on the experience of *women* in early labour sent home following hospital assessment, in fact three of the partners who were present did add their voice to the interview. One spouse answered one question by the woman; a second partner contributed more. When this happened I was able to capture the partner’s data and allow the woman to continue speaking as she was ready. In a third interview, the spouse was present specifically at the request of the woman who was unsure that her English language skills were adequate for the interview. I wanted to ensure sensitivity to her cultural background where men historically have been the decision makers. The husband freely added to the interview and questions were redirected to the woman as I was able to, to show respect for each of them. When the husband posed questions about predicting labour onset I took the time to answer him and was able to continue the interview after this brief departure. I believe that the data from this interview was as rich as the data from other interviews and that having the husband present and involved was not a deterrent to the research. Some of the women spoke English as a second or third language yet all were able to communicate well in English and the content of the interviews was understood.

Some women spoke of their experiences freely, with minimal prompting or pauses required during the interview. One of the women seemed straightforward and brief in her responses and by purposely utilizing lengthy pauses, the woman was given opportunity to elaborate if she wished and share further about her thoughts and feelings of being sent home in early labour following hospital assessment.

Each interview audiotape was copied onto my personal computer and assigned a numeric code and interview date which corresponded with the information in the log. Following this, I transcribed each of the audiotaped interviews verbatim as soon as possible and incorporated any notes taken during the interview. For some of the interviews the transcription was completed on the day that the interview was conducted while other transcriptions were completed over a number of days. While the process of transcribing each interview was painstaking and time consuming it allowed me to become very familiar with each woman's story so that in reading a transcription, visual cues come to mind - a picture of the woman and the setting; and her words and speech nuances can be heard. Thorne et al. (1997) explained this as knowing individual cases intimately. Transcribing an interview also allowed me to reframe future interview questions or prompts and to become increasingly more comfortable with strategies to encourage a woman to tell her story. Each transcribed phrase was labeled as "I" for interviewer or "P" for participant. When a spouse contributed to the interview, information was bracketed and written in italics so that it would stand out from the woman's responses. Once each transcription was completed it was compared with the complete audiotaped interview numerous times to ensure accuracy. After all of the interviews were transcribed a final verification of each transcription was carried out. Two of the

audiotaped interviews had several phrases which could not be deciphered and these were noted on a tracking tool for follow up.

Within three weeks of the interview attempts were made to contact each woman by phone to explain the status of the research to date and to ask for clarity of content if needed. During the interviews some women had spontaneously shared background demographic data such as language spoken or made reference to a country of origin. This information was clarified as it enhanced understanding the context.

**Data Analysis.** Thorne, Reimer-Kirkham and MacDonald-Emes (1997) recommended techniques for data analysis by Giorgi, Knapf and Webster, or Lincoln and Guba, all of whom valued repeated immersion in the data prior to inductive analysis. The outcome of analysis is a, “coherent conceptual description that taps thematic patterns and commonalities believed to characterize the phenomenon,” explained Thorne, Reimer-Kirkham, and O’Flynn-Magee (2004, p.4). The analysis process for this research reflects the writing of Giorgi (2006) who explained the method as painstaking and lengthy; each interview transcription must be reviewed through an iterative process. Since Giorgi first explicated a method of data analysis in 1985, he published numerous articles about analysis and his methodological steps have been cited frequently.

Giorgi (2012) reported that his desire to understand, “the whole human person,” led him to psychology yet he found in psychology that, “human functions were separated ... and explored in isolation” (pp.3-4). To research humans psychologically, Giorgi (2012) based his method of analysis upon the work of Husserl and Merleau-Ponty (p.3). Giorgi (2012) explicated a five-step process for data analysis:

1. The researcher first reads the whole description in order to get a sense of the whole...;

2. The researcher then goes back to the beginning of the description and begins to reread it... the process of constituting parts [or] meaning units and they are ... correlated with the attitude of the researcher;
3. The researcher transforms the data, still basically in the words of the subject, into expressions that are more directly revelatory of the psychological import of what the subject said...;
4. The direct and psychologically more sensitive expressions are then reviewed and with the help of free imaginative variation an essential structure of the experience is written...; and
5. The essential structure is then used to help clarify and interpret the raw data of the research (pp.5-6).

A review of Giorgi's methods of data analysis yields a focus on iterative immersion in the data, making sense of the data from the perspective of the participant yet in relationship to the researcher, and recreating a structure of meaning to explicate the phenomenon investigated. This supports the writings of Thorne, Reimer-Kirkham and MacDonald-Emes (1997) who explicated data analysis as being inductive. Deductive analysis with a focus on "overly small units of analysis, such as words or phrases" can inhibit inductive analysis and should be avoided, reported Thorne et al. (1997, p. 174).

Data analysis began with each interview that I transcribed verbatim. Once completed, the transcription was left for at least one day before it was reviewed while listening to the audio recording for omissions or errors. After each transcription had been verified for accuracy with the audio interview, the transcription was read through along with the audio recording one more time. It was only after this process that a written analysis of each interview was begun. Key words and phrases were jotted down in order

to understand the experience chronologically and as a whole. Instead of isolating small units of words or phrases in this iterative process questions were posed about larger data segments. Thorne et al. (1997) reported that, “struggling to apprehend the overall picture with questions such as, ‘what is happening here?’ and ‘what am I learning about this?’” will typically stimulate more coherent analytic frameworks for interpretive description,” than would a focus on small data units (p.174). Other questions that were asked throughout this phase were, “what role does this play?” or “why is this different?” and “is there a connection between these?” Thorne et al. (1997) explicated that an effective interpretive description required a, “purposeful selection of research participants whose accounts reveal elements that are to some degree shared by others” and that commonalities and eccentricities will be differentiated (p.174). From the perspective of the researcher, each transcription yielded significant data some of which was common to other transcriptions as themes, while other data was considered significant because of the impact which it had for the woman interviewed (See Appendix D, Table 2).

A description of each experience was summarized to comprehend the whole. Each transcription was then reviewed and notes jotted down about each passage. The questions “what?” and “why?” were recorded in the margin beside the entries to focus the analysis on meaning. The resulting document was put in chronological order and patterns and themes were considered from each woman’s experience using prompts such as questions posed earlier. To further align common experiences each transcript and all notes were reviewed and data gathered chronologically. All the responses to hospital assessment, data from the transition to home, and data from being at home until transition back to hospital were located on large flip chart papers. The data was written from the woman’s perspective as internal processes of, “think” and “feel” and external processes

of, “say” and “do”. Two final categories were support persons, their involvement and roles, and messages from the women about their experiences in early labour sent home following hospital assessment. The data was compared for patterns and common themes and the resulting structure was used to help clarify and interpret the transcriptions.

### **Ethical Considerations**

It was imperative throughout this research that participant harm was avoided and that participants’ rights to confidentiality, privacy and anonymity were upheld (Speziale & Carpenter, 2007). In addition, it was imperative that these same rights were applied to staff members and physicians at the site of research. Research Ethics Board approval was granted at both the hospital where participant sampling occurred, and at Trinity Western University, the educational facility, prior to any data collection. Verbal and written consent was obtained from each woman and was ongoing, as Speziale and Carpenter (2007) explained. A copy of the research information letter was given to each woman who wished to participate. Elements of the participant consent form explained that audiotape recording would be turned off and the interview concluded at any time that a woman requested. Process for withdrawing from the research was explained. The process for storage of information was reported in the participant consent form. Women were given a choice to be interviewed in their hospital room or in a private office on the unit. A small non-monetary reward, a \$5 Tim Horton’s card, was given to each woman upon completion of the audiotaped interview.

Throughout the research stage, no discussions occurred with hospital staff members following interviews about any of the participating women aside from numbers of women who were interviewed. No identifying patient information was on the audiotaped interviews nor in the final written work as assigned code numbers and

alphabetical pseudonyms were utilized for each woman. No identifying staff information was included on the transcriptions, nor in the final written work. Blanks were used in place of any names referred to by any of the women interviewed.

### **Scientific Quality: Trustworthiness**

Qualitative research must demonstrate good quality yet controversy has accompanied the debate of how to define quality, reported Polit and Beck (2008). Polit and Beck (2008) explained that some qualitative researchers advocate that terminology to demonstrate scientific quality should differ from terminology to demonstrate quality in quantitative research while Sandelowski (as cited in Polit & Beck, 2008) believed that the spirit of qualitative work could be negatively affected by, “the uncritical application of rules”. Guba and Lincoln (as cited in Polit & Beck, 2008) reported a framework of trustworthiness with five criteria as follows: Credibility, dependability, confirmability, transferability, and authenticity.

Credibility in this research was supported through the use of field notes incorporated into the transcriptions from interviews which were transcribed by the researcher verbatim; through a commitment to researcher reflexivity and transparency which Polit and Beck (2008) reported as significant. Saturation in the data was inherent in the process of transcription as was the method analysis employed: an iterative process of reading, reflecting, and finally recording themes and salient findings as reported by the women. Dependability was enhanced as detailed notes of analytic steps were kept thereby allowing verification of findings over time and in different conditions. In fact, much of the literature about early labour was generated internationally and some themes were consistent in different contexts. To reflect confirmability or objectivity I repeatedly reflected upon my values of the phenomenon in question as a nurse and educator with

experience in the labour and delivery unit, as a prenatal educator and also, as a woman who has laboured and given birth. I ensured that a comprehensive reading of literature pertaining to aspects of early labour was performed. I attempted to maintain an open mind, to focus on the experiences of the *women* interviewed, those in early labour sent home following hospital assessment, throughout data collection and analysis so that the impact of researcher was minimized. It is hoped that the methods of analysis and the findings presented will demonstrate both transferability and authenticity to the reader as, “sufficient information must be available ... for readers to follow the analytic reasoning process”, reported Thorne, Reimer-Kirkham and MacDonald-Emes (1997, p.175).

Member checking is a controversial measure of validation, specifically dependability in data generation as reported by Polit and Beck (2008). Polit and Beck (2008) explained that member checking must be congruent with the methodology and Giorgi’s phenomenological analysis did not advocate for member checking. When the research plan was developed, due to the life stage of the women interviewed, all had a newborn and some had other children at home, it was not thought to be ethically appropriate to request a follow up critical review. This is where I have departed from suggestions of Thorne et al. (1997) in that, “beginning conceptualizations representing the entire sample,” were not brought to the participants for critical review. To ensure accuracy in representing the experiences of women sent home in early labour, a phone call was made to each participant following transcription. The purpose was to report on progress of the research and to seek clarity of meaning from individual interview transcriptions or to clarify what could not be determined from the audiotape recording. All women were contacted by phone but clarification was required only for two interviews.

**Summary**

In chapter three research design and methodology that were utilized for this research were described. Ethical considerations and scientific quality were also discussed in this chapter as a prelude to chapter four in which the findings from the interviews are explicated within a framework of current literature on the subject of women in early labour sent home following hospital assessment.

### **Chapter Four: Findings and Discussion**

Between June 17, 2012 and July 10, 2012, I interviewed ten women admitted on the postpartum unit within 24 to 48 hours following the birth of a healthy full term infant. I transcribed the interviews verbatim and included significant field notes. Extensive time was allowed to read and reread each transcription. Member checking was done with each of the participants followed by analysis of each transcription for themes of relevance to women in early labour sent home following hospital assessment.

Patterns, concepts and themes are highlighted in this chapter that are salient based on the written transcribed notes and on the way in which the women described their stories and include mood of the interview (i.e. humour when used); background information; emotions, thoughts, physical experiences and coping strategies; support persons; and the decision-maker and the return to hospital. Psychosocial concepts and aspects of physical discomfort were central to the interview discussions and findings for the women. However, physical discomforts discussed revealed further psychosocial impact. For example, women talked about fear and anxiety related to contractions and feeling afraid or unsure of how to cope with ongoing fatigue.

Four of the women had one outpatient visit to the labour unit related to labour symptoms, five women had two outpatient assessments, and one woman had one outpatient visit to the labour unit and a follow up appointment in her physician's office prior to being admitted to hospital in labour. In order to understand the experiences of these women it is prudent to know why women went to the labour unit. The women reported going to hospital because of physical symptoms: six women experienced uterine contractions and wanted to be checked for labour progress while the other women experienced additional symptoms and were concerned about the baby. One woman had

some bleeding which was different when compared with her prior labour experiences; another woman felt that her membranes were going to rupture; a woman who had had a prior caesarean section felt labour was beginning; the last woman was told by a family member that she needed to go to hospital for the baby's safety.

Five women specifically reported that they either liked being at home for a time in early labour following hospital assessment or that it did not matter that they had to go home. None of the women explicitly stated that they did not want to go home but all women described challenges that they experienced while at home and three expressed a desire to be in hospital. The time spent at home in early labour following assessment in hospital varied from under three hours to eight days yet a number of commonalities of experience were evident and are presented here as themes. Three women who returned to hospital were again diagnosed as being in early labour but remained as an outpatient from under two hours to eight hours, until criteria for admission in labour was met. Also included in the findings are the responses to the question, "Is there a message you would like to share to help people understand the experience when you are sent home not far along enough in labour to be admitted?"

Themes which resulted from the analysis of the ten women's experiences from time of assessment in hospital until return prior to admission are described here to facilitate understanding of the phenomenon researched. The themes are presented in a sequential manner where possible. They are reported as themes noted on arrival to the labour unit, during the experience at home, and during preparation and return to hospital for admission. It is important to note that the themes were exhibited by different women at various phases of the experience of being in early labour and sent home following hospital assessment. Five themes generated from this research are as follows:

1. conflict between knowledge of labour symptoms and women's initial responses;
2. background influences and current pregnancy concerns;
3. impact of the unspoken;
4. experiences of pain and coping; and
5. influence of others.

### **Conflict Between Knowledge of Labour Symptoms and Women's Initial Responses**

Each woman who presented to the hospital labour unit was assessed which included an internal examination. Communication with the nurse or physician which followed, focused on labour status or not being far along enough in labour to be admitted. The women verbalized that they knew when to go to hospital as this had been explained in prenatal classes, or medical appointments. Prior experience with labour and birth also provided memories of lived knowledge of the labour process for multiparous women. While each of the women articulated the standard criteria for going to the hospital – when contractions are painful, coming every five minutes, lasting 50 to 60 seconds, and have been that pattern for an hour – only one of six women with labour symptoms presented to hospital meeting that criteria. Four others presented with contractions which were less frequent or not very painful yet still they came. The primiparous women verbalized that they knew that labour with a first baby was long; that the cervix had to dilate to 10 cm; and that “there was a long way to go from 1cm”.

When told that the women were not far along enough in labour to be admitted, feelings and thoughts were not aligned with the knowledge base of the primiparous women for the most part as some comments demonstrate: “Really? After all this time that's all I have?”; “What! Only 1 [cm]? ... I was just surprised it was only 1 cm”; “I

was really disappointed [pause] I felt that I had gone through a lot already and I was not sure of what to expect then moving forward”; “Oh no, ... I’m gonna have it [the baby] early in the morning the next day;” and

what I thought was kind of a strong contractions, she said that it was just really mild ... I wonder how real contractions are? ... I was kind of devastated ... I’ve been having ... what we thought was supposed to be contractions for this long and [pause] and ... my body’s not even working.

The primiparous women expressed emotions that ranged from surprise and a little disappointment, disappointment, feeling upset and letdown, frustration with self, to feeling really disappointed, and devastated. While one multiparous woman reported that she was frustrated, the others were more neutral as they expressed that they had no concerns or were positive in anticipation that active labour may come soon. Cheyne et al. (2007) reported that the most common response when sent home in early labour is disappointment as women hoped to be further in labour. Carlsson et al. (2009) explained that a lack of progress in the latent phase can lead a woman to doubt her body is normal which was similar to what one primiparous woman believed.

