Nurse Attitudes Toward Childbirth: A Concept Clarification

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AIM. To clarify the concept of “nurse attitudes toward childbirth.”

BACKGROUND. It has been suggested that the international trend of escalating cesarean birth rates can be attributed to attitudes that perceive childbirth as an illness. Nurses’ attitudes about childbirth direct their nursing care and may influence patient outcomes like cesarean birth. However, the concept “nurse attitudes toward childbirth” must be clarified to inform future research.

DATA SOURCES. An English-language literature review, from 1990 to present, was performed using CINAHL, PubMed, and Ovid.

REVIEW METHODS. Norris’s model of concept clarification was used.

RESULTS. Although the nursing literature poorly defined “nurse attitudes” and rarely used a conceptual framework, the discipline of psychology has been refining this concept for over 40 years. Psychologists have established that attitude can predict behavior as demonstrated through testing of the theory of planned behavior. Various types of “nurse attitudes toward childbirth” were identified through our literature review, and five central beliefs were noted. This resulted in the development of a preliminary model using theory of planned behavior as a foundation. Finally, potential research hypotheses were generated.

CONCLUSIONS. This paper clarifies “nurse attitudes toward childbirth” and supports its use for research. Nurse scholars have demonstrated that labor and delivery nurses do have individual attitudes toward childbirth, and the measurement of these attitudes may predict nursing care intentions and behavior. This concept is appropriate, important, and may be used as a means of exploring relationships between nursing care and the rising primary cesarean birth rate.

Summary Statement

What Is Already Known About This Topic

• The concept of “attitude” is frequently used in the nursing literature as if the definition was already known, but the concept remains ambiguous.

• International cesarean birth rates are rising, and little research exists exploring a potential relationship with nursing care.

What This Paper Adds

• Labor and delivery nurses have different individual attitudes toward childbirth that may be described using five core evaluative beliefs.
• The theory of planned behavior is an appropriate theoretical framework for the concept of “nurse attitudes toward childbirth.”

Implications for Practice and/or Policy
• Further research is needed to understand possible relationships between “nurse attitudes toward childbirth” and actual nursing care behavior.
• While the theory of planned behavior has been used in the healthcare setting, the appropriateness of its use has not been established in the intrapartum setting.

Introduction

For the past several decades, the rate of cesarean birth has been on the rise worldwide (World Health Organization [WHO], 2010). Nurse scholars have attributed this trend to the increasing dominance of the biomedical model of obstetric care. This model is manifested as an attitude wherein childbirth is treated as an illness (Davis-Floyd, 2001). This attitude toward childbirth as an illness consists of a system of beliefs wherein birth is dangerous and requires the intervention and constant vigilance of expert healthcare practitioners (HCPs).

Registered nurses (RNs) are the HCPs providing the majority of the bedside care and support during a woman’s labor and birth. A nurse’s attitude toward childbirth is represented by her beliefs about the relative normalcy or dangers inherent in the process of labor and birth. These attitudes inform her nursing care planning, could alter her nursing care decisions, and therefore alter patient outcomes. It has been suggested that a link exists between nurse attitudes toward childbirth that can promote or hinder vaginal birth and that this link may be related to the rising cesarean birth rate (Regan & Liaschenko, 2007). Our intention is to eventually explore the relationship between nurse attitudes, the care of women in labor, and the outcomes of childbirth. Consequently, it is imperative to use a clear, universally understood definition of the concepts being studied (Norris, 1982).

“Attitude” was selected as the concept of interest in this clarification for several reasons. First, “attitude” and “nurse attitude” appear with great frequency in the nursing literature, but these concepts are imprecisely defined. Second, the concept “nurse attitudes” is rarely used within a theoretical framework, which presents a serious challenge for knowledge development. Third, “nurse attitudes” have not been explored in the specific context of childbirth, which represents a gap in the literature and a need for concept clarification. Finally, although the discipline of nursing has not developed a clear definition of “attitude” within a theoretical framework, social psychology has been refining this concept for several decades and even suggests ways to operationalize the concept (Ajzen, 2006).

