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EXPERT OPINION ▪ PERINATAL

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Promoting Maternal Confidence, Coping, and Comfort in Latent Labor

Evidence-Based Strategies and Resources

A national quality goal is reduction of cesarean births in low-risk women.[1,2] One of the most common reasons for cesarean birth in low-risk women is labor dystocia.[2-5] The definition and parameters for active versus latent labor have changed in recent years to recognize that early labor is a gradual and sometimes long progression to active labor that begins at approximately 5- to 6-cm dilation rather than 4 cm.[2-5] To minimize inadvertent diagnosis of dystocia, admission in active labor is advised.[2-5] Early admission to a labor unit is associated with the overuse of interventions, including cesarean birth.[4,6] Delaying admission to a labor unit until active labor in healthy women has the potential estimated annual cost savings of almost $700 000 000 per year.[4] Encouraging a woman's confidence to employ comfort measures in her own home, armed with evidence-based strategies and resources, is key to delaying admission until active labor. Obstetric nurse interaction and communication with women during the evaluation time are vital components in relaying the appropriate information and techniques for a safe and positive latent labor experience that occurs outside of the inpatient setting.[6] Women may turn to the hospital setting seeking information, reassurance, and advice.

Women experience the onset of labor in a range of ways.[6,7] The maternal perception of active labor is complex, influenced by physical, emotional, and environmental factors.[8,9] The decision as to when to head to a birth facility is often beset with uncertainty and confusion.[6,7] Provision of support, reassurance, and nonpharmacological coping strategies for comfort is crucial to facilitating a physiologic labor process and minimizing intervention.[2,4,9] A process of shared decision-making, coupled with detailed, specific guidance that includes comfort measures at home or in the support of an early labor lounge (ELL), contributes to a satisfying labor and birth experience.[9,10]

Clinical decision-making in determining latent versus active labor is also a complex phenomenon. The definitions for latent and active labor have changed in the last decade, determining that active labor for many women may not occur until 5 to 6 cm.[3,5,9] Neal and colleagues[3] propose a standard approach to assessment that includes active labor diagnosis of 3 or more painful contractions in 10 minutes and more than 75% effacement *and* 4 to 5 cm immediately preceded by more than 1 cm of cervical change in less than 2 hours *or* more than 6-cm dilation. This is important, as there are many ramifications to early admission. For example, observational studies of latent labor admission point to an increase in oxytocin, intrauterine pressure catheters, and antibiotics for fever.[9] In particular, low-risk, nulliparous women admitted during the latent phase of labor are at increased risk for overuse of clinical interventions and cesarean birth.[7,9] In addition to these outcomes, the estimated gestational age is a critical determinant of neonatal outcome as the late-term infants (37-39 weeks) show a higher incidence of morbidity, necessitating expectant management.[11]

MATERNAL CONFIDENCE

The childbirth preparation movement in the 1960s and 1970s, specifically, Lamaze International, encouraged confident birth through preparation.[12,13] The broad construct of confidence refers to a belief in abilities and personal qualities.[12] This concept was recently explored in depth by Neerland[12] in a Rogerian concept analysis. Key findings include knowledge and information as defining attributes for confidence for physiologic birth.[12]

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This knowledge, attained through a process of shared decision-making with a trusted maternity provider, increases confidence.[12] A more in-depth understanding of maternal confidence may help understand prenatal approaches that support and empower women in birth. The characteristics of maternal confidence may be found in Table 1.