**Fatigue as influence on responses.** For most women in the current research, fatigue was a common concern upon arrival at hospital. Four of the ten women in the current research had had contractions while at home for more than 10 hours; two of these women had had contractions over 20 hours. Two were not able to sleep as contractions continued and wakened them at night and six of the women went to hospital during the night. A primiparous woman stated that she could not handle not sleeping after having had contractions all day and late into the night prior to going to hospital. Another

primiparous woman who came to hospital in the morning elaborated on her concern of fatigue,

I was so well rested uh, that day... I was thinking, this is good ... 'cause I didn't want the epidural ... it'll be easy to handle the pain if, um, I'm in a good mood like this ... But then I was like, I'm probably not going to be able to sleep all day with these contractions.

Beebe and Lee (2007) in a study of 35 primiparous women found that total amount of sleep time decreased from an average of 7.5 hours to 4.5 hours over the last five days prior to admission in labour or for induction of labour (p.106). Fragmented, reduced sleep hours is correlated with increased pain perceived in labour, reported Beebe and Lee (2007). Barnett et al. (2008) reported a theme of sleep deprivation among six primiparous women diagnosed in early labour and sent home. Tzeng, Chao, Kuo, and Teng (2008) in a study of childbirth-related trajectories of fatigue through labour reiterated that "fatigue is a distressing symptom that affects women's well-being and their capacity to undergo the arduous labour process" (p.248). Tzeng and colleagues (2008) outlined two trajectories of fatigue as low intensity or high intensity upon admission in labour and reported that maternal anxiety in labour consumes energy especially in the active phase (p.247). Tzeng, et al. (2008) demonstrated that primiparous women who presented in labour with a higher level of fatigue experienced more anxiety than those with a lower level of fatigue upon admission however, those with high intensity fatigue generally experienced a decline in fatigue levels with onset of second stage of labour (p.245). By experience, women in the first stage of labour sometimes express concerns with fatigue and think they will not have the energy to push when the cervix becomes fully dilated.

**Unknown as influence on responses.** Another factor in the responses of women when assessed in early labour was the impact of the unknown. While the women could verbalize details about the labour process, four primiparous women reported that they just wanted to be checked; to see if there was progress. This demonstrated a lack of confidence in physical symptoms correlated to labour and criteria for admission. One primiparous woman said that by 5:00 a.m. she had not slept and wanted to go to hospital: “Let’s just go check.” Another primiparous woman explained, “I figured I should just go in and see.” Yet another primiparous woman stated,

I do some research ... before you have the real contractions you have to, you need to bleed or you, sometimes you have to, you need to break water but I don’t have either of signs – know maybe it’s not, not a right time but I just want to go to check how many centimetres my cervix was open.

One woman explained her reason for going to the labour unit as wanting a “frame of reference,” as she had been contracting since early in the morning and it was now midnight,

We came in not knowing how far along I was and knowing that I would probably get sent home because I think the contractions were between seven and eight minutes ... this being my first time, I wanted to know if anything was happening in terms of was I dilating at all? ... just to give me a frame of reference for, would I be another sort of eight hours in this same stage or is it gonna come on quickly? Similar to this participant’s views, in the study by Cheyne et al. (2007), one woman described not having anything against which to “benchmark” her labour.

In the current research women shared the questions: How far dilated is the cervix? Is the pain going to get worse? How much longer? “How much longer,” was

explained in the context of either predicting the time until active labour begins and the woman is admitted to hospital or until the baby is born. The women sought information for the labour process which they viewed then as unknown. Many of these were primiparous women who seemed to need much more information than multiparous women at the time of early labour in the form of a personalized labour forecast. One woman explained,

Just not knowing how much longer ... if they could have told us ... 'you're going to be back soon don't worry about it. Labour, it will pick up ... for you shortly' ... that would have helped for sure.

**Feelings of disappointment and frustration.** Although women in this study had knowledge about the onset and progression of labour, there was a common feeling of disappointment and frustration at not being further along in labour when assessed in hospital. Especially for primiparous women this began a cascade of thoughts and emotions such as: When will my cervix dilate? How long will this [labour] be? I knew I came in too soon. How much pain can I expect? How can I cope without sleep? Why do I have to wait? This isn't "textbook" labour! Why is my body not working? Who do I believe? Can you induce me? Will someone help me to get home? How do I know when to return to hospital? I am disappointed ... sad ... impatient to see my baby ... fine to go home for a while ... frustrated ... excited ... afraid ... confused ... terrified.

**Anxiety and fear as influences on responses.** For some primiparous women, when given information about their individual status in early labour, fear was a concern as the thought of labour pains over an unknown number of hours was unsettling. Three primiparous women wanted "to be induced" which they explained as having the labour process sped up and one woman verbalized this request to the nurse. Carlton et al. (as

cited in Cheyne et al., 2007) reported that women who “lack confidence in their ability to cope with labour without medical assistance” may desire induction of labour or caesarean section (p.608). Another woman who had experienced contractions for 20 hours shared,

I had no issues with the advice that the hospital gave us or the fact that we were going home and I thought it would be more comfortable there ...but I was [pause] terrified of like, of just what to expect.

A primiparous woman stated that it would be easier next time she was in labour as she would know what to expect. While this perspective is understood, many know from experience working in the labour unit, that for multiparous women, having laboured and given birth or having had a caesarean section, a whole new set of emotions and thoughts can arise. Each of the multiparous women in this research compared their prior labour and birth experiences with what was happening in the current pregnancy and in early labour. Two of the women wondered if the baby would be born sooner than their other children who were born at term or postterm. Even the strength of the contractions and new physical symptoms were compared with prior labours. One woman explained that she did not know what to do with her different early labour experience while another said that after having one child everything concerned her.

Every little bump or crick worries you and you know, you say to yourself, ‘It’s probably nothing and I don’t want to bother them...’ Then you say to yourself, ‘I’ll never forgive myself if something happens and I hadn’t taken myself [to hospital].’

**Source of confidence.** Confidence in physical symptoms or external confirmation was shown throughout the research to be something that most women struggled with at various times and may be related to the fact that women are not

confident in determining labour and require external feedback. Contributing to that struggle is the current criterion-based admission philosophy: Admit when in active labour with a defined minimum cervical dilation and contraction pattern. Low and Moffat (2006) in a study of women transitioning into the labour unit, reported a theme of “Don’t trust your body, trust us” (p.307). Women discussed various external sources of information such as the internet, prenatal classes, books, and the information sheet which was reviewed and given when women were sent home. Three women also phoned the labour unit to seek information. Prior to return and admission, three of the ten women commented that they “knew” it was time to go to hospital; they were confident in knowing their body in labour yet seven women wanted feedback and relied upon the nurse or physician for confirmation of labour.

Recent reports gave insight into the research topic. Cheyne et al. (2007) stated that women sent home experienced uncertainty as they anticipated that stronger contractions would be experienced. Carlsson et al. (2009) reported, “At times the woman wants to remain at the hospital due to anxiety, need of pain relief or because she is suffering from sleep deprivation” (2009, p.173). Other current literature report a psychological burden on women and, some authors believe, on their partners when women are sent home in early labour. Scotland, McNamee, Cheyne, Hundley, and Barnett (2011) noted that sending women home “may serve to increase anxiety in those who are seeking care because they are struggling to cope with the latent phase of labor on their own” (p.37). Greulich and Tarrant (2007) reported that women who leave the hospital may be afraid because of the responsibility they have to identify when active labour begins. “This process contributes to the woman’s mental and emotional workload in the latent phase of labor,” explained Greulich and Tarrant (2007, p.191). Barnett et al.

(2008) stated, “most women sought reassurance and being sent home made them feel unsupported and may have actually increased their anxiety” (p.153). Being sent home, “can be extremely stressful for women and their partners and can result in feelings of being neglected,” reported Baxter (2007, p. 765). Anxiety and fear were two psychosocial concepts prominent to the theme of conflict between knowledge of labour symptoms and women’s initial responses when at hospital too early in labour to be admitted.

### **Background Influences and Current Pregnancy Concerns**

This theme encompassed broad information learned from the women in early labour who had been sent home following hospital assessment. Having an impact on women in this research were current concerns such as having a positive Group B Streptococcus (GBS) swab at 35 to 36 weeks gestation, history of pregnancy loss, and the influence of culture or country of origin. This last influence could be from the woman who had been born and raised in a country outside of Canada, or from extended family members of the woman or partner, who came to Canada but remember their experiences or stories about labour and birth.

**Positive GBS status.** Both women who reported having a positive swab for GBS bacteria during the pregnancy verbalized a concern for the unborn baby as she knew that intravenous antibiotics for four hours prior to birth was the required prophylactic treatment to reduce the risk of bacterial infection in the neonate. This presented a challenge for women, whether primiparous or multiparous, as they verbalized that safety for the baby was important yet they were unsure as to how to predict the time to go to hospital. One woman had a heightened awareness of any bodily sensations because of her GBS status and felt that her membranes were going to rupture. Once she had been

sent home in early labour, it was still the knowledge of being GBS positive which made her want to return to be in hospital in time for the antibiotics. (When she was found to be in active labour she expressed that she was happy; she now could get the antibiotics.)

Another woman who had been home for a number of hours and was compelled to return to the labour unit stated,

Even if they tell us to come back [go home] ... let's just go and check ... I just want to make sure that I do get the uh, antibiotics ... so that the baby doesn't get the bacteria. ... that's why I didn't want to go late.

For women with a positive GBS status, being at home brought a different orientation in thinking and emotions to the experience of early labour and was a factor in how long women in this research tolerated staying at home compared with women with a negative GBS status. Of the literature reviewed, only the work of Simpson (2008) mentioned GBS status. Simpson (2008) wrote that one primiparous woman with positive GBS status chose to return to hospital every 4 hours for intravenous antibiotics prior to the onset of active labour so that she could be at home in early labour. The current research demonstrated that positive GBS status adds to the mental and emotional workload of women regarding return to hospital.

**Prior pregnancy loss.** A significant factor in how one woman experienced early labour was a history of pregnancy loss (see Table 2). For this woman, the overriding thought in early labour was about the safety of the baby. Although she was “very, very comfortable” with going home following assessment in hospital, she explained, “this is my fifth pregnancy so I lost two...I was worried about this baby um, because when you lose two pregnancy, next one is always, fears.” She shared that when she and her husband were at home they realized how quiet it was with their children at a friend's

home; they missed the children and talked about what it was going to be like with one more child around the table, glad that their family was growing. When asked what was going through her mind while at home she answered, “Healthy. My baby healthy. Yes only this. I didn’t care about...boy or girl...No, only I want ... the baby to be healthy. So this is for me, it was number one.” The other woman who had had one pregnancy loss did not discuss the loss past the opening comments of the interview.

Fisher, Astbury, Cabral de Mello, and Saxena (2009) reported that those with prior pregnancy birth loss demonstrated higher anxiety and depression. Côté-Arsenault and Donato (2007) wrote of the experiences of women late in pregnancy following a pregnancy loss and reported that “a few women were free of worry,” but that most of the women’s journal entries “focused on excitement tempered with doubt and fear” (p.554). For women who have had a late pregnancy loss or multiple losses, anxiety was reported as remaining high or increasing with the approach of the due date and anniversaries of past losses (Côté-Arsenault & Donato, 2007). As a means of coping, Côté-Arsenault and Donato (2007) stated that “Women attempt to balance their emotions using several strategies: (a) seeking reassurance from care providers, spouses, family and friends, support groups, and the baby; (b) being hypervigilant; and (c) relying on internal beliefs” (p.551). The woman with pregnancy losses sought reassurance to deal with the anxiety of a new symptom, thus she came to the labour unit, was assessed, and was sent home.

**Cultural background.** Other influences from women’s backgrounds contributed to the experience of early labour. One woman described how she had gone back to China, was seen by a physician during the fourth month of pregnancy and had an ultrasound there which showed uterine fibroids. She was advised to have a caesarean section birth and uterine fibroids removed at the same time. She understood that this was

for her safety as the fibroids could cause bleeding if vaginal birth was attempted. Upon her return to Canada, her physician told her that the fibroids were a small problem; that she did not need to have a caesarean section. The woman was worried because of the different plans of care advised her. This worry continued through her pregnancy and was magnified during early labour. When she was sent home from hospital with contractions she thought that the pain experienced may have been due to the fibroids as her cervix had not yet dilated. She had her spouse search on the internet for information about fibroids but without finding any relevant information. She then rationalized that if there was a problem with the fibroids, she would bleed a lot and as she was not bleeding a lot perhaps the fibroids were not a big problem. The worry decreased to concern as the distracting pain of labour increased.

In China, it was described that health care is paid privately by individuals and hospital policy is different from policies in Canadian hospitals. In China, pregnant women could go to hospital three to four days or even a week before the baby is born. “In your mind, you know uh, when it’s ready. But here [in Canada], it’s ... like you know nothing unless the nurse tell, tell you.” She explained that while at home she does not know what the pain means: Is it a sign of labour or not? Is it a problem because of the fibroids? “So we don’t know the knowledge that’s why we want to come to hospital.” She explained how first time mothers in hospital in China are not afraid because they trust the doctors and if the doctor says everything is fine, the woman relaxes; if anything happens, the doctor is there and things are prepared.

The doctor will take care of you, ... if you have any uncomfortable like, if you have a pain, even if it’s fake contraction and if you have a little bleeding, if you

feel anything uncomfortable, they gonna come to examine you. They will examine you and tell you the reason and tell you, “Relax, it’s normal.”

Her perspective on obstetrical care in Canada was that because hospitals are short of nurses, hospitals do not take women until the *final* stage of having a baby, such as when the “water breaks” or very strong contractions occur. This is in contrast to healthcare providers in the western world who look upon early labour as just the *beginning* of labour; active labour is the time for women to be in hospital.

One primiparous woman, coping at home with contractions, had planned to go to hospital when the contractions were closer yet became afraid when her partner’s grandmother said, ““You have to go – It’s dangerous. The baby could die if you don’t go get it checked out now.”” Seeing a little blood and not recalling fetal movement made her decide to go to hospital where she was checked and sent home. Family members were upset that she had been sent home as in Poland women would stay a week in hospital, she thought. Similarly, Barnett et al. (2008) reported that family members were involved in the decision for women to go to hospital in early labour: some mothers “actively encouraged attendance at hospital” (p.148).

Three multiparous women who were not born in Canada were the most explicit in verbalizing their contentment with going home if advised by hospital staff. Perhaps an element of socialization to authority or healthcare based on country of origin and/or combination with being a multiparous woman fostered this attitude. A primiparous woman born outside of Canada wrestled with advice she received from two healthcare systems regarding plans for birth. Conflicting advice caused her to feel worried as labour began and as she experienced it away from hospital. Callister (as cited in Wong, Hockenberry, Wilson, Perry, & Lowdermilk, 2006) encouraged nurses to assess the

women with respect to cultural and religious preferences, for example, to determine whether childbirth is viewed as a “wellness or illness experience” (p.497).

Pregnancy concerns such as positive GBS status, prior pregnancy losses, and conflicting information from a variety of sources such as different healthcare philosophies and providers contributed to anxiety for women in early labour. Influences of cultural background cannot be ignored but should be explored. Redshaw and Heikkila (2011) reported that women from black and minority groups in England worried about pain, unknown aspects of labour, and embarrassment twice as much when compared with Caucasian women. Similarly, the level of anxiety for a woman in labour “rises when she does not understand what is happening to her or what is being said,” reported Wong et al. (2006).

### **Impact of the Unspoken**

For some women, there appear to be unspoken thoughts which contributed to the experience of being in early labour and sent home following hospital assessment. This concept overlapped with the theme of conflict between knowledge of labour symptoms and women’s initial responses. An example was repeated here to demonstrate the impact of one woman’s response: devastation and feeling of an abnormal body. Throughout the interview, these concepts were verbalized a number of times. The primiparous woman who went to the labour unit with contractions every five minutes described her response to the news that she was in early labour as

I was kind of devastated. ... my body’s not even working. Like I thought it was just something wrong with my body. So it was more on me than on anything else... we were really upset and ... I think I cried that night. But it was just [pause] kind of a bad feeling when you feel that your body’s not doing what it’s

supposed to be doing or when it's just acting really completely different from what everybody tells you 'come in when you have this' or people tell you what happens ... and they're telling you, 'No, no you're not ready yet.'