An important way to strengthen knowledge development is to use an existing theory as a foundation. The theory that is most germane to the concept of “nurse attitudes toward childbirth” is the theory of planned behavior (TPB). Developed by social psychologists Ajzen and Fishbein (1980), this theory has been well tested and includes the concept of attitude as a predictor for behavior. The TPB defines attitude as a person’s positive or negative evaluation of performing a specific behavior. Furthermore, attitude is determined by the strength of beliefs about the behavior and its outcomes. The definitions of the concepts in the TPB make it an ideal lens through which to view nurse attitudes toward childbirth (Ajzen, 2006). As a result, this paper will use Norris’ (1982) method to clarify the concept of “nurse attitudes toward childbirth,” with the TPB as a conceptual framework.

Method of Concept Clarification

Meleis (2007, p. 167) describes concept clarification as a method to “refine concepts that have been used in nursing without a clear shared, and conscious agreement on the properties or meanings attributed to the concept.” Presently, the concept “nurse attitudes” in nursing research has been used without a clear definition or theoretical foundation. Because concepts and theory are inexorably connected, a theoretical foundation is critical to concept development. Paley (1996, p. 578) argues that concept clarification in the absence of a connection to theory is “a vacuous exercise in semantics.” This clarification of the concept “nurse attitudes toward childbirth” using the TPB as a theoretical framework will distill current knowledge, as well as inform and enhance future knowledge development on this topic.

The most commonly used method of clarifying a concept is the model by Walker and Avant (2010). Although this model is considered to be a classic, it has also been highly criticized. The Walker and Avant model is intended to analyze concepts that are
unknown to nursing, whereas concept clarification is intended to refine concepts that are already in use by the discipline (Meleis, 2007). Norris (1982, p. 16) listed several strengths of concept clarification: synthesis of practice and theory, a richer description of a phenomenon with a theoretical connection, and beginning the theoretical development of a concept starting with “common sense analysis.” The concept of “attitude” is already used extensively in nursing literature; consequently, Norris’ concept clarification model was the most appropriate model for this analysis.

Norris (1982, pp. 14–19) describes concept clarification as a means to explore and explicate a phenomenon of interest using critical thinking skills. She describes her method of accomplishing this as requiring the following five steps:

1. Identify the concept and describe the phenomenon of interest from within the discipline and from the viewpoint of other disciplines.
2. Conduct a systematic review of the literature describing the phenomenon. Look for hierarchies, patterns, and categories. What events lead up to the phenomenon? What occurs as a result?
3. Develop operational definitions and describe how one recognizes the concept.
4. Construct a model, including relationships and other related concepts.
5. Begin to develop hypotheses in preparation for experimentation.

Despite having been written almost 30 years ago, Norris’ method of concept clarification continues to be relevant with important implications for nursing theory, research, and practice.

Step One: Identify the Concept

Clarifying the concept of nurse attitudes toward childbirth must be situated in the context of contemporary hospital obstetric care and measures of natality outcomes. International health care agencies, such as the WHO, and agencies in multiple countries such as the United Kingdom, the United States, New Zealand, and Canada have developed guidelines to address concerns about rising cesarean birth rates. In 2009, the rate of cesarean birth in the United States rose to a record high of 32.9% (U.S. Department of Health and Human Services, 2010). The primary cesarean rate (surgical birth for first-time mothers) is of special interest because all future pregnancies are affected by this mode of delivery. Thus, low-risk (term gestation, a singleton fetus in a head-down position) first-time mothers are particularly affected by the increasing prevalence of cesarean birth. Simultaneously, vaginal birth after cesarean rates have sharply declined (Centers and for Disease Control and Prevention, 2010). The significance of this information is that the vast majority of women who have a primary cesarean birth will have surgical births for all subsequent pregnancies (CDC, 2010).

This trend, wherein one-third of all women give birth by cesarean, has led many national and international healthcare agencies to develop guidelines intended to support and promote vaginal birth and decrease the overall cesarean birth rate (CDC, 2010; National Childbirth Trust, NICE, Royal College of Midwives, & Royal College of Obstetricians and Gynaecologists, 2007; National Institute for Health and Clinical Excellence, 2008; Society of Obstetricians and Gynecologists of Canada, 2008; WHO, 2010). While cesarean birth may have a legitimate medical indication, it is a major abdominal surgery with significant related risks such as increased morbidity and mortality for mothers and infants (Bernstein, 2005).