A shared decision-making approach that consists of checking a woman's knowledge, such as "What do you know about early versus active labor?" to elicit understanding and preferences is recommended. A list of the available options reviewed and described, for example, home with support, medication before going home, walking, and returning. It is essential to point out differences between options, as well as the harm and benefits, and to provide the patient with decision support. This may need more than 1 encounter, as the family may need time to reflect. A summarization and then a teach back to consider the patient's understanding are vital. Women who are encouraged to go home from hospital desire clear instructions on what comfort measures to use and when to return, including signs of active labor.[14]

COPING AND COMFORT

Coping consists of the cognitive and behavioral efforts to manage a stressor.[15] The coping with labor algorithm is appropriate in all stages of labor.[9] In latent labor, the observational cues in the assessment include the woman's perspective, rhythmic activity, breathing, focus, and relaxation.[16] Women often request a desire for better management of pain but not necessarily pharmaceutical relief.[6] Promotion of comfort includes advice as to hydrotherapy, use of hot/cold packs, and other available measures. Environmental suggestions include ambient lighting, music, and visualization. Hydration, eating, and mobility are consistently reported in studies as important to women's satisfaction with care, whether laboring at home or in the hospital.[6] Comfort measures may be taught by a nurse in the setting of a triage unit, labor evaluation, or, when appropriate, telephone triage.[6] An expanded table of nonpharmacological options is available in Table 2.

Apprehension, fear, and the lack of early labor support are challenges to sending women home to await the onset of active labor.[17] To address these obstacles, hospitals have piloted an ELL with stations aimed at

Table 1. **Attributes, antecedents, and consequences of maternal confidence for physiologic birth[a]**

Characteristics of a concept	Definition	Physiologic birth
Attributes	Clusters of characteristics that make it possible to identify situations that can be categorized under the concept	Belief that labor and childbirth are a normal process Confidence in the innate ability to birth Past experiences Knowledge and information
Antecedents	The events or phenomena previously related to concept	Uncertainty Support Communication Trusted relationship with provider Continuity of care Birth stories Shared decision-making Feeling equipped or prepared Sources of information and preparation Confidence in the system and place of birth
Consequences	Situations that occur as a result of the concept	Feeling prepared Increased confidence during labor and birth Confidence in ability Confidence in coping Decreased labor pain Positive birth experience Increased satisfaction Empowerment Increased confidence, autonomy, and responsibility Decreased fear of childbirth

[a]Adapted with permission from Neerland.[12]

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Table 2. **Nonpharmacological coping strategies for laboring women**

Method	Techniques	Effects
Cognitive pain management	Childbirth preparation Information Guided imagery	Decreases pain perception Decreases anxiety Promotes comfort
Behavioral	Relaxation • Patterned breathing • Slow, light, and accelerated Positioning and movement • Ambulation • Side lying • Hands and knees • Birthing/exercise ball	Decreases catecholamine response Increases oxygen Enhances uterine blood flow, uterine activity, descent Increases personal control Facilitates mechanisms of labor, fetal descent, fetal position Relieves pressure
Sensory	Music Aromatherapy Touch, massage, effleurage Acupressure Transcutaneous electrical nerve simulation units (TENS) Hot/cold therapy Hydrotherapy • Shower • Tub • Pool	Promotes comfort Decreases anxiety Reduces pain, promotes progress Decreases pain Relieves pain Promotes comfort
Labor support	Therapeutic presence Maintain comfortable environment Encouragement Anticipation of needs	Promotes comfort Decreases anxiety
Physical support	Hydration and nutrition Promotion of rest	Provides energy Promotes progress

instilling confidence in the birth team, promoting relaxation and comfort, and reducing anxiety for laboring women. These lounges are based on current evidence on maternal confidence and need for information and appear successful in delaying admission to labor units while maintaining a positive and empowering patient experience.[17]

The literature on latent labor confirms that early admission is less than ideal, leading to unnecessary intervention. However, there are times when women may benefit from inpatient support services, particularly when they are fatigued or have exhausted existing coping resources.[18] The clinical management options include therapeutic rest, uterotonic drugs or amniotomy, and induction/augmentation of labor.[17]

Women's perception of labor cues and when to arrive at the hospital are predicated on prior knowledge, experiences, and confidence in physiologic birth.[7,12] A woman's latent labor experience that promotes delayed admission to a maternity unit will include specific information, resources and advice on coping, comfort measures, and a trusted relationship with the birth team.[6,12] The possibility of a calm, confident birth experience is contingent on shared decision-making, sensitivity to a woman's existing coping and support resources, and evidence-based resources.

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