This woman was at home for eight days after assessment in hospital. After two days while following the instructions on an information sheet for women in early labour, she saw her physician who determined that she was not even in early labour yet. While this was not the typical experience for the women in this research it was her experience.

**Relationships of trust.** Trust, an unspoken element, was important for women who presented to the labour unit. Three women verbalized trust in the labour unit staff. One woman when assessed and told there was no reason to stay in hospital explained "they know what they do. So I trust them. So yes, I, I'm going home." Another woman explained about the impact of the early labour information sheet which she had been given following hospital assessment. She recalled, "If you're not satisfied, if you have any questions, you can come back any time. No matter if it's concerned with the labour or whatever like, if you have any questions you can come back even if you're scared." The underlying unspoken message which she understood and which may have contributed to her early labour experience was one of feeling welcome to return to hospital; to trust the healthcare system.

Lack of trust was an unspoken concern for a primiparous woman who perceived two different opinions: "You're starting labour" and "You're not even in labour yet." She thought the messages were so contradictory that either the doctor was wrong or the nurse was wrong. It made her question, "Should we actually go see that person then because if they're wrong or if, should we actually go to that hospital because if it's wrong I mean, what's gonna happen next?" The woman explained,

It was just that disappointing part of that kind of, made my view, the view of the situation ... it wasn't a good experience so I just didn't think they were nice enough or they were helping me enough, um , but they obviously were. It's just ... the feeling, the emotions of it at the time ... more chances that it made me feel like they weren't treating me properly even though they were. ... I just didn't want to see the same nurse just because I didn't want her to tell me, uh, 'Go home' again ... it wasn't a bad experience, it was just that uh, the outcome of it that made me feel like it was.

Other unspoken thoughts for this same woman related to her feeling that her body was not working; that it was incompetent because her cervix was not dilating. She questioned, "But what if my body doesn't dilate, then what's gonna happen? Are they gonna send me home again? Am I gonna have my baby at home?" She had talked about her body as incompetent throughout the interview and when asked when her thoughts about her body changed in her mind, she responded, "When they told us that I was five, 4 to 5 cm dilated. I didn't even think I could, uh, my body could dilate because my mom's didn't for either labour..." Unspoken thoughts and fears of having an experience similar to that of her mother predominated her thinking and emotions and were almost crippling in their effects upon her.

**Expectations.** When a woman first went to the labour unit she felt, "we were just ready to have her [the baby]. She was too big and we were tired so that's why we were so frustrating just to go home again an' to wait." Another mother reported,

Well I think in the back of my brain I thought, I'm due to have this baby in a week anyways, ... We already know he's going to be a big boy and I, I think I

thought that they were going to keep me because I did go to the extent of bringing all my stuff in the car.

It was unclear whether a physician had measured either of the babies as large for gestational age or whether the women believed their baby to be big in the absence of a medical diagnosis. There are many physical changes in pregnancy which lead to discomfort, especially in the third trimester, and it is understandable that a woman feels she does not want to wait to have the baby especially if she feels the baby is big.

Carlsson et al. (2009) reported that “for different reasons women expected to give birth prior to the estimated due date, which caused impatience and an unwillingness to wait” (p.175).

A woman was booked to have a repeat caesarean section and told that “we had a date in mind where our life was sort of revolving around that and ... we didn’t realize that things were going to get shaken up the way they did.” She recalled, after having cramping and spotting prior to the date of the caesarean section, that a change in plans “sort of throws a wrench into your life.” Two days later she wakened with cramps which quickly progressed to painful contractions and she explained, “but that wasn’t part of the plan.” With humour she recalled how she envisioned the date of the birth and explained, “I remember gloating about that – it will be nice. I won’t have to labour. I’ll just walk in for a C Section.” When admitted and while arrangements were being made for the caesarean section she remembered that she, “was not dealing with the pain at all and I think because the whole time I wasn’t ... psychologically prepared for that... it was not discussed you know.”

Were there unspoken thoughts for the other women? The primiparous woman who went home “terrified of ... what to expect” wondered if “16 more hours” would pass

before she was in active labour while already feeling a lot of pain. At home her husband went to sleep seemingly at ease knowing that there may be 24 or 48 hours until labour really started while she thought labour was “coming on way too slow, way too gradual.”

**Positive thoughts.** Another primiparous woman returned to hospital hopeful that labour had progressed. She reflected that,

I was remaining positive. I knew no matter what she was, she was in a good position from the ultrasounds I had previously; her heart rate was healthy. I knew, you know, she would come out one way or the other and the fact that I was in pain was because I am going to have a baby so, it didn't really upset me too much. I was just like, oh my gosh, please hurry up and dilate [chuckling] that's just it ... so I can get my epidural! ... So I knew if I just sucked it up for a little bit longer and got to one more centimeter then I would be okay.

Perhaps these were unspoken thoughts of anticipating progress and a positive outcome no matter how labour is experienced.

**Lack of confidence.** Nine of ten women portrayed a lack of confidence in determining labour status independently and often stated to the nurse, “I *think* I am in labour.” A multiparous woman, had “a sense that I knew what was happening” when she first came to hospital. This is in contrast to what transpired over the next day. While at home prior to returning to hospital, she felt like pushing; a sign of advanced labour. In hospital the cervix was still closed; her labour later augmented because of slow progress. A primiparous woman whose cervix was not dilated in hospital explained, “I think he [her spouse] thought it was false labour; that it was Braxton-Hicks, not, not real contractions.” She then added, “and maybe they were, I don't know.” However within two hours of being home her contractions changed in frequency and she told her spouse,

“I’m pretty sure we’re there.” She displayed some confidence that it was time to return to hospital. Another primiparous woman at home was *hopeful* that she was progressing in labour because of more pain and more frequent contractions. A woman who had had a previous caesarean section made two visits to the labour unit prior to admission and recalled wondering,

Was I losing my mucous plug ... I don’t have any cramping but I had spotting so how could there be a problem? If there was cramping and spotting together then I could have a problem. But I wasn’t putting two and two together. I didn’t want to overreact. ... I wanted to call first and ... [ask] ‘Should I be worried about this?’ ... your whole life goes on hold. You have no confidence ... just go home and keep an eye on it.

For these women, reliance on an external source of information guided their thinking as they were unsure of the physical signs they were experiencing at some point in their labour. In contrast, one multiparous woman who saw some blood was worried and went into hospital to be assessed. When asked how she knew it was time to return in labour, she responded that she *knew* it was time and she was admitted in active labour.

Nolan (as cited in Spiby et al., 2009) in a roundtable discussion questioned, “But what do women want? In fact, most of them want to come to hospital” as they have become used to being monitored closely in pregnancy and do not feel confident outside of the hospital setting (p.334). One woman reported not knowing how to ask questions. In reviewing her early labour experience, one primiparous woman thought that her independent extensive reading to determine whether she was in labour, was problematic. She spoke of the key to determine labour not as being contractions every five minutes

lasting 50 or 60 seconds, but having a broader focus on, “how your body feels and if there is any discharge or anything like that.”

Nolan (as cited in Spiby et al., 2009) explained that labour and birth are viewed as a hazardous undertaking because of exaggerated media examples and because government educational initiatives tell women how to care for themselves during pregnancy. The fact that women are educated about pregnancy and early labour, Nolan believed (as cited in Spiby et al., 2009) affected how the women perceived their confidence in labour: they were not assumed to know anything about pregnancy and so would not be expected to know when they are in active labour. Lowe (as cited in Cheyne et al., 2007) reported that a lack of confidence in coping abilities in labour is a predictor of labour pain. Women have learned that, “real knowledge about their ‘condition’ is medical/midwifery knowledge not their own instinctive womanly knowledge,” explained Nolan (as cited in Spiby et al., 2009, p.334). Low and Moffat (2006) explained that, women are expected to identify labor and arrive in a timely fashion at the birth setting but then have a confirmation of labor by professional staff. This creates a potential for discrepancy between the woman’s assessment and the healthcare providers’ diagnosis of her labor status (p.308).

Nolan and Smith (2010) reported about the confidence of women and stated, “Until women’s own faith in their ability to labour and give birth can be restored, women may feel obliged to stay at home in early labour, rather than feeling comfortable to do so” (p.286).

Unspoken thoughts contributed to experiences of early labour in diverse ways. For some women, unspoken thoughts were positive. The ability to trust someone or something as a source of information was described. For others, unspoken thoughts were

negative and contributed to anxiety expressed as feelings of inadequacy, fear, and confusion. Some women were unable to identify any thoughts experienced throughout the early labour experience as they were fatigued, had heightened body awareness, were coping with contractions, or had family obligations.

### **Experiences of Pain and Coping**

What transpired from the time the women left hospital until they returned and were admitted? While early labour was reported physically, mentally and emotionally for some women, experiences also included roles as mother.

**Role as mother.** For three multiparous women there was an immediate focus on resuming “normal” activities: pick up a child on the way home or prepare meals and children’s belongings to take with the children to a friend’s home. One mother explained that there was no time to talk with her husband about her labour because they have two active children at home; the youngest, a toddler. When it was time to return to hospital the children were present until admission was confirmed then the spouse took the children to a friend’s home. Another multiparous woman drove 30 minutes to hospital by herself the second time as she did not want to cause additional upheaval for her child and spouse; but suitcases for her and the child were packed and she was “geared up for anything”. She explained that late in pregnancy a woman is “like a walking, ticking little water bomb” and anything can happen at any time.

**Pain.** I acknowledge that there are many views of pain in labour which could be placed on a continuum. Experiences of pain and coping were described diversely by women in this research yet all women discussed pain as a focus of early labour while at home. Barnett et al. (2008), in a study of primiparous women sent home in early labour, reported a theme of coping and pain with different strategies utilized by women such as

varied positions and baths to alleviate the pain. Barnett et al. (2008) stated that all six women identified pain as the reason for returning to hospital. In the current research one primiparous woman felt contractions were so intense that she wanted to roll on the floor with the pain while still another woman preferred to slip away and be alone during a contraction; coming back to talk with her mother after the contraction ended. A woman in the study by Barnett et al. (2008) verbalized that there was “no way I can put up with this pain I was literally rolling about on the floor” while at home in early labour (p. 151).

The primiparous women spoke readily of the pain of labour early in the interview. One recalled how she was so focused on managing the pain that she thought of nothing else while at home. While the multiparous women also verbalized pain, they discussed pain and coping strategies later in the interview in a more casual way that required an element of probing. It seemed almost an unnecessary discussion, something taken for granted, this challenging part of becoming a mother. These women explained, “I was afraid about pain because I didn’t take any medication so it always, you know, it’s [pause] it’s always nothing nice...” When asked what she was thinking then her answer was, “how long it’s gonna take ... how many hours pain.” Another multiparous woman recalled what was going through her mind while at home. She stated,

I was in fear. Yeah, because, first time, we don’t know like what’s going to happen so this is my second one so I know [laughing] what’s gonna happen there.

So it was a little hard for me to cope and so [pause] but we have to, right?

What specifically caused this woman concern was the delivery time and the pain associated with it, she chuckled as she explained.

Two primiparous women described how labour quickly became more intense once at home. For another primiparous woman, back pain prohibited her from lying

down and she rested in a rocking chair as she had all night. Physical pain was experienced most often in the abdomen only, in the back and abdomen for one woman, only in the back for one primiparous woman while one woman described the labour pains as in the back and thighs. In addition to these physical discomforts one of the women had episodes of nausea and vomiting.

**Coping in early labour.** A number of strategies were used to cope with the discomforts of labour such as breathing, varied positions, lying down or taking a bath. Many of the primiparous women walked to speed up labour. Two multiparous women coped by lying down alone. One woman explained that her husband knew that she needed him to be close by but “when I have contraction the best way it’s not talking to me; do not touch me. I am ... not screaming, nothing like that but uh, I try to be, you know with, with myself, my pain...”

Six women reported performing typical activities, especially cleaning, as a diversion or as an activity to speed up labour. As much as the women wanted to sleep or had been advised to try to sleep, five women had contractions which continued to waken them and two women were up alone at night with contractions while their partners had been left to sleep for a time. One primiparous woman described,

I just stood in the bathroom for about 15 or 20 minutes and I put my hands on the sink and I was swaying my hips back and forth and forward and back and just sorta [pause] waiting and then I had one really bad contraction and I got down on my hands and knees and it was like, ‘Oh my goodness, that was the most painful thing I’ve ever felt!’ ... Then I was down on my knees again and halfway through the contraction my water broke and then it was like, I just started crying, ‘cause I

was excited and [pause] scared and in pain and alone. I didn't really know what to do and I kind of got myself together and started to breathe ...

Little information was located about what women do to encourage early labour to progress other than what is often advocated by health professionals: walk. One primiparous woman shared what she had done to help labour progress. Her comments began, "I don't know if I should tell you ... that day I drink a lot of brown sugar water. ... It's like a medicine push you fast, have the baby faster. ... we saw on the internet." She continued and chuckled when she recalled blaming her husband for giving her so much brown sugar water causing a lot of pain but not dilating the cervix.

Barnett et al. (2008) found that the information received from hospital was viewed as inadequate to assist with coping. Although this was not confirmed in the current research, the woman with significant back pain did not verbalize any specific techniques used to relieve her back pain. It is possible that no information was offered or demonstrated.

**Thoughts and emotions.** In addition to physical sensations, thoughts and emotions about labour occupied much of the time for the women. One primiparous woman described, "It was just a really surreal experience 'cause nothing prepares you for pregnancy and labour and the feelings that you experience when you're in labour...my feelings were just kind of all over the place."

After being at home for three days with no news to share, one woman became frustrated with people who were calling for a labour status update.

They kept asking us like, how far, how I was ... if things had progressed ... it was kind of brutal just asking constantly and constantly, 'What's going on?...'

They're excited, we're excited but then it just got to being like, a[n] uncomfortable anxiety.

The woman explained that she wanted to feel excited and joyful for herself and for her husband but instead she “just kept feeling that letdown from myself.” When labour became more evident for this woman, she did not want to go to hospital because she did not want to be sent home again.

One primiparous woman was concerned that the nurses would be angry when she first arrived as her contractions were further apart than five minutes in frequency. Two multiparous women explained that they did not want to be seen as an annoyance to the hospital staff by returning to the labour unit and then being sent home again. One was concerned with how she would be perceived; the other was divided in thinking about the needs of the hospital unit and staff and her own need to know if she should be admitted in labour. One woman shared, “I didn't want to overreact – I hate to be that person who's showing my face you know, in the um, labour and delivery department and they say like, ‘Hi \_\_\_\_\_. You're back!’” Beebe and Humphreys (2006) reported that for women who had had a labour assessment and were sent home, “the thought of repeating that pattern was even more distressing,” (p.351). One woman discussed her internal struggle.

You are not the only pregnant woman but you ... put your blinders up and you, you think you are the only one going through it.... You know being sent away – frustrating yes, but [pause] what are they going to do for me? I mean, are they going to keep me in all night? ... There are so many different ways of looking at it, I suppose ... I have to kind of understand where they are coming from and that there could be an emergency walking in the door and that bed is free. ... I'm going to go home ... have a shower, ... go to bed and I'm going to wake up and

feel good [pause] but now I have spotting.

**Return to hospital.** Returning to hospital had its challenges as the women felt more tired and uncomfortable than when they had left the hospital and now had to endure the ride back to hospital. Two women had difficulty walking with contractions. The elevator posed a challenge for another woman. She was concerned that the elevator would pass the floor where she needed to get off if she remained inside. With some difficulty she managed to leave the elevator during a contraction.