Some of the potential short-term complications of cesarean delivery for a woman include increased bleeding (possibly requiring blood transfusion); infection of the incision, uterus, or other nearby organs; reactions to medications or anesthesia; injuries to the bladder or bowel, or other pelvic organs; blood clots; emergency hysterectomy; and maternal death (Bernstein, 2005). Long-term complications include increased pain, a longer hospital stay, extended recovery time, negative birth experience, higher probability of readmission to the hospital, and formation of adhesions (Bernstein, 2005).

Cesarean delivery may also have a lasting effect on a woman’s reproductive health, with increased risks of infertility and subfertility. This is an important consideration because the decision to proceed with cesarean birth is frequently focused on the immediate pregnancy, because future reproductive plans are uncertain or deemed insignificant in that moment. All future pregnancies are also at increased risk for complications such as miscarriage, ectopic pregnancy, uterine rupture, and placental abnormalities such as placenta previa and placenta accreta (Bernstein, 2005).

The woman is not the only one at risk for complications from cesarean birth; the baby is also vulnerable to potential sequelae. Neonatal complications can
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include respiratory difficulties, asthma, iatrogenic pre-
maturity, admission to the neonatal intensive care unit, trauma, difficulties with breastfeeding, and even neonatal death (Bernstein, 2005).

While many of these complications are rare, they have been well described in clinical literature and are real threats associated with cesarean delivery. Meanwhile, the high cesarean birth rate has not contributed to better maternal/child health quality. In fact, in 2002, the American College of Obstetricians and Gynecologists (ACOG) concluded that among the low-risk population of nulliparous (first-time) mothers, a higher rate of cesarean birth did not result in improved outcomes. A reduction in cesarean rates for low-risk nulliparous women is consistent with international safety and cost-effectiveness goals.

The development of guidelines supporting and promoting vaginal birth demonstrates the international interest in addressing the widespread trend toward the cesarean birth. Even popular media has taken note of the rising cesarean birth rate. In recent years, there has been an explosion of nonfiction books and films, such as the book Pushed: The Painful Truth About Childbirth and Modern Maternity Care (Block, 2008), that draw attention to a major attitude shift in modern obstetric care. Authors have even gone so far as to call this trend “an epidemic of unnecessareans” (Arnold, 2011).

Within this contemporary context, the attitude of childbirth perceived as an illness consists of several corresponding beliefs. The alternate extreme is an attitude that considers childbirth to be a normal, yet significant, life event (Aparicio, 2006; Callaghan, 1993; Davis, 2010; Davis-Floyd, 2001; Gagnon, Meier, & Waghorn, 2007; Gould, 2000; Klein et al., 2009, 2010, 2011; Regan & Liaschenko, 2007; Sauls, 2007; Sleutel, 2000). There are a number of beliefs that accompany the attitude of childbirth as an illness versus the attitude of childbirth as a normal life event (Callaghan, 1993; Davis-Floyd, 2001; Regan & Liaschenko, 2007). These attitudes and corresponding beliefs from the literature review are described as key findings in Table 1.

Almost 20 years ago, Radin, Harmon, and Hanson (1993) found that nurses had specific individual cesarean birth rates even when controlling for a wide range of variables. These investigators encouraged future research on this topic because the results of their study indicated that nurses provide different styles of care that may promote or hinder vaginal birth. As a result of their study findings, Radin et al. (1993) encouraged future research to explore possible connections between specific components of individual nurse’s care and patient outcomes. Since that time, research findings have indicated that it may be that the attitude of specific nurses is what influences patient outcomes.

Sauls (2007) conducted a key study on intrapartum (labor/delivery) nurse attitudes and intentions to perform nursing care using the TPB as a theoretical framework. In particular, Sauls was interested in exploring nurse attitudes as a predictor of intentions to provide professional labor support in the hospital setting. Consistent with the relationships proposed by the TPB, Sauls found that nurses who felt positively about labor support were more likely to actually provide it and that intrapartum RNs do believe that supportive care is part of their role.

The nurses who participated in Sauls’ (2007) study acknowledged a strong desire to provide professional labor support but did not receive support or time to provide it from their colleagues or nursing administration. Furthermore, the participants felt that their unit culture did not value labor support or even discouraged it. In fact, 87% of individual nurses reported that they were unable to provide adequate labor support because of perceived unit barriers (Sauls, 2007, p. 121). A negative unit attitude toward labor support was identified by the participating nurses as the most significant barrier to providing professional labor support.

Not only are intrapartum nurses influenced by their own individual beliefs, and the unit’s cultural or subjective norms, but nurses are deeply affected by the overall hospital culture. In addition, Western healthcare systems are highly regulated and structured and reward technical proficiency such as procedural and policy adherence rather than care activities such as labor coaching and emotional support. This has a profound effect on nurses’ perceived ability to control their behavior and may inhibit nurses from performing care that could prevent unnecessary cesarean births.

The study by Sauls (2007) is an excellent example of how the TPB can inform the concept of “nurse attitudes toward childbirth.” Sauls found that the combination of individual nurse attitudes, subjective norms (unit attitude/culture/beliefs), and the nurse’s perceived behavioral control influenced the nurse’s intentions to provide care (professional labor support). Sauls strongly recommended the development of future research on this concept, and her study
<table>
<thead>
<tr>
<th>Article</th>
<th>Discipline</th>
<th>Categories/Synonyms</th>
<th>Patterns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aparicio (2006)</td>
<td>Nursing</td>
<td>Master's thesis</td>
<td>To test the validity and reliability of a new instrument, the Nurse Attitudes and Beliefs Questionnaire.</td>
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<tr>
<td></td>
<td></td>
<td>Midwife Beliefs</td>
<td>RM's birth beliefs from a more humanistic perspective; this defines birth as a normal but deeply meaningful and significantly spiritual life event that is measured in holistic terms.</td>
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<td></td>
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<td></td>
<td>It is critical that the individual birthing woman's health beliefs be honored.</td>
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<td></td>
<td>Urged HCPs to be aware of dominant health beliefs and the resultant routine care practices.</td>
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<td></td>
<td>Biomedical model is the most dominant healthcare model in the Western world.</td>
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<td></td>
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<td></td>
<td>Per this model, women take passive roles in their births, and the HCP is the expert labor, not the woman.</td>
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<td></td>
<td></td>
<td></td>
<td>Physician is the hero who will “rescue” them from the pain of childbirth: “trust me and do what I say, and I will relieve your suffering” (p. 14).</td>
</tr>
<tr>
<td>Davis-Floyd (2001)</td>
<td>Anthropology</td>
<td>Qualitative analysis</td>
<td>Compared/contrasted three different paradigms of birth. See Table 4 for themes.</td>
</tr>
<tr>
<td>Gagnon, Meier, and Waghorn (2007)</td>
<td>Nursing</td>
<td>Retrospective exploratory</td>
<td>The fewer RNs that care for patient, the lower her cesarean risk.</td>
</tr>
<tr>
<td>Klein et al. (2009)</td>
<td>Medicine</td>
<td>Large quantitative study</td>
<td>OB, RM, FP, and RN attitudes toward childbirth are different.</td>
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<tr>
<td></td>
<td></td>
<td>Obstetric care provider</td>
<td>Studied HCP's attitudes toward a variety of technologies used frequently in childbirth such as epidural, procin augmentation and induction, electronic fetal monitoring, and artificial rupture of membranes.</td>
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<tr>
<td></td>
<td></td>
<td>Birth technology</td>
<td>The majority of Canadian OBs were very supportive of childbirth technologies and interventions.</td>
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<tr>
<td></td>
<td></td>
<td>Birth interventions</td>
<td>OBs felt that a laboring woman’s attitudes did not have a role in influencing her own birth outcome (p. 834).</td>
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<tr>
<td></td>
<td></td>
<td>Attitudes</td>
<td>RM's relied less on technology and medication, and preferred to use natural techniques such as water therapy, walking, positioning, and massage.</td>
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<td></td>
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<td></td>
<td>RM's strongly agreed with statements such as “women’s attitudes towards birth influences their birth outcomes” (p. 838).</td>
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<td></td>
<td></td>
<td></td>
<td>In RM model, the laboring woman is an expert and active participant in her birth while the HCP stands by as expert guide.</td>
</tr>
<tr>
<td>Klein et al. (2010)</td>
<td>Medicine</td>
<td>Large quantitative study</td>
<td>Younger Canadian OBs were more supportive of birth technologies than the older generation of practitioners.</td>
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<td></td>
<td></td>
<td>Physician attitudes</td>
<td>Canadian healthcare policy acknowledges vaginal birth as the ideal mode of birth for both women and their babies</td>
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<tr>
<td></td>
<td></td>
<td>Cesarean births</td>
<td>(SOGC, 2008, p. 839).</td>
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<tr>
<td></td>
<td></td>
<td>Vaginal Births</td>
<td>Majority of younger OBs did not agree with this policy and had attitudes consistent with the biomedical model that views birth as an illness with inherent risks of morbidity and mortality for both mother and fetus.</td>
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<td></td>
<td></td>
<td>Birth dangers</td>
<td>Younger OB group had significantly more concerns than any other HCP group about possible negative consequences of vaginal birth.</td>
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<td></td>
<td>Complications were perineal tearing, urinary or fecal incontinence, and pelvic floor damage.</td>
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<td></td>
<td>This included the belief that elective cesarean birth is just as safe as vaginal birth.</td>
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<td></td>
<td></td>
<td>Younger OBs were very comfortable with cesarean births and almost seemed to prefer it.</td>
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<tr>
<td>Radin, Harmon, and Hanson (1993)</td>
<td>Nursing</td>
<td>Quantitative study</td>
<td>RNs have a cesarean rate that is specific to individual RNs even when controlling for many variables.</td>
</tr>
<tr>
<td>Regan and Lisachenko (2007)</td>
<td>Nursing</td>
<td>Large qualitative study</td>
<td>See Table 3 for an overview of group frames.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Labor/delivery Nurse care</td>
<td>Identified three different labor/delivery nurse care cognitive frames.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Relationship to cesarean delivery</td>
<td>Different attitudes about who the most important patient of the woman/baby dyad.</td>
</tr>
<tr>
<td>Sauls (2007)</td>
<td>Nursing</td>
<td>Large qualitative study</td>
<td>Both attitude and social pressure affected intentions to provide labor support.</td>
</tr>
<tr>
<td>Sleutel (2000)</td>
<td>Nursing</td>
<td>Qualitative pilot study</td>
<td>“Following the woman’s body,” (p. 43).</td>
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<td></td>
<td></td>
<td>Labor approach to labor</td>
<td>“ Hastening and controlling labor,” (p. 43).</td>
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<td></td>
<td></td>
<td>TPB</td>
<td>“Labor support techniques,” (p. 43).</td>
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<td></td>
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<td>Ethical dilemmas arising from collaboration with physicians and practice differences.</td>
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</tbody>
</table>