Experiences at home were varied with some similarities. All women felt physical discomfort and coped using different techniques. Multiparous women had the added burden of caring for and arranging care for their children. Fear, frustration, and attempts to balance personal needs of care and support with the needs of the hospital staff and others were concerns for women in this research project.

**Powerful words.** Words are powerful. They serve to propel, maintain status quo, or change an outlook or feelings. In this research words were used by four women in the form of self-talk; positive phrases on which to focus and assist in coping with early labour and to prevent fear from taking over. Three others formulated a plan that involved interface with a healthcare professional in the labour unit or at the office appointment.

The multiparous woman who had had two pregnancy losses described how she coped with the pain of labour, “I said to myself, *this one, you will make it*. So just like, like this: *healthy* and [pause] ... *I have to do it. Everything will be okay.*” A woman who had experienced seven days at home prior to admission to hospital in labour explained her plan emphatically, “I’m just gonna wait until they’re five minutes apart each. I’m gonna wait until they last *at least* 60 seconds. I’m gonna wait until they are really, really excruciatingly painful because that’s what they told me to do.” She was determined not

to return to hospital too early and be sent back home again. Once she was found to be in active labour her self-talk immediately was refocused to become a positive driving force to propel her forward in labour. She enthusiastically stated: “So my body can do this! So I can do this!”

While experiencing labour that had intensified a primiparous woman chose not to be overwhelmed. She exhorted herself: “Hold yourself together!” Another primiparous woman had a goal to remain at home for 12 hours. While driving home from hospital another primiparous woman and her husband discussed what they would do as she was one day past her due date and in early labour. They decided upon a plan: If labour did not progress by morning, she would go to her prenatal appointment and ask the physician to induce her two days earlier than had been previously discussed. When contractions intensified they changed their plans. They would return to hospital and tell the nurse that there is so much pain that they do not want to go home; they want the woman to stay in hospital.

Another woman had contractions which increased. She knew it was time to return to hospital and explained,

I had a plan on telling them to induce me [exuberant laughter] to get this show on the road because I could not handle not sleeping and not, you know, for 48 hours if that’s what it was going to be ... just the pain that I was in for, for that much longer. So, I had planned on asking them to induce me.

When asked if she was worried that she might be sent home again she replied,

But I was quite determined that I was going to demand to be induced....and I don’t know, they probably have a policy of not doing that, I don’t know. I don’t

know what the case was but I had in my mind that that was the plan and I was okay with that. So that gave me some comfort.

This also allowed an element of control in an otherwise uncontrollable situation – being admitted in labour.

In considering when to return to hospital four women wondered if they would be admitted or be sent home again. The primiparous women verbalized: “I hope they let us stay,” and “Can’t be arguing with something that, you know, you don’t have control over ... Hopefully they won’t send me home.” One multiparous woman expressed these thoughts, “Maybe they gonna send me back again ... because two times I went back, so maybe this time again. Sometimes it’s a false labour, right? ... So I said ... what is it going to be, true or false?” Another multiparous woman verbalized that whether she was able to stay in hospital or had to go home it would be fine.

The presence and use of powerful words, a means of coping, was not replicated in other research which focused on women in early labour. This is not surprising. The 2009 World Health Organization (WHO) publication, “Mental Health Aspects of Women's Reproductive Health: A Global Review of the Literature” reported, “the study of women’s bodies and reproductive events has generally been rigidly separated from the study of their minds including how women might think, feel and respond to these events and experiences” (ch. 1, p.2). However, self-talk remains a current discussion and application in the realm of psychology and sports psychology.

### **Influence of others**

A systems view of labour and birth where women do not labour, “in a vacuum,” is an important acknowledgement as the influence of support, either psychosocial or physical, contributes to the women’s experiences of early labour. Barnett et al. (2008)

reported similar themes as reassurance from hospital professionals and influence of others, from their research of women sent home in early labour. The women in the current research all had a partner present and two had extended family living in the same home. Two women did not have family members on whom they could rely because of geographical distance. Two women did not refer to anyone for support aside from the partner.

Janssen (as cited in Spiby et al., 2009) compared the historical traditions of labour where experienced women would provide support and care to women in labour with findings of the recent ELASH trial where the male partner took over the supportive role. Janssen (as cited in Spiby et al., 2009) explained that the male was expected to, “keep his partner comfortable, relaxed, hydrated, rested, reassured, and to diagnose her progression to active phase labor accurately so as to avoid the stigma of coming ‘too early’ to hospital” (pp.332-333).

**Negative impact of others.** While people gave support to women in early labour on different levels, people also contributed to stress. Nolan (as cited in Spiby et al., 2009) described women in early labour at home surrounded by people who are also anxious and who believe that women belong in hospital to be safe. The primiparous woman who was urged, “You have to go. It’s dangerous...,” experienced anxiety which influenced her decision to go to hospital earlier than she had planned. Other family members were upset when this woman was sent home in early labour; they were unfamiliar with routine hospital practices. For the woman who was at home for a week before being admitted in labour, people who called to find out about her progress were seen as contributing to her anxiety. One woman had contractions at home for three hours while her husband slept – he was unsure that they should return to hospital so soon.

**Positive impact of others.** Friends and family were viewed positively by all the women interviewed. They provided childcare day or night for multiparous women who returned to hospital or called and texted to ask how labour was progressing. A family member who had had a long labour was seen as strategically supportive to one woman. The woman in early labour explained,

I kind of was able to talk to her and not, not feel like she was going to pressure us into, 'Ok, what's going on? Tell us what's going on.' She ... [said] 'let me know if anything happens, if you need anything;' just there for me so that's why I kept talking to her.

Three husbands returned to work for a number of hours or days during early labour and telephoned to talk with their partner. Four other husbands walked sometimes for hours with the woman in early labour throughout the day or night. Family wakened at night to help out; stayed up late while women laboured at home; drove the woman and partner to hospital; drove to the home at any hour of the day to cook and bring food or provided a place closer to the hospital for the woman and partner while in early labour. One woman told how after labouring since early in the morning, after almost 24 hours her partner would record each contraction then drop off to sleep and waken quickly with the next contraction. Another woman said of her husband,

He's doing all that he can to help with everything around the house and keeping me comfortable and um, I mean he's got to go to work ... He tries to be on the up and up ... he said [pause] ... 'for tomorrow you just take it easy and ... don't worry about dinner we'll go out or I'll bring something home' or ... 'don't worry about the laundry' ... he's trying to you, you know, cover up all little things that I could be doing at home that would be attributing to my discomfort ... Definitely

trying to make a, a *not* nice situation better ... I think it's hard for your spouse too, being away from you like that and [pause] not knowing how to help you and not knowing how to make it all better.

**Choosing to return.** Eight women made the choice to return to hospital independently. A spouse at work, while talking with his wife on the telephone, heard her during a contraction. He decided that they would return to hospital based on her response to labour while she had planned to stay home to avoid the stigma of going to hospital too early a second time. She explained that she was glad she listened to her husband as she was in active labour when she returned to hospital. Another spouse decided that if labour continued to intensify, the woman would need an ambulance to go to hospital because of difficulty she had developed in walking. He proposed that they return sooner and the woman agreed. Her brother was also needed to assist en route to the hospital labour unit. "And he stayed for a bit just to help my husband out 'cause I was vomiting a lot and when I was contracting I needed, like, someone to hold and someone else to hold the bucket," she recalled while laughing. "So, yeah, it was a lot of help."

### **Messages from Women**

In concluding the interviews, nine women responded to a prompt and verbalized specific messages to help others learn of their experience being in early labour and sent home following hospital assessment. Some women chose to direct the message to healthcare staff while other women directed their messages to women in early labour.

A woman commented on the environment. She felt that it was not busy in the waiting area and wondered why she had to wait more than five minutes to be assessed. A primiparous woman expressed that it was helpful that the nurses did not rush her and allowed her to make her own decision regarding walking and going home.

Other women talked about relationships with healthcare providers and of needing more information. Another woman affirmed that communication added anxiety to her early labour experience as the messages she received about her status in early labour were contradictory. She also believed that educating woman about the criteria for admission based on contractions every five minutes lasting 50-60 seconds should not be the key focus; this was not her experience. Instead include, “how your body feels,” and other symptoms, she explained. One woman expressed that as she felt like she was, “the only pregnant woman in the world,” she would have liked more time in discussion so that she could better understand what was happening both during office appointments and labour assessments. A woman stated that the nurses took good care of her.

Other women reported that the written information sheet was helpful and that healthcare providers were welcoming and trustworthy. A multiparous woman explained that the information sheet which she received was beneficial as was the way in which the information was presented and how she and her husband were addressed. They felt that they would be welcome to call or return to the labour unit. A multiparous woman suggested that women follow the information they are given at the hospital because the professional staff can be trusted.

A primiparous woman offered advice for other women. She felt that if a woman does not live too far from hospital that it is a good opportunity to take advantage of being at home where time passes quicker; to make the most of the time at home and sleep or do whatever promotes relaxation.

**Humour.** Something noted in each of the interviews was humour. No matter how difficult the experience was at times for the women in early labour sent home following hospital assessment, there was a positive attitude which surfaced often as

humour with chuckling and laughing as women retold their experiences. The most laughter came from the woman who planned on demanding an induction of labour in spite of what the hospital policies may have been. The lighthearted attitudes may have been due to the effects of hormone levels still higher than prepregnant levels when the interviews were conducted – most within 24 hours after birth. Another reason could be that women felt unused to sharing so deeply about their experiences and in effect had a “nervous giggle.” Women who looked back upon the experience of early labour having “made it” through labour and birth may have felt a little embarrassed for what they had thought, felt, said or done. Limited literature addressed the topic of women in early labour who were sent home after hospital assessment and no research was located which commented on humour as an aspect of interviews; of retelling an experience.

### **Discussion**

Salient concepts which crossed the five themes will be discussed in more detail and will be compared with current literature. These concepts are anxiety and fear, low self-efficacy, support, and culture and background influences. Following this, a phenomenological essence of the experience of being sent home following hospital assessment will be explicated as an “uncomfortable anxiety.” How this “uncomfortable anxiety” impacts women to empower or disempower them will be presented.

**Anxiety and fear.** These concepts, which include other descriptors such as stress and worry, are described as psychological or mental discomfort. They are sometimes discrete; sometimes present together; and at times anxiety can progress to fear. How they are experienced can vary from person to person depending upon contributing factors. It is important that the unknown aspects of early labour which could

lead to anxiety or fear are explored with women. Research of fear and anxiety for women in labour is reviewed here to ground the findings of women in early labour.

Alehagen, Wijma, Lundberg, Melin, and Wijma (2001) studied 50 primiparous women in labour with respect to the stress hormones: adrenaline, noradrenaline and cortisol. Alehagen et al. (2001) found that when 30 women received epidurals for pain management, levels of adrenaline and noradrenaline decreased yet the levels of cortisol did not decrease. The explanation may be “that even if women experience less or no pain, they can still label the situation as unpleasant, can feel helpless, and can experience loss of control,” reported Alehagen et al. (2001, p.62). When the data for the hormone level changes for all 50 women were correlated, Alehagen et al. (2001) concluded that mental stress is more dominant than physical stress in labour.

Pirdel and Pirdel (2009) studied 300 multiparous women and 300 primiparous women to determine implications of perceived environmental stressors on pain perception in labour. Labour stress as defined by Pirdel and Pirdel (2009) is “the level of psychological stress, representing a combination of fear and pain, which is experienced by women during labor” (pp.218-219). Excessive stress has been correlated to longer labours because of suppression of oxytocin levels. Pirdel and Pirdel (2009) reported that women have experienced their labour stopping when they have entered “unfamiliar surroundings and crowded wards of a hospital” (p.218). Melender (as cited in Wong et al. 2006) stated that,

Major fears and concerns relate to the process and effects of childbirth, maternal and fetal well-being, and the attitude and actions of the healthcare staff.

Unresolved fears increase a woman’s stress and can inhibit the process of labor as

a result of the inhibiting effects of catecholamines associated with the stress response on uterine contractions. (p.496)

Pirdel and Pirdel (2009) explained that “psychological factors may increase perceived pain during labor. Many of these factors are attributes of the laboring women, and others are components of their relationships with others and the environment” (p.222). As an example of environmental impact, Pirdel and Pirdel (2009) stated that for multiparous women the most commonly reported stressor was noise. Odent (as cited in Pirdel & Pirdel, 2009) linked exposure to unpleasant noise with stimulation of the brain and a release of Beta-endorphins that can reduce the oxytocin levels and as a result, slow labour. At times, noise in a labour and birth unit cannot be controlled; nor can personal attributes of women in labour be controlled. Based on the writing of Pirdel and Pirdel (2009), it would follow that the quality of relationships with healthcare providers would be even more important at those times to support women in labour.

Women in the current study reported aspects of anxiety universally when in early labour. Anxiety was experienced when women considered going to hospital: for one woman when bleeding occurred early in labour following prior pregnancy losses; when contractions began before the date scheduled for a repeat caesarean section for another woman; when early labour was experienced as slower to begin when compared with prior labours; and when women did not stay in hospital. At home, anxiety was evident for some women when early labour was long and fatiguing; when there was a discrepancy between plans for birth verbalized by two physicians; when waiting for days for labour to start; when pain started and information was lacking (was it caused by fibroids? was it labour? was it because of the brown sugar water?); when information was discrepant and

trust was threatened; when women did not know what to do or how to cope at home; and when return to hospital was discussed or debated. Anxiety in early labour was pervasive.

Fear has a significant impact on some women with respect to labour and birth. Eriksson, Westman, and Hamberg (2005), studied 419 women who had had a healthy baby and found that 23% of the women reported “intense fear” related to childbirth (p.68). Eriksson et al. defined four factors which contributed to this fear as follows: “exposedness and inferiority”, “communicative difficulties”, “norms of harmony”, and “insecurity and danger” (p.68). Women who described feeling exposed and inferior compared themselves with women who were not fearful and their level of confidence or self-efficacy then became lower, Eriksson et al. (2005) reported. Communicative difficulties revolved around women feeling that they could not speak about their fears and this was further complicated for 11% of the women with intense fears: these women believed that acknowledging their fear would exacerbate the fear, stated Eriksson et al. (2005). Although not highlighted by the authors, 77% of women assessed as having intense fear and 72% of women assessed as having mild to moderate fear felt that they had to talk about their fears (Eriksson, et al., 2005, p.67). Norms of harmony, where women feel obligated to be positive and ignore fears, and the present medicalized maternity care with a focus on potential dangers of pregnancy and birth, as opposed to birth as a natural process, increase fear for pregnant women as reported by Eriksson et al. (2005). One suggestion by Eriksson et al. (2005) for women with intense fear of childbirth and who may be afraid of more fear or anxiety is that communication needs to be handled with sensitivity and care. Eriksson et al. (2005) suggested further research “to develop approaches that might identify and reduce fear without ‘talking’, or to find ways to talk and communicate about the fear that minimizes negative implications and create

calmness and confidence” and linked this with the need for more support during pregnancy (p.70).

In the current research, fear was a common concept. It was reported by women in early labour when they considered going to hospital: one woman was afraid of repercussions by the nursing staff if she went to hospital with contractions less than five minutes in frequency. This fear was magnified when a family member, born outside of Canada, told her the baby could die if she did not go to hospital then. Fear of unknown hours of labour pain and being “terrified” of what to expect going home; fear for the health of the unborn baby because of prior losses; fear of not being able to progress in labour as a mother had experienced; fear of the pain of birth for two multiparous women; fear when in pain and alone and the water broke; and fear of being too fatigued to cope in labour were verbalized by the women. One woman also reported that first time mothers were not afraid when in hospital in China because of the trusting relationship they have with the doctors. This implied that she was afraid when she was at home, in early labour, in Canada. In order to support women, Melender (as cited in Hall, Stoll, Hutton , & Brown, 2012) suggested that “caregivers ask women about their fears, provide opportunities to discuss them, and pay special attention to primiparas and multiparas reporting negative experiences of earlier pregnancies and births” (p.7).

**Low self-efficacy.** Women in the current research demonstrated elements of both high and low self-efficacy. Lack of confidence or low self-efficacy with respect to the labour process was discussed in the themes, Conflict Between Knowledge of Labour Symptoms and Women’s Initial Responses; and Impact of the Unspoken; along with academic literature about confidence or self-efficacy from numerous researchers.

The concepts of anxiety and fear for multiparous women, based on prior experience in labour and birth, have been studied by numerous authors with links to feelings of lack of control and being disrespected, reported Elmir, Schmied, Wilkes, and Jackson (2010). Ford, Ayers and Wright (2009), conducted a study to determine how best to measure the “maternal perceptions of control and support in birth” as “high control and support during labor are associated with improved birth outcomes and increased maternal satisfaction with the birth experience” (p.245). Ford et al. (2009) reported that “the environment in which women gave birth was a factor in determining control, with home being a place of more control and hospital resulting in less control” (p.247). Feeling supported by hospital staff and feeling more in control in labour were correlated for these women, Ford et al. (2009) found.

In the current research, low self-efficacy was typified by women when physical symptoms were noted and a decision had to be made regarding when to go to hospital. Primiparous women gave more evidence of low self-efficacy. Some commented that it would be easier next time – the woman would be more confident after labour had been experienced once. Other indicators of low self-efficacy from women in this research are reviewed here: feeling that her body is incompetent or not working; wondering what would happen based on belief that her body was not working; not understanding physical signs as compared to “textbook labour” and needing external feedback; looking back and wondering if it still was Braxton-Hicks contractions or really labour; and wondering if the woman would be sent home a second time from hospital. Several women used the words “confidence” in the interviews. A primiparous woman felt she knew nothing and had no confidence based on the healthcare system in Canada where women stay home

from hospital in early labour. A multiparous woman expressed not having confidence, not knowing what was happening within her body.

**Support.** Goberna-Tricas, Banús-Giménez, Palacio-Tauste , and Linares-Sancho (2011) found that relationships between women and care providers were one of three significant factors in a study of satisfaction with pregnancy and birth services in Spain. The other two factors were safety as evidenced by technology and technical expertise, and structural aspects of care such as the hospital environment, shift work with changeover of nursing staff, and one-to-one care in labour. Larkin, Begley, and Devane (2012) conducted research following the birth experience of 25 women in Ireland. Many women had “felt anxious, lonely and unsupported prior to the professional judgement that they were in labour,” reported Larkin et al. (2012, p.103). Hodnett et al. (2002) studied 7000 women in North America who either had a nurse with them one-to-one throughout 80% of their labour or usual nursing care and support. When women were asked which model of care they would prefer for a subsequent labour and birth, the majority of women in both groups indicated one-to-one care by a nurse, reported Hodnett et al. (2002).

In another study by Hodnett et al. (2008), 5000 women in early labour were assigned either to structured care or usual nursing care in twenty hospitals throughout North America and the U.K. Nurses who provided structured care remained one-to-one with a woman in early labour for a minimum of one hour and up to four hours. During this time, a thorough assessment of the woman to determine fetal position, indicators of pain, and emotional status was followed by education and demonstration of techniques such as position changes, visualization and behavioural adaptation to manage labour, reported Hodnett et al. (2008). Of those women who had had a minimum of one hour with a nurse in structured care, only 11.3% of women were unhappy with the amount of

attention they received (Hodnett et al., 2008). However, for women who received the usual nursing care where one nurse is responsible for several women, 19.7% of the women were dissatisfied with the amount of attention they received (Hodnett et al., 2008). Of all outcomes assessed in this study, only women's views of their nursing care yielded statistical significance and as a result, a consideration for hospitals is to incorporate aspects of structured care into routine practice, Hodnett et al. reported (2008). Utilizing structured care for women in early labour gives "the advantage of mirroring the real world of practice, in which assessments and interventions are tailored to individual needs," Hodnett et al., (2008) stated.

**Communication.** On the topic of support during the birth experience, seven themes associated with improved birth outcomes and increased maternal satisfaction were noted by Ford et al. (2009) as follows: "coaching and coping techniques, staff attitude, empathy and understanding, reassurance and encouragement, listening, informational support, and support with pain relief" (p.249). Communication is foundational to at least six of the seven themes.

Goberna-Tricas et al. (2011), reported that there was a clear demand for a more personal approach ... to be not only technically skilled but also capable of respecting their autonomy and values as women, in order to foster the trust and empathy that are seen as essential features of an effective therapeutic relationship. The women in this study wanted professionals to show a caring attitude and empathy. (p.e234)

**Culture and background influences.** The influences of culture and background such as prior pregnancy losses and birth experiences were found to be prominent within the current research. Six of ten women were born outside of Canada and represented

diverse backgrounds, languages spoken, perspectives and values. Two women spontaneously spoke of prior losses. Much of the knowledge learned from these women is novel. For example, no research articles about early labour referred to women who travelled in their pregnancy and received care from a physician in another country, specifically the woman's country of origin. However, it is not uncommon for pregnant women in the research site to travel out of the country for several months and receive prenatal care on two continents. There was also, significant influence from women and family members who compared current practice in Canada with what was known from another culture, and possibly another time. Larkin et al. (2012) acknowledged that, "Women who had experienced care in other countries were more critical, indicating that the shortage of staff in Ireland was unacceptable" (p.102). Expectations of labour and birth, healthcare, and healthcare providers may be different for women and their extended families who immigrated to Canada. It is important to support women in early labour by communicating with cultural sensitivity and being open minded to their needs, unspoken questions and concerns.

As noted earlier in this discussion section, researchers have reported indicators of satisfaction for women in labour. Some of these summarized here include the desire for physical presence by a nurse through most of labour; a quality relationship with the caregiver including an attitude of caring and empathy; acknowledgment of fear related to labour and birth; opportunities to communicate concerns and fears; use of coaching and coping techniques; reassurance and encouragement; listening; information; and support with pain relief. What is common to these indicators is communication between the healthcare provider and the woman. Communication is the venue from which flows support to the woman and to her chosen "support persons" for the experience of labour

and birth. Greulich and Tarrant (2007) stated that it is a challenge to help women navigate through early labour. Gross, Haunschild, Stoexen, Methner and Guenter (2003) reported, "If a woman says, 'my labor lasted 4 days...' this is likely to mean that she was mostly without caregiver support at a time when she needed it" (p.270).

**An "Uncomfortable Anxiety."** Analysis of the interview data, themes and concepts led to an overall interpretation of the phenomenon as an "uncomfortable anxiety." This was a phrase used by one of the women as she described what it was like to wait at home for active labour while people called to ask for an update. Throughout the experience of being in early labour from the decision to go to hospital, hearing the early labour diagnosis, going home, coping with pain, deciding to return to hospital, and finally being admitted, the women endured a unique "uncomfortable anxiety." Learning about the experiences from the women in this research in combination with academic literature supported denoting this phenomenological essence as an uncomfortable anxiety.

The words resonate well with the experience of early labour. Background influences such as prior losses, labour and birth experiences, culture of origin, personal attributes, and attitudes to labour and birth from a wellness or illness model; and current impact such as fatigue, sources of information, positive GBS status and available support, and level of trust in healthcare providers added layers to the uncomfortable anxiety of women in early labour. These were most often experienced as anxiety and fear, low self-efficacy, lack of required support and influence of culture. Anxiety can be both a positive and a negative tension which motivates or overwhelms depending upon the situation and other influencing factors. The result can be empowerment or disempowerment.

**Psychosocial concepts of disempowerment and empowerment.** In the current research empowerment is defined as having a sense of increased ability to choose, increased power, or increased control. Disempowerment is defined as having a sense of reduced ability to choose, reduced power, or reduced control. Through an examination of the themes and cross-cutting concepts of anxiety and fear, low self-efficacy, support, and culture and background influences each woman in the current research was found to be disempowered by the experience of being in early labour and sent home following hospital assessment.

Summarized from the research of Hodnett et al. (2002), feeling disempowered as evidenced by anxiety and fear, and lower self-efficacy can in turn lead to exacerbated feelings of the same. It can contribute to: slow progress in labour; greater level of pain perceived; erosion of trust in relationships with caregivers; and feelings of loss of control and overall dissatisfaction with labour and birth. Disempowerment may also negatively affect the support persons and the relationship with the healthcare providers. Following the birth, disempowerment can contribute to psychological poor health such as anxiety disorder, birth trauma, or post-traumatic stress disorder.

Chamberlin (1997) explicated empowerment as a “complex, multidimensional concept, and that it described a process rather than an event” (p.44). Chamberlin (1997) reported that an individual would be considered empowered if that person displayed some of 15 specific qualities. From that list several qualities are as presented here:

1. Having decision-making power;
2. Having access to information and resources;
3. Having a range of options from which to make choices (not just yes/no, either/or);

4. Assertiveness; and

5. A feeling that the individual can make a difference (being hopeful). (p.44)

Empowerment as a process leads to change according to Chamberlin (1997): “As a person becomes more empowered, he or she begins to feel more confident and capable. This, in turn, leads to increased ability to manage one’s life, resulting in a still more improved self-image” (p.46). Lindgren and Erlandsson (2010), in a study of women who chose to give birth at home concluded that these women “find empowering sources within themselves, from their environment, and from active and passive support by the persons they have chosen to be present at the birth” (p.316). The significance of this statement to the current research is not the context of giving birth at home but is the source of empowerment – from within, from the environment, and from others. Larkin et al. (2012) maintained that, “Withholding or giving information could contribute to an empowering or disempowering birth experience. Relationships with professionals had a pivotal influence on women’s experiences of control ...Communication and information-giving to women needs to be addressed, and more support given, particularly in the latent and early stages of labour” (p. 103). Larkin et al. (2012) acknowledged the women’s sense that the goal of labour and birth for health professionals was, “having a live healthy baby”; the women’s experience of labour and birth was considered secondary (p.103). In the Cochrane Review which focused on continuous support in labour, Hodnett, Gates, Hofmeyr, Sakala, and Weston (2011) maintained that, “Every effort should be made to ensure that women’s birth environments are empowering, non-stressful, afford privacy, communicate respect and are not characterized by routine interventions that add risk without clear benefit” (p.14).

## Summary

In this chapter, interview data analyzed through methods promoted by Thorne et al (1997): iterative processes outlined by writings of Giorgi (2006; 2012), were presented. Themes were discussed in sequential order where possible from time of arrival on the unit, through the experience at home, and in preparation to return to hospital. Five themes of the experiences of early labour were supported with diverse examples. Themes often overlapped and were woven throughout the experiences of women in early labour. Cross-cutting concepts contributed to empowerment or disempowerment of women and were discussed along with the overarching impression of an “uncomfortable anxiety.” The findings were situated in literature which served to foster a deeper understanding of the research topic.

A concluding review of the literature (see Appendix C) was performed to ensure the research data were presented in comparison with current published research and reports. Numerous research articles, commentaries, and websites were located as sources of information on labour and early labour. One study by Barnett et al. (2008) had a focus on women sent home in early labour and reported a theme of undervaluing of the latent phase. Some themes generated from the analysis were unique in that no data on the topic was located in the current literature. In the next chapter limitations of the research, recommendations for practice and concluding remarks will be presented.

## **Chapter Five: Limitations, Recommendations and Conclusions**

This final chapter begins with an acknowledgment of the limitations of this research as it was designed, conducted and analyzed. Recommendations follow which may be considered by hospitals for policies, education and nurses caring for women in early labour. Concluding remarks will summarize this research. The purpose of this research was to generate new knowledge about women's experiences to determine: How women describe their experiences, including psychosocial aspects, of being sent home in early labour following assessment in hospital; and, what recommendations can be formulated for nurses when assessing women in hospital. From the results of this research it is assumed that knowledge about the experiences of women sent home following assessment in early labour can be described and interpreted within one hospital site in Canada.

### **Limitations**

Limitations of this research are discussed here. The first limitation relates to my position as researcher as I understand the influence of researcher on participant. I acknowledged my personal beliefs of labour and birth as a natural experience, of the importance of comfortable labour environments and of family influences, prior to data collection and throughout data collection and analysis. I attempted to distance myself as researcher from roles of nurse, educator, and mother to minimize the effect of researcher on participant. This distancing was important to enable an understanding of the perspectives of the women who had different labour experiences or who held different meanings of experiences of labour and birth. Being born and raised in Canada I do not have the capacity to determine all that is significant to other women from diverse backgrounds and I may have inadvertently overlooked some meaning to data that was

shared in interviews. However, presenting data from diverse cultures represented in this research is a beginning expression of the meaning of the phenomenon to others beyond my own sphere.

Sampling was limited due to time constraints of this educational research so that convenience sampling was utilized. Once a woman met criteria she was approached with the intent to include her in the research should she give consent. Purposive sampling may have yielded more rich or broad findings. Being a novice researcher, hindsight demonstrated that not all participants were able to effortlessly identify and articulate their experience, however, each woman wanted to tell her story. Thorne and colleagues (1997) explained, it may be difficult for a researcher to, “untangle the shared component of a subjective experience from the narratives that people place them in,” meaning that people may approach life with a positive outlook and others with dissimilar outlooks which could infuse a different meaning to the data (p.174): I recognize this as a possible limitation. Because one of the spouses was present and freely gave input to the interview, perhaps the woman was influenced in her choices or depth of responses; for better or worse.

From demographic information gathered, each woman in the study identified a spouse or partner living with her. Single women and those with no family supports did not participate in the research, although invited. Similarly the educational backgrounds of the participants were fairly homogenous: all women had completed a minimum of high school and all but one had postsecondary education. Cultures were not represented in large numbers within this research. Women were not asked about first language spoken therefore possible cultural influences could be overlooked.

This research was contextual with the setting one hospital site. By restructuring the research to include other hospital sites, findings may be verified or enriched. Including women giving birth in rural hospitals, at teaching facilities and across other provinces of Canada, may broaden the findings of the research phenomenon enhancing research trustworthiness. One difference in care at the research site compared with current published literature is that women are welcome to call or come to the labour unit for assessment of pregnancy concerns without calling in advance; day or night. Some health services reported in literature required women to be granted permission for a labour assessment on-site, often by a midwife. This may have resulted in findings dissimilar to the findings of the current research.

Structuring the research to include data collection over a longer time frame would enable a return visit later in the postpartum period to select participants. The purpose would be a critical review of beginning conceptualizations from across the sample which may promote rigor by building confidence in the findings, as reported by Thorne et al. (1997).

The data presented were the opinions expressed by the women in this research. No verification of the information from health professionals or from patient charts occurred. Experiences may have been omitted during the interview or highlighted or exaggerated due to the effect or significance perceived by the woman. Broad generalizations cannot be made: all women in early labour sent home following hospital assessment may not have experiences which incorporate all the findings explicated within this research.

Another limitation of this research is that there was no screening nor were there direct questions about prior pregnancy loss, prior traumatic birth experience or prior

mental health concerns such as anxiety, depression or post-traumatic stress disorder.

Two women acknowledged a prior pregnancy loss and one woman elaborated upon her experience but it is unknown how many other women may have been impacted by prior pregnancy losses. While none of the women exhibited symptoms of concern during the interviews it is possible that a prior pregnancy loss, prior traumatic experience or history of mental health concern may have affected the current experience of being in early labour and sent home following hospital assessment.

### **Recommendations**

It is acknowledged that nurses want to provide the best care for women in labour and therefore current research is required. This research was a small-scale qualitative study in the context of one hospital setting; recommendations are supported by literature where possible. It is not assumed that each recommendation will be applicable to every hospital setting. Recommendations are listed for consideration to enhance the experience by empowering women in early labour sent home following hospital assessment. These are grouped by cross-cutting concepts of anxiety and fear, low self-efficacy, and support which includes communication, culture, and background influences. Although all women in this research had partners with them in labour, the focus was on the experience of women; recommendations will refer to women. Some recommendations support more than one concept but are reported here once. For ease of reading the recommendations are in bullet format.