FP, family practice physician; HCP, healthcare practitioner; MD, medical doctor; OB, obstetrician; RM, registered midwife; RN, registered nurse; TPB, theory of planned behavior.
provides evidence that the TPB is an appropriate theory to explore the concept of “nurse attitudes toward childbirth.”

Data Sources

An extensive literature review was performed and refined using the following databases: CINAHL, Ovid, and PubMed. The initial search used the keywords nurse attitudes. Literature from the year 1990 forward was included unless the article was a seminal work, as evidenced by large numbers of citations. The search using keywords nurse attitudes yielded 8,263 articles in CINAHL and 35,004 in Pubmed, and a similar number in Ovid. To begin eliminating some of this large number of articles, we used more specific search criteria.

Specifically, we were seeking articles directly addressing the relationship of nurse attitudes and childbirth. Therefore, the search was expanded by searching for the term nurse attitudes and adding childbirth, parturition, and labor and delivery. When the search term childbirth was added, 23 articles were found in CINAHL, and 470 articles were identified in PubMed.

The articles appeared in a wide variety of peer-reviewed journals from various disciplines, including nursing, anthropology, and psychology. To further reduce the number of articles for the complete review, the following inclusion criteria were specified:

1. The article was written in English.
2. The article involved an exploration of nurse attitudes (or other closely related synonym) AND childbirth (or other closely related synonym).
3. The article used an empirical methodology, either quantitative or qualitative, a literature review, or a concept analysis.
4. Later, healthcare provider attitude AND childbirth (or synonym) were added as criteria for inclusion rather than exclusively nurse attitudes.

Using the criteria identified, articles were screened by reading the abstracts of 23 articles. The majority were theoretical discussions. Of the 23 CINAHL results, two articles and one master’s thesis met the inclusion criteria. The PubMed search provided the same articles. Most articles did not have an empirical approach to their methodology. As a result, a secondary search was used.

The search was expanded to include healthcare provider and the following synonyms for attitude (Attitude, n.d.c): beliefs, perceptions, views, opinions, paradigms, opinions, approach, belief, bias, mindset, perspective, philosophy, position, predilection, prejudice, standpoint, and models. Several additional articles were found using synonyms. The majority of articles found during this search were related to physicians’ and midwives’ attitudes toward childbirth. While this concept clarification is intended to explore nurse attitudes toward childbirth, the articles regarding other caregivers provide important background on the topic and were therefore included.