Recommendations for consideration based on the concept anxiety and fear are described as follows:

1. When pain, needs, and desires are assessed, nurses may describe and demonstrate interventions to decrease physical discomfort including back pain to empower women and decrease anxiety and fear. This is supported by the research of

Barnett et al. (2008) and Greulich and Tarrant (2009). A written handout with explanations and diagrams of techniques for coping with labour and contact information can be given to the woman leaving the assessment area. This is supported by Nolan (2011).

2. The influence of fatigue can be assessed and acknowledged by nurses as a concern which relates to pain and anxiety and fear for most women in early labour. Explanation can include information that for many women with higher levels of fatigue a decrease in fatigue is noted with onset of second stage. This is supported by Tzeng et al. (2008).
3. Hospitals may gather data to determine numbers of women who received inadequate antibiotic prophylaxis in labour for known GBS positive status and who had presented in early labour and were sent home. Hospitals may develop policies for caring for women with positive GBS status who present in early labour to minimize maternal anxiety while maximizing opportunity for adequate antibiotic prophylaxis in labour.

Recommendations for consideration based on the concept low self-efficacy are described as follows:

1. Hospitals may develop policies to offer women open contact with the hospital labour unit or assessment area to minimize anxiety and build confidence in women who present to the unit because of physical symptoms or concerns. This is supported by Low and Moffat (2006) and Nolan and Smith (2010).
2. Hospitals may develop policies to enable women in early labour to be attended by a nurse for a minimum of one hour. The purpose would be to establish rapport and assess women based on individual concerns or needs. This longer time frame would enhance support and empower the women as reported by Hodnett et al. (2008).

Recommendations for consideration based on the concept support, which includes communication, are described as follows:

1. Clinically, nurses may determine to understand each woman by being open-minded and engaged, offer kind and respectful individualized care, and not treat women according to cultural or group stereotypes, as reported by Redshaw and Heikkela (2010) and Carlsson, Ziegert, Sahlberg-Blom and Nissen (2012).
2. Education for nurses can include information about experiences of women in early labour sent home from hospital; and strategies for assessment and intervention of maternal “psychological state, pain, and positioning” as reported in the study by Hodnett et al. (2008, p.621). Communication techniques can be educated to enhance nursing perception of unspoken concerns; “powerful words”;

and to have crucial conversations to determine the impact on the woman, her needs or wants. Using questions and prompts such as “What are you thinking?” or “What are you feeling now?” may address factors hidden behind more prominent concepts such as pain and status in labour. Utilizing positive affirmation which may include acknowledging the silent support which women receive from being present in hospital; using open-ended questions which promote listening; and providing responses which do not cause the woman to “shut down” or minimize her contractions, for example, are beneficial techniques. Carlsson et al. (2009) reported that women coped “better with the uncertainty and pain, when they were properly informed and their feelings were confirmed by the midwives” (p.179).

3. Setting a time when women call back to the unit for follow up, in six hours for example, may assist women to feel that they are not without support. This is supported by the research of Ness, Goldberg, and Berghella (as cited in Greulich & Tarrant, 2009). This may decrease need for hospital resources. By initiating communication, women who otherwise may have felt that contacting hospital staff is intrusive or bothersome may feel more support and be willing to call.
4. Nurses can recognize the influence of anxious family members on women going to hospital and can ask women about support persons and include them in conversations and explanations as women want a support person with them in early labour at home and in hospital. This is supported by Barnett et al. (2008) who explained that anxious partners and family strongly influenced women in pain to go back to hospital. Carlsson et al. (2012) found that women needed a support person present at home and even more when in hospital.
5. Hospitals may review policies to ensure individualized patient-centred and family-centred care is offered for women seeking care in perinatal units. This is supported by Carlsson et al. (2012) and Redshaw and Heikkela (2010).

Recommendations for consideration based on the concept culture and background influences are described as follows :

1. Education regarding significant background influences and current pregnancy concerns can be shared with nursing staff to enable a more informed means of supporting women in early labour. This is supported by Nyman, Downe and Berg (2011). Nurses may consider personal beliefs, values, prejudice and bias toward women in labour, cultures or groups of people and the current healthcare system. More effective communication patterns may result from this reflection.
2. Nurses can include assessment questions regarding current pregnancy concerns and background influences such as GBS status and prior experiences in pregnancy, labour and birth; prior losses, and impact and influences of culture, family and friends in addition to assessment of contractions and cervix. This is supported by Nyman et al. (2011).

3. Education can provide information to enable staff to be attuned to women's psychological needs following miscarriage using empathy and sensitivity. This is supported by WHO, 2009, ch. 4. Initiating a conversation with a woman who had a prior pregnancy loss at any gestation provides opportunity for her to dialogue about unspoken thoughts and concerns if she wishes.
4. Hospitals may develop policies to assess and provide psychological care for women who experience a pregnancy loss both for the immediate and long-term. This is supported by WHO, 2009, ch. 4.

Other recommendations for consideration in empowering women in early labour are described as follows:

1. Telephone logs in assessment areas can be tabulated monthly to yield data specific to the population of women for which the hospital provides care. Although no information was located for this recommendation, further data about which groups of women call, when women call, and the concerns and questions that women have may be incorporated into prenatal education classes or prenatal registration appointments to assist other women. Equally important to know is which groups of women do not call and may therefore experience higher degrees of disempowerment.

These recommendations for consideration place an emphasis on a supportive hospital culture which provides assessment of women in early labour and individualized care – communicating to understand – listening and drawing out information not always shared. Support of women also involves education that can be provided in ways which builds confidence in the woman to know her own physical symptoms and to trust her body to labour. The result can be reduced frustration, anxiety and fear, and pain, and increased perception of support and empowerment for women in early labour who are sent home following hospital assessment.

### **Suggestions for Future Research**

Further research targeted at women with varied educational backgrounds, with women of diverse cultural backgrounds and values, and women with limited social supports may add to greater understanding of the phenomenon studied. Also, by comparing the responses of larger numbers of primiparous women and multiparous

women, findings could be enhanced. Some women giving birth in Canada may have had prenatal care outside of Canada. Studying the impact of potential differences in international healthcare philosophies and practice would be beneficial for healthcare providers to better understand the perspectives of some women. One woman wanted to participate in this research with her spouse present. Research interviews of women alone, women accompanied by their labour and birth support person and by the support person alone may generate new understanding of this phenomenon.

### **Conclusions**

Increasing costs to the healthcare system, a focus on patient-centred care, family-centred care, and quality improvement; staffing shortages and a more informed consumer create challenges in caring for patients. Since the mid-1980s, evidence has linked early labour admissions with increased medical interventions and policies with admission criteria were developed. Studies have probed the impact of birth on post-traumatic stress disorder since the late-1990s. The results highlighted the need to explore birth from the psychosocial perspective of the woman. Gaps in knowledge have been identified internationally in understanding needs of women in early labour and related care to empower these women.

This research was conducted in order to understand the experiences of women in early labour sent home following hospital assessment. Understanding this phenomenon created what Thorne, Reimer-Kirkham and O'Flynn-Magee (2004) refer to as a, "backdrop for assessment, planning and interventional strategies" (p.4). Interpretive description utilizing iterative analytic methods from writings of Giorgi (2006; 2012) served as the structure for this thesis work. Ten women were interviewed within the first 48 hours following birth while in hospital. Themes common to the women interviewed

included: conflict between knowledge of labour symptoms and women's initial responses; background influences and current pregnancy concerns; impact of the unspoken; experiences of pain and coping; and influence of others. Significant concepts noted within these themes were anxiety and fear, low self-efficacy, support, culture, and background influences which contributed either to empowerment or disempowerment. The overarching essence of the phenomenon was described as an "uncomfortable anxiety." In a review of literature a gap in knowledge was identified, as only one prior study had focused on women who had been sent home in early labour. A number of other articles reported aspects of the early labour experience, most from the midwifery perspective and many located within Europe.

New knowledge gained from this research can assist nurses to empower women by providing physical and psychosocial support through individualized assessment, strategic communication and education to foster self-efficacy in labour, reduce anxiety and fear, and pain for women in early labour who are sent home following hospital assessment.

### References

- Ayers, S., Joseph, S., McKenzie-McHarg, K., Slade, P., & Wijma, K. (2008). Post-traumatic stress disorder following childbirth: Current issues and recommendations for future research. *Journal of Psychosomatic Obstetrics & Gynecology*, 29(4), 240-250. doi:10.1080/01674820802034631
- Alehagen, S., Wijma, K., Lundberg, U., Melin, B., & Wijma, B. (2001). Catecholamine and Cortisol Reaction to Childbirth. *International Journal of Behavioral Medicine*, 8(1), 50–65.
- Barnett, C., Hundley, V., Cheyne, H., & Kane, F. (2008). 'Not in labour': Impact of sending women home in the latent phase. *British Journal of Midwifery*, 16(3), 144-153.
- Baxter, J. (2007). Care during the latent phase of labour: Supporting normal birth. *British Journal of Midwifery*, 15(12), 765-767.
- Beck, C.T. (2004). Birth trauma: In the eye of the beholder. *Nursing Research*, 53(1), 28-35.
- Beebe, K.R., & Humphreys, J. (2006). Expectations, perceptions, and management of labor. *Journal of Midwifery & Women's Health*, 51(5), 347-353.
- Beebe, K.R., & Lee, K.A. (2007). Sleep disturbance in late pregnancy and early labor. *Journal of Perinatal and Neonatal Nursing*, 23(2), pp. 103–108.
- Carlsson, I., Hallberg, L., & Odberg Pettersson, K. (2009). Swedish women's experiences of seeking care and being admitted during the latent phase of labour: A grounded theory study. *Midwifery*, 25(2), 172-180. doi:10.1016/j.midw.2007.02.003

- Carlsson, I., Ziegert, K., Sahlberg-Blom, E., & Nissen, E. (2012). Maintaining power: Women's experiences from labour onset before admittance to maternity ward. *Midwifery*, 28(1), 86-92. doi: 10.1016/j.midw.2010.11.011
- Cesario, S. K. (2004a). Conversations with colleagues. Research into practice: Evaluating Friedman's labor curve & assessing the "normal" length of labor. *AWHONN Lifelines*, 8(6), 506-510.
- Cesario, S. K. (2004b). Reevaluation of Friedman's labor curve: A pilot study. *JOGNN: Journal of Obstetric, Gynecologic & Neonatal Nursing*, 33(6), 713-722. doi:10.1177/0884217504270596
- Chamberlin, J. (1997). A Working definition of empowerment. *Psychiatric Rehabilitation Journal* 20(4), 43-46.
- Cheyne, H., Terry, R., Niven, C., Dowding, D., Hundley, V., & McNamee, P. (2007). 'Should I come in now?': A study of women's early labour experiences. *British Journal of Midwifery*, 15(10), 604-609.
- City of Mississauga website. (2012). Retrieved from <http://www.mississauga.ca/portal/cityhall>.
- College of Midwives of Ontario, 2012. About Midwifery: Philosophy of Midwifery Care in Ontario. Retrieved from [http://www.cmo.on.ca/midwife\\_philosophy.php](http://www.cmo.on.ca/midwife_philosophy.php)
- Côté-Arsenault, D., & Donato, K. L. (2007). Restrained expectations in late pregnancy following loss. *JOGNN: Journal of Obstetric, Gynecologic & Neonatal Nursing*, 36(6), 550-557. doi: 10.1111/j.1552-6909.2007.00185.x
- Dencker, A., Taft, C., Bergqvist, L., Lilja, H., & Berg, M. (2010). Childbirth experience questionnaire (CEQ): Development and evaluation of a multidimensional instrument. *BMC Pregnancy and Childbirth*, 10(81). doi: 10.1186/1471-2393-10-81

- Elmir, R., Schmied, V., Wilkes, L., & Jackson, D. (2010). Women's perceptions and experiences of a traumatic birth: a meta-ethnography. *Journal of Advanced Nursing*, 66(10), 2142-53.
- Eri, T. S., Blystad, A., Gjengedal, E., & Blaaka, G. (2010). 'The waiting mode': First-time mothers' experiences of waiting for labour onset. *Sexual & Reproductive Healthcare: Official Journal of the Swedish Association of Midwives*, 1(4), 169-173.
- Eriksson, C., Westman, G., & Hamberg, K. (2005). Experiential factors associated with childbirth-related fear in Swedish women and men: A population based study. *Journal of Psychosomatic Obstetrics and Gynaecology*, 26(1), 63-72.
- Fisher, J., Astbury, J., de Mello M.C., & Saxena, S. (2009). Mental health aspects of women's reproductive health : A global review of the literature. Retrieved from: [searo.who.int/LinkFiles/Publications\\_Mental\\_Health\\_Aspects\\_of\\_Women's\\_Reproductive\\_Health.pdf](http://searo.who.int/LinkFiles/Publications_Mental_Health_Aspects_of_Women's_Reproductive_Health.pdf) Geneva, Switzerland: WHO Press.
- Ford, E., Ayers, S., & Wright, D.B. (2009). Measurement of maternal perceptions of support and control in birth (SCIB). *Journal of Women's Health* 18(2), 245-252. doi: 10.1089/jwh.2008.0882
- Giorgi, A. (2006). Concerning variations in the application of the phenomenological method. *Humanistic Psychologist*, 34(4), 305-319. doi:10.1207/s15473333thp3404\_2
- Giorgi, A. (2012). The descriptive phenomenological psychological method. *Journal of Phenomenological Psychology* 43, 3-12.
- Giorgi, A. P., & Giorgi, B. M. (2003). The descriptive phenomenological psychological method. In P. M. Camic, J. E. Rhodes & L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design*. (pp. 243-273). American Psychological Association. doi: 10.1037/10595-013

Goberna-Tricas J., Banús-Giménez M.R., Palacio-Tauste A., & Linares-Sancho, S.

(2011). Satisfaction with pregnancy and birth services: The quality of maternity care services as experienced by women. *Midwifery*, 27(6), e231-e237.

Greulich, B., & Tarrant, B. (2007). The latent phase of labor: Diagnosis and management.

*Journal of Midwifery & Women's Health*, 52(3), 190.

Gross, M. M., Burian, R., Frömke, C. A., Hecker, H., Schippert, C., & Hillemanns, P.

(2009). Onset of labour: Women's experiences and midwives' assessments in relation to first stage duration. *Archives of Gynecology & Obstetrics*, 280(6), 899-905. doi: 10.1007/s00404-009-0990-7

Gross, M. M., Haunschild, T., Stoexen, T., Methner, V., & Guenter, H. H. (2003).

Women's recognition of the spontaneous onset of labor. *Birth: Issues in Perinatal Care*, 30(4), 267-271. doi: 10.1046/j.1523-536X.2003.00257.x

Hall, W.A., Stoll, K., Hutton, E.K., & Brown, H. (2012). A prospective study of effects

of psychological factors and sleep on obstetric interventions, mode of birth, and neonatal outcomes among low-risk British Columbian women. *BMC Pregnancy and Childbirth*, 12 (78), 1-10. doi:10.1186/1471-2393-12-78

Hanna, A. (2007, October). Ontario Medical Association Policy Paper: Maternal and

newborn care in Ontario [Online exclusive]. *Ontario Medical Review*. Retrieved from <https://www.oma.org/Resources/Documents/2007MaternalNewbornCare.pdf>

Hemminki, E., & Simukka, R. (1986). The timing of hospital admission and progress of

labour [Abstract]. *European Journal of Obstetrics, Gynecology, and Reproductive Biology*, 22(1-2), 85-94.

Hodnett, E.D., Gates, S., Hofmeyr, G.J., Sakala, C., & Weston, J. (2011). Continuous support for women during childbirth (Review). *The Cochrane Library* 2011 (2).

Retrieved from <http://www.thecochranelibrary.com>.

Hodnett E. D., Lowe N. K., Hannah, M. E., Willan, A. R., Stevens, B., Weston, J. A., . . . Stremler, R. (2002). Effectiveness of nurses as providers of birth labor support in North American hospitals: A randomized controlled trial. *JAMA: The Journal of the American Medical Association*, 288(11), 1373-1381.

Hodnett, E. D., Stremler, R., Willan, A. R., Weston, J. A., Lowe, N. K., Simpson, K. R., . . . Gafni, A. (2008). Effect on birth outcomes of a formalised approach to care in hospital labour assessment units: International, randomised controlled trial. *BMJ: British Medical Journal (International Edition)*, 337(7670), 618-622. doi: 10.1136/bmj.a1021

Hoh, J., Cha, K., Park, M., Ting Lee, M., & Park, Y. (2012). Estimating time to full uterine cervical dilation using genetic algorithm. *The Kaohsiung Journal of Medical Sciences*, 28(8), 423-428.

Holmes, P., Oppenheimer, L. W., & Wen, S. W. (2001). The relationship between cervical dilatation at initial presentation in labour and subsequent intervention. *BJOG: An International Journal of Obstetrics and Gynaecology*, 108(11), 1120-1124.

Jackson, D. J., Lang, J. M., Ecker, J., Swartz, W. H., & Heeren, T. (2003). Impact of collaborative management and early admission in labor on method of delivery. *JOGNN: Journal of Obstetric, Gynecologic & Neonatal Nursing*, 32(2), 147-157. doi:10.1177/0884217503252045

- Janssen, P. A., Still, D. K., Klein, M. C., Singer, J., Carty, E. A., Liston, R. M., & Zupancic, J. A. (2006). Early labor assessment and support at home versus telephone triage. *Obstetrics & Gynecology*, *108*(6), 1463-1469.
- Kwast, B. E., Poovan, P., Vera, E., & Kohls, E. (2008). The modified WHO partograph: Do we need a latent phase? *British Journal of Midwifery*, *16*(8), 527-532.
- Larkin, P., Begley, C. M., & Devane, D. (2012). 'Not enough people to look after you': An exploration of women's experiences of childbirth in the Republic of Ireland. *Midwifery* *28*, 98-105.
- Lauzon, L., & Hodnett, E. (2001). Caregivers' use of strict criteria for diagnosing active labour in term pregnancy. Abstract retrieved from *Cochrane Database of Systematic Reviews (Online)*, (2), CD000936.
- Lauzon, L., & Hodnett, E. (2009). Labour assessment programs to delay admission to labour wards. *Cochrane Database of Systematic Reviews* *2009*(1), 1-18.  
doi:10.1002/14651858.CD000936.
- Lindgren, H., and Erlandsson, K. (2010). Women's experiences of empowerment in a planned home birth: A Swedish population-based study. *Birth: Issues in Perinatal Care*, *37*(4), 309-317.
- Low, L. K. & Moffat, A. (2006). Every labor is unique: But "call when your contractions are 3 minutes apart". *MCN, American Journal of Maternal Child Nursing*, *31*(5), 307-312.
- McDonald, G. (2010). Diagnosing the latent phase of labour: Use of the partogram. *British Journal of Midwifery*, *18*(10), 630-637.

- McNiven, P. S., Williams, J. I., Hodnett, E., Kaufman, K., & Hannah, M. E. (1998). An early labor assessment program: A randomized, controlled trial. *Birth: Issues in Perinatal Care*, 25(1), 5-10.
- Nolan, M. (2011). What is women's experience of being at home in early labour? *New Digest 53* (January). Retrieved from <http://www.nct.org.uk>
- Nolan, M., & Smith, J. (2010). Women's experiences of following advice to stay at home in early labour. *British Journal of Midwifery*, 18(5), 286-291.
- NRC Picker Canada. (2011). Retrieved from <http://www.nrcpicker.ca/>
- Nyman, V., Downe, S., & Berg, M. (2011). Waiting for permission to enter the labour ward world: First time parents' experiences of the first encounter on a labour ward. *Sexual & Reproductive Healthcare*, 2(3), 129-134.
- Olde, E., Kleber, R. J., van der Hart, O., & Pop, V. J. M. (2006). Childbirth and posttraumatic stress responses: A validation study of the Dutch impact of event scale-revised. *European Journal of Psychological Assessment*, 22(4), 259-267.  
doi:10.1027/1015-5759.22.4.259
- Pates, J. A., McIntire, D. D., & Leveno, K. J. (2007). Uterine contractions preceding labor. *Obstetrics & Gynecology*, 110(3), 566-569.
- Pirdel, M., & Pirdel, L. (2009). Perceived Environmental Stressors and Pain Perception During Labor Among Primiparous and Multiparous Women. *Journal of Reproduction and Infertility*, 10(3), 217-23.
- Polit, D.F., & Beck, C.T. (2008). *Nursing research: Generating and assessing evidence for nursing practice* (8th ed.). Philadelphia, PA: Lippincott.
- Public Health Agency of Canada. Maternity Experiences Survey, 2006. Questionnaire. Retrieved from <http://www.phac-aspc.gc.ca/rhs-ssg/survey-eng.php>.

- Rahnama, P., Ziaei, S., & Faghihzadeh, S. (2006). Impact of early admission in labor on method of delivery. *International Journal of Gynecology and Obstetrics*, 92, 217-220.
- Redshaw, M., & Heikkila, K. (2011). Ethnic differences in women's worries about labour and birth. *Ethnicity & Health*, 16(3), 213-223.
- Reeves, S., Albert, M., Kuper, A., & Hodges, B. D. (2008). Qualitative Research: Why use theories in qualitative research? *BMJ: British Medical Journal (International Edition)*, 337(7670), 631-634. doi:10.1136/bmj.a949
- Reid, L. (2008). Research unwrapped 'Not in labour: how women feel.' *The Practising Midwife* 11(8) 37-39.
- Saisto, T., Salmela-Aro, K., Nurmi, J., & Halmesmaki, E. (2001). Psychosocial predictors of disappointment with delivery and puerperal depression. *Acta Obstetrica Et Gynecologica Scandinavica*, 80(1), 39-45.
- Scotland, G., S., McNamee, P., Cheyne, H., Hundley, V., & Barnett, C. (2011). Women's preferences for aspects of labor management: Results from a discrete choice experiment. *Birth: Issues in Perinatal Care*, 38(1), 36-46. doi: 10.1111/j.1523-536X.2010.00447.x
- Simkin, P. (1991), Just Another Day in a Woman's Life? Women's Long-Term Perceptions of Their First Birth Experience. Part I. *Birth: Issues in Perinatal Care*, 18, 203-210. doi: 10.1111/j.1523-536X.1991.tb00103.x
- Simpson, M. J. (2008). *Women's perspectives on supportive care during labour and delivery* (Unpublished master's thesis). Vancouver, Canada: University of British Columbia.

- Speziale, H. J. & Carpenter, D. R. (2007). *Qualitative research in nursing: Advancing the humanistic imperative*. Philadelphia, PA: Lippincott Williams & Wilkins.
- Spiby, H., Crawshaw, C., & Fyle, J. (2006). ELSA trial update: Support trial almost complete... early labour support assessment. *RCM Midwives*, 9(5), 184-184.
- Spiby, H., Green, J., Janssen, P. A., Nolan, M. L., Gross, M. M., Cheyne, H., . . . Buitendijk, S. (2009). Roundtable discussion: Early labor: What's the problem? *Birth: Issues in Perinatal Care*, 36(4), 332-339. doi: 10.1111/j.1523-536X.2009.00361.x
- Spiby, H., Green, J. M., Hucknall, C., Foster, H. R., Andrews, A. (2006). Labouring to better effect: studies of services for women in early labour. The OPAL study (Options for Assessment in early Labour). Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO). Retrieved from National Institute for Health Research Evaluations, Trials and Studies Coordinating Centres: [http://www.netscc.ac.uk/hsdr/files/project/SDO\\_FR\\_08-1304-064\\_V01.pdf](http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1304-064_V01.pdf)
- Spiby, H., Renfrew M.J., Green J.M., et al. (2008). Improving care at the primary/secondary interface: A trial of community-based support in early labour. The ELSA trial. Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation. Southampton, United Kingdom: National Coordinating Centre for the Service Delivery and Organisation (NCCSDO). Retrieved from National Institute for Health Research: <http://www.sdo.nihr.ac.uk/files/project/64-final-report.pdf>

- Stadlmayr, W., Schneider, H., Amsler, F., Bürgin, D., & Bitzer, J. (2004). How do obstetric variables influence the dimensions of the birth experience as assessed by Salmon's item list (SIL-Ger)? *European Journal of Obstetrics & Gynecology and Reproductive Biology* 115, 43-50.
- Stålhammar, A. & Boström, B. (2008). Policies for labour management -- existence and content. *Scand. J. Caring Science*, 22 (2), 259-264.
- Stanton, A. L., Lobel, M., Sears, S., & DeLuca, R. S. (2002). Psychosocial aspects of selected issues in women's reproductive health: Current status and future directions. *Journal of Consulting and Clinical Psychology*, 70(3), 751-770.  
doi:10.1037/0022-006X.70.3.751
- Suzuki, R., Horiuchi, S., & Ohtsu, H. (2010). Evaluation of the labor curve in nulliparous Japanese women. *American Journal of Obstetrics and Gynecology*, 203(3), 226.e1-226.e6.
- The Royal College of Midwives (2008). Latent phase: Midwifery practice guideline. Retrieved from <http://www.rcm.org.uk/college/policy-practice/guidelines/practice-guidelines/>
- Thorne, S., Reimer-Kirkham, S., & MacDonald-Emes, J. (1997). Focus on qualitative methods. Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing & Health*, 20, 169-177.
- Thorne, S., Reimer-Kirkham, S., & O'Flynn-Magee, K. (2004). The analytic challenge in interpretive description. *International Journal of Qualitative Methods*, 3(1), 1-21.
- Thorne, S., Oliffe, J., Kim-Sing, C., Hislop, T. G., Stajduhar, K., Harris, S. R., . . . Oglov, V. (2010). Helpful communications during the diagnostic period: An interpretive

description of patient preferences. *European Journal of Cancer Care*, 19(6), 746-754. doi: 10.1111/j.1365-2354.2009.01125.x

Tzeng, Y.; Chao, Y. Y., Kuo, S.; & Teng, Y. K. (2008). Childbirth-related fatigue trajectories during labour. *Journal of Advanced Nursing*, 63(3), 240-249. doi: 10.1111/j.1365-2648.2008.04732.x

Walsh, D. (2009). Care pathways and the latent phase of labour. [Editorial]. (2009). *British Journal of Midwifery*, 17(2), 74.

Wong, D. L., Hockenberry, M. J., Wilson, D. Perry, S. E., & Lowdermilk, D. L. (2006). *Maternal child nursing care* (3rd ed.). St. Louis, Missouri: Mosby.

World Health Organization. (2009). *Mental health aspects of women's reproductive health: A global review of the literature*. World Health Organization. Retrieved from <http://books.google.ca>.

Zhang, J., Troendle, J. F., & Yancey, M. K. (2002). Reassessing the labor curve in nulliparous women. *American Journal of Obstetrics and Gynecology*, 187(4), 824-828.

## Appendix A

### Participant Consent Form for Research Study: Experiences of Women in Early

#### Labour Sent Home Following Hospital Assessment

Principal Researcher:

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This research is related to Marilyn Morson's MSN thesis.

Research is currently being done on the unit to understand the experience of women in labour. While labour and birth are life events common to many women, the physical process itself is often quite varied as are women's emotional, mental, social and spiritual experiences. It is routine to delay admission until active labour (the cervix is open at least 4 cm) as this will often reduce the chance of medical procedures throughout labour and birth. Patient satisfaction is an important part of healthcare but understanding how women feel about their experiences when sent home from hospital when not far along enough in labour (the cervix is open less than 4cm) has not often been studied in Canada, nor in other countries.

The purpose of the study is to gather information which can be shared to help nurses, doctors and midwives understand the experiences of some women sent home not far along enough in labour to be admitted to hospital.

You are being invited to participate in this study because you are under the care of a physician and before your baby was born you were sent home from hospital when you were not far along enough in labour to be admitted to hospital. Participation in the research is voluntary and you can withdraw at any time. Whether you participate or not will not affect your care as a patient.

This research has 3 parts:

Part 1: Participants will complete a brief form with information such as name, age, and contact information and should take a few minutes to complete.

Part 2: Before discharge, participants will be interviewed about their experience when sent home from hospital. This may require 45 – 60 minutes. Each interview will be conducted by Marilyn Morson who will record the interview with a small audio or tape recorder. Following the interview the recording will be written out word for word by the researcher.

Part 3: Within 3 weeks after the hospital interview, participants will receive a phone call to arrange a time convenient to discuss by phone or in person, a review of the interview with Marilyn Morson. This will take a maximum of 30 minutes. The purpose of this interview is to check the information you discussed during the audiotaped interview while in hospital.

No incentives will be offered to influence women to participate in this research.

Confidentiality is very important. The researcher will know the identity of each participant but no one else will have access to identifying information. The researcher will use a code for each woman in the study. Information, from Part 1 above, will be locked in a file drawer with the reference sheet of names and code numbers. No identifying information will be on the written interview notes, in the written thesis nor in published information. Coded interview discussions will be kept on the researcher's laptop computer which is password protected and has antispyware programs installed. The thesis supervisor will have access to the interview notes for educational purposes.

Following completion of the thesis work, all paper or electronic information, will be kept in a confidential manner for 5 years. Once the thesis work has been evaluated, the audio recordings will be erased. Paper documents will be shredded and any computer files will be deleted after 5 years.

There are no risks anticipated because of taking part in this study. Some of your experiences you may have already shared with friends or family but some information you may share the first time during the interview. It is possible that you may have strong feelings that arise during the interview as you retell your experience of being sent home not yet far along enough in labour to be admitted. Pauses and supportive responses by the researcher are intended to allow you to continue in your time. You have the right to request that audiotaping is paused or turned off.

If you choose to withdraw from this study, please contact Marilyn Morson, Researcher. All your data will then be removed and destroyed.

Do you have any questions about this study?

Should you wish to speak further about anything related to this study please contact

Marilyn Morson, Researcher, at 905 848-7580 ext 2545, or Dr Landa Terblanche,

Faculty Advisor, 1 604 888-7511 ext 3268 or [Landa.Terblanche@twu.ca](mailto:Landa.Terblanche@twu.ca)

If you have any concerns about your treatment or rights as a research participant, you

may contact Ms Sue Funk in the office of Research, Trinity Western University at 1 604

513-2142 or [Sue.funk@twu.ca](mailto:Sue.funk@twu.ca)

Your signature below indicates that you have had your questions about the study answered to your satisfaction and have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study and that your responses may be put in anonymous form (using identification codes) and kept for further use for a period of 5 years after the completion of this study.

Research Participant's Name: \_\_\_\_\_

Research Participant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Principal Researcher Signature: \_\_\_\_\_

I have carefully explained to the research participant the nature of the above research study. To the best of my knowledge, the research participant signing this consent form understands the nature, demands, risks, and benefits involved in taking part in this study. I acknowledge my responsibility in the protection of the rights and well-being of the above research participant, to respect the rights and wishes of the research participant, and to conduct the study according to applicable good clinical practice guidelines and regulations.

Principal Researcher Signature: \_\_\_\_\_

**Appendix B: Interview Guide**

Is there any background information you want to tell me such as the number of children  
this is for you ... the baby's due date?

Tell me about your experience when you were sent home – when you were not far along  
enough in labour to be admitted to the hospital.

**Other prompts to assist with participant response - to be used as needed**

Tell me what was happening that caused you to go to the hospital.

When did you go to the hospital?

What did you think then?

How satisfied were you with the care you received?

What were you feeling? What did you physically experience?

Was anyone with you?

Do you remember any conversations you had with anyone?

When did you leave the hospital?

When that happened what did you think? What did you feel? What did you experience  
physically?

When you returned to the hospital what happened?