Finally, the reference lists of articles were explored in an effort to identify any salient literature that may have been missed or was not identified using the previous process. This review revealed very little empirical research in the peer-reviewed literature studying the relationship between nurse attitudes and childbirth. Eight articles met the final criteria and were included in the review and are outlined in the literature review (Table 1).

Results

Step Two: Literature Review

The clarification of a concept begins with an overview of common definitions. An attempt was made to explore a wide variety of sources to define the concept and identify as many uses and aspects of the concept as possible. Sources included dictionaries, thesauri, scholarly articles within nursing, and articles from outside the discipline including psychology, sociology, anthropology, and lay literature. Because the concept of “nurse attitudes toward childbirth” is quite specific, definitions will be addressed from broad to narrow.

Attitude. In spite of its frequent use both in general conversation and in scientific literature, the concept of “attitude” often lacks a distinct definition. A few generalizations can be made regarding the use of the term. Attitude is generally used as a noun and described as a positive or negative reaction to a person, thing, object, or situation. The concept is usually described as a mental or emotional “state of mind” that indicates a tendency to act or react in a certain way (Altmann, 2008; Attitude, n.d.a, n.d.b).
Table 2. Definitions of Most Commonly Used Synonyms

<table>
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<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Attitude</td>
<td>A favorable or unfavorable evaluative reaction toward something or someone exhibited in one’s beliefs, feelings, or intended behavior.</td>
</tr>
<tr>
<td>Perception</td>
<td>A single unified awareness derived from sensory processes while a stimulus is present.</td>
</tr>
<tr>
<td>Belief</td>
<td>A principle, proposition, or idea that is accepted as true.</td>
</tr>
<tr>
<td>Value</td>
<td>Principles of living that include moral beliefs and standards of conduct; values differ from attitudes in that they are broader, more abstract.</td>
</tr>
<tr>
<td>Cognitive frame</td>
<td>A frame in social theory consisting of a schema of interpretation.</td>
</tr>
<tr>
<td>Schema</td>
<td>A collection of anecdotes and stereotypes that individuals use to understand and respond to events.</td>
</tr>
<tr>
<td>Opinion</td>
<td>A belief or judgment that is not sufficient to provide absolute certainty.</td>
</tr>
<tr>
<td>Paradigm</td>
<td>A worldview.</td>
</tr>
<tr>
<td>View</td>
<td>A conception of something: an opinion or theory.</td>
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</table>


Because this paper is using the TPB as a foundation, that conceptual definition will be used. This definition has an extensive history of use in psychological research and has been operationalized; consequently, it is the most salient. However, we are including a few other definitions for comparison. The Online Medical Dictionary (Dark, 2005) defines attitude as “an enduring learned predisposition to behave in a consistent way toward a given class of objects, or a persistent mental and/or neural state of readiness to react to a certain class of objects, not as they are but as they are conceived to be.”

Some of the key synonyms from Roget’s Thesaurus are (Attitude, n.d.c) mental outlook, approach, belief, bias, frame of mind, inclination, mental state, opinion, perspective, perceptions, philosophy, point of view, position, view, aspect, mien, cognitive frames, schemas, and paradigms. Additionally, there were several definitions involving position or posture as used in aeronautics or ballet, and while interesting, were not included. Table 2 reflects the definitions of the most commonly used synonyms found in the literature, but the most appropriate definition of attitude comes from the TPB. This definition states that attitude is a multidimensional evaluative response to a stimulus and consists of three components: cognitive, affective, and behavioral elements. The most critical aspect of the operational and theoretical definition of attitude lies in the evaluative nature of attitudes, or “Is this something that is good or bad?” (Fishbein & Raven, 1962).

Nurse attitude toward childbirth. Labor and delivery nurses have developed their own individual evaluative attitudes toward childbirth that include cognitive, affective, and behavioral components. These attitudes are developed from previous personal and professional experiences with birth, and include the opinions of friends and significant others, education, and the media. These evaluative beliefs about childbirth may be conscious or unconsciously held, include emotional reactions toward, and finally, overt behaviors that express these beliefs.

Describe Patterns, Categories, and