What were you feeling then?

What were you thinking?

Was anyone with you for support?

How did you experience the care you received?

If you had anything that you would like to share to help people understand the experience  
when you are sent home not far along enough in labour to be admitted, what would that

be?

**Appendix C**

*Follow up literature search strategy and results, August 25, 2012*

Keywords: early labour, latent phase of labour, onset of labour, labour onset outpatient, active labour, hospital admission, experience, perception, pregnancy, triage, childbirth, intrapartum care, hospital birth, psychology, discharge, and the previously listed 'labour'" (and "labor" with all combinations above)

Database	Keyword & Result	Results	Relevant/New
Aug 25, 2012 Ebscohost – CINAHL, Academic Premier, Medline, Psychinfo, EJournals, PsycARTICLES	Labor  Document Type: Article; Language: English; Human; Sex: Female; Pregnancy; Age: 19- 44 years	412582	
S1			
S2	1982-2012	372752	
S3	NOT Market	316728	
S4	NOT Market, NOT Job	286107	
S5	"Early labor"	302	
S6	NOT Market, NOT Job	262	
S7	"Latent phase of labor" 1.Scotland et al 2011 Women's Preferences 2.Greulich & Tarrant 2007 Latent Phase	40	2
S8	outpatient	208370	
S6 & S8 = S9	1.Janssen 2006 ELASH	1	1
S10	"Onset of labor"	2109	
S11	"labor onset"	932	
S12 = S8 & S11		3	0
S13	"active labor"	2137	
S14	Hospital admission	182844	
S15 = S11 & S14	1.Gross, Petersen et al. 2010 Association between self dx of labour 2.Janssen 2009 Roundtable 3.Beebe 2007 Sleep disturbance 4.Beebe Humphries 2006 Expectations 5.LauzonHodnett 2000Antenatal ed re: dx labour	29	2
S16 = S10 & S14		36	0

S17 =S6 & S14	1.McNiven et al 1998 Early Labor	9	1
S18= S13 & S14		59	0
S19	Experience	1867668	
S20 = S6 & 19	1.SpibyRenfrew 2008 Achieving best from care early	18	1
S21= S14 & S19		11322	
S22= S4 & S14 & S19	1.Eri 2010 Negotiating credibility before 2.Carlsson 2009 Swedish women's... adm during latent 3.Cheyne et al 2007 Should I come in now? 4. Low et al. 2006 Every labor is unique... call when 3 min apart (5. Beebe Lee et al. 2007 The effects of childbirth self-efficacy..anxiety)	90	4
S23 = S8 & S19		15978	
S24	pregnancy	1166824	
S25 = S8 & S19 & S24		297	
S26 = S6 & S14 & S19		3	0
S27 = S6 & S8 & S14		0	
S28 = S6 & S8 & S19		0	
S29 = S6 & S10		10	0
S30= S14 & S24		6134	
S31 = S6 & S14 & S24		6	0
S32	perception	1080770	
S33 = S6 & S32	(1.Beebe PhD paper The Influence of biopsychsocial...)	3	
S34 = S6 & S8 & S19 & S24		0	
S35 = S10 & S32	(1.Gross 2003 Women's recog onset labour) (2. Simkin Just another day)	11	0
S36 = S11 & S32	(1.Eri 2010 The waiting mode) (2.Gross 2009 Onset of labor women.midwives)	15	0
S37	triage	27226	
S38 = S6 & S8 & S37		1	0
S39 = S13 & S37		59	0
S40	childbirth	52526	
S41 = S8 & S19 & S40	(1.Nilsson et al 2009 Women's fears)	31	0
S42	"Hospital birth"	639	

S43 = S6 & S42		2	0
S44	“Intrapartum care”	1812	
S45 = S6 & S44		3	0
S46 = S19 & S42	(1.Jimenez 2010 FCC)	89	0
S47 = S8 & S19 & S42		0	
S48	psychology	3370273	
S49 = S6 & S48		13	0
S50 = S8 & S48		31469	
S51= S8 & S10 & S48		0	
S52 = S8 & S11 & S48		0	
S53	discharge	425380	
S54 = S48 & S53		19286	
S55 = S10 & S53		19	0
S56 = S11 & S53		5	
S57 = S24 & S53		8337	
S58 = S6 & S53		0	
S59 = S4 & S53		1862	
S60 = S4 & S19 & S53		83	0
	Canadian spellings		
S61	labour	525850	
S62	Document Type: Article; Language: English; Human; Sex: Female; Pregnancy; Age: 19- 44 Date: 1982 - 2012	365808	
S63	NOT market, NOT job	281816/280801	
S64	“Early labour”	186/191	
S65	NOT market, NOT job	144	
S66	“Latent phase of labour” 1.Carlsson 2012 Maintaining power 2.Kotasthane 2011 Latent phase 3.McDonald 2010 Dx latent phase 4.Walsh 2009 Care pathways 5.Barnett et al. 2008 Not in labour impact of sending women home 6.Baxter 2007 Care during latent	17	6
S67	“Onset of labour”	571	
S68	“labour onset”	62	
S69 = S8 & S65	Outpatient ...	1	0
S70 = S8 & S67		3	0
S71 = S8 & S67	(With limits)	3	

S72 = S8 & S68		0	
S73/S61	“active labour”	573	
S74 = S67 & S14	(S14 is hospital admission)	24	0
S75 = S68 & S14		0	
S76 = S14 & S65		6	0
NEW SEARCH BEGUN with spelling of “Labour” and combinations Aug 26, 2012			
S1	outpatient	208370	
S2	“active labour”	573	
S3	Labour NOT market NOT job	280801	
S4	“early labour”	191	
S5 (See S66)	“latent phase of labour”	17	0
S6	“onset of labour”	571	
S7	“labour onset” (1.Redshaw & Heikkila 2011 Ethnic diff. worries) (2.Stalhammar 2008 Policies) (3.Burvill 2002 Midwife Dx)	63	3
S8	“hospital admission”	18561	
S9	experience	1292851	
S10	perception	735646	
S11	Pregnancy	508299	
S12	Childbirth	11787	
S13	Triage	28912	
S14	“Intrapartum care”	536	
S15	“Hospital birth”	375	
S16	Psychology	2104123	
S17	Discharge	282219	
S18 = S6 & S8		1	0
S19 = S7 & S8		0	
S20 = S4 & S8		0	
S21 = S2 & S8		0	
S22 = S4 & S9	1.Weavers 2012 Telephone 2.Nolan 2011 Fathers 3.Nolan 2011 Fathers 4.Nolan 2011 Fathers 5.Larkin 2012 Not enough people – experiences 6.Nolan 2010 Women –told stay home 7.Nolan 2009 Experience Wom 8.Nolan 9.Nolan	32	9
S23 = S8 & S9		1239	

S24	Hospital admission yr 1982-2012, age 19-44, female	27876	
S25 = S2 & S24		4	0
S26 = S4 & S24		6	0
S27 = S6 & S24		23	0
S28 = S7 & S24		0	
S29 = S9 & S24		5726	
S30 = S3 & S9 & S24		84	0
S31 = S1 & S9		15978	
S32 = S1 & S9 & S11		297	
S4 & S8 & S9	Redundant as = trail above	32	
S33 = S4 & S6 & S8		0	
S34 = S4 & S6 & S9		1	
S35 = S4 & S6		4	
S36 = S4 & S8 & S11		0	
S37 = S4 & S10		2	
S38 = S4 & S1 & S9 & S11		0	
S39 = S6 & S10		7	
S40 = S7 & S10		3	
S41 = S2 & S13		2	
S42 = S4 & S1 & S13		0	
S43 = S4 & S15		0	
S44 = S4 & S14		0	
S45 = S4 & S16	1.Clift-Matthews 2010 confidence	18	1
S46 = S1 & S6 & S16		0	
S47 = S1 & S7 & S16		0	
S48 = S6 & S17		10	
S49 = S7 & S17		0	
S50 = S11 & S17		5046	
S51 = S4 & S17		0	
S52 = S3 & S17		1803	
S53 = S3 & S9 & S17		81	0

## Appendix D

Table 2

*Impressions of Significant Data from Individual Interview Transcriptions using Pseudonyms*

Woman	Impressions of Significant Data
<p>A01 Anna</p>	<p>Reason for visit to hospital (and call to hospital)</p> <ul style="list-style-type: none"> <li>• Contractions and concern for baby's health</li> </ul> <p>Consumed with body's symptoms vs confidence in meaning of symptoms</p> <p>Lack of control</p> <ul style="list-style-type: none"> <li>• "Roller coaster" with physical symptoms coming and going</li> <li>• "Walking, ticking little water bomb"</li> <li>• life revolved around date booked for C Section</li> </ul> <p>Frustration with coming and going to hospital</p> <p>Concern with</p> <ul style="list-style-type: none"> <li>• Upheaval of family (going to hospital)</li> <li>• Spouse – difficult for him to know how to support woman</li> </ul> <p>Support available: Family and friends</p> <p>Coping</p> <ul style="list-style-type: none"> <li>• Kept busy in role of mother ( and "probably did too much"; could have relaxed more)</li> </ul> <p>Thought: would have C Section early: big baby, contractions</p>
<p>A02 Barb</p>	<p>Reason for visit</p> <ul style="list-style-type: none"> <li>• to check and see progress with contractions</li> </ul> <p>Liked being in home (parents' home)</p> <ul style="list-style-type: none"> <li>• Comfortable, familiar, close to hospital</li> </ul> <p>Overtaken by painful contractions with vomiting</p> <p>Conflict between knowledge and feelings:</p> <ul style="list-style-type: none"> <li>• Knows 1<sup>st</sup> labours are slower vs felt disappointed in initial assessment</li> </ul> <p>Concern for baby: refusal of morphine and gravol</p> <p>Thought: confident in baby's health and <i>birth</i></p> <ul style="list-style-type: none"> <li>• based on Fetal heart rate</li> <li>• ultrasound with baby in good position</li> <li>• baby would come one way or other</li> </ul> <p>Positive Thought or focus: "Just need to get to 3 cm"</p>

- A04  
Donna
- Reason for visit
- contractions
- Conflict between knowledge and feelings:
- Knows 1<sup>st</sup> labours are slower vs felt disappointed in initial assessment
- Concern with symptoms:
- Are they normal? Are they a sign of labour or not?
  - Will I bleed? Will I be safe?
- Confidence in body affected by her background
- In China, women know when to go to hospital
  - In Canada, women know nothing unless the nurse tells them
- What is source of trust or confidence?
- Familiar (healthcare system & Dr in China) vs OB in Canada vs internet
    - Plan for C Section needed for safety (may bleed from fibroids - China)
    - Admitted in hospital with lot of time to have any symptom checked and reassurance for normal process of labour
    - Plan for vaginal birth (fibroids are small problem - Canada)
    - Limited time to speak with OB in Canada
    - Brown sugar water (Should I tell you?)
- A05  
Ella
- Reason for visit to hospital
- Worry about bleeding
- Influence of prior pregnancies ( Compare)
- Worry - symptom not experienced in prior labours
  - Worry about baby - Lost two pregnancies
  - Pain – knows how it will be like
  - Experience of other hospital – feedback from friends so feels comfortable, confident with current hospital
- What does concern for baby look like?
- All next pregnancy is fears (after losses)
  - Go to hospital earlier
  - Think only about healthy baby
- Coping
- Role of mother continues
  - Quiet, rest on own, be with self
- Trust
- RNs are professional, know what they are doing; so follow advice and go home
- Positive thoughts: You can do it!
- Confidence in body: knows when it is time to return to hospital

- A06  
Faye
- Reason for visit to hospital
- Contractions & worry about baby
- What does concern for baby look like?
- Going to hospital earlier than planned (Not yet contracting every 5 minutes)
- Conflict with knowledge and opinions of others
- Baby could die – go and get checked out
  - Should stay in hospital as women do in Poland
- Liked being at home (comfortable) and advised same for others if live close to hospital; and rest
- Confidence in opinions of healthcare professionals vs family members
- Thoughts: Want baby out on specific date; wants labour faster
- Coping: breathe and walk, move and breathe (listening to body)
- Possible Knowledge gap: don't touch me – back pain*
- Positive thoughts: pull yourself together
- 
- A07  
Georgia
- Reason for visit to hospital
- Need for information and GBS positive status (*possible teachable moment*)
- Influence of prior pregnancy (compare)
- Other babies were overdue
  - When labour started baby born that day
  - Conflict with sense of what is happening in body with feeling unsure because it is different
- Influence of current pregnancy concern:
- GBS bacteria so would need antibiotics at least 4h before birth when in labour
- Role of mother overshadowed everything
- Two children including toddler at home
  - No time to talk with spouse
  - Brought children to hospital then when admitted, spouse dropped them off
- Coping
- Busy with children
  - Could not sleep with contractions at night so fatigue was significant
- 
- A08  
Helen
- Reason for visit to hospital
- Contractions every 5 minutes
- What is the source of truth (trust and confidence)?
- Hospital assessment: early labour
  - OB appointment: not in early labour
  - Internet: am I in early labour?
- Thoughts: big baby, will be born early
- Negative thoughts: Disappointed, devastated, upset with body not doing what supposed to; incompetent body
- Felt letting everyone down because of this
- What role does family play in outlook of labour?
- Mother had never progressed in labour and thought she could not (*unspoken fear?*)
- Positive thoughts: My body can do this. I can do this. (Once given results of cervical progress to 4 -5 cm dilation)

- A09  
Isabelle
- Reason for visit to hospital
- Wanted to be checked as tired and confused with timing of contractions
  - Concern for baby because GBS positive status
- Conflict between knowledge and feelings: (First labour usually longer)
- Went to hospital when contractions every 7-8 min vs surprised when 1 cm dilation at assessment
- Influence of pregnancy issues: Back pain
- Thought was pinched nerve since early pregnancy
  - Worse last month of pregnancy
  - Could not lie down in bed
  - Worried about how bad back pain would be in labour
- Comfortable being at home: recognize advantages (doing different things)
- Coping
- Sat in rocking chair with blanket as could not lie down, walked up and down stairs, preferred to be alone when contracting
- Recognize no control over admission to labour unit
- Support available in home
- Positive thoughts: able to calm self
- Plan: stay strong and wait until 6:00 pm to return to hospital
- Possible Knowledge gap: back pain coping strategies*
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- A10  
Jane
- Reason for visit to hospital
- Cramps, GBS positive status and concern for baby as felt water was going to break
- Assessment: felt anticipation that maybe labour would be that day
- Influence of prior pregnancies
- Fear of what will happen
  - Pain at time of birth
  - Knows has to cope
- Pain: back and thighs
- Coping
- At home, by self, rest in bed
- Child care – not concerned
- Spouse playing with son
  - Parents will look after when go to hospital
- Concern
- How hospital staff would view her if return
  - Overshadowed by concern for baby because of GBS status and need for safe care (cannot shop around)
- Trust & confidence:
- Written Early Labour info was helpful as was culture of staff on unit (friendly) so felt could come in for any reason, even if scared
- Possible Knowledge gap: back pain coping strategies*

- A11  
Kate
- Reason for visit to hospital
- Seek information & frame of reference (*milestones for progress & encouragement*)
  - How far dilated? How long will labour last?
  - Tired with 20h of contractions
- Conflict between knowledge and feelings:
- Thought would be sent home vs really disappointed in slow progress
- Terrified of what to expect in labour (*possible teachable moment*)
- Conflict re: confidence in body:
- was it “false labour”? vs knew “she was there” – ready to be admitted
- Coping: Early labour instructions helpful
- Bath, Tylenol (after called labour unit)
- Spouse
- Relieved went to be checked (thought it was false labour and maybe 24 to 48hrs more)
  - Hesitant to return when woman ready to go back to hospital
- Plan
- Determined to demand induction; Would not go home 2<sup>nd</sup> time
  - Gave her some comfort

*Data gathered from individual interview transcriptions during analysis of significant diverse themes.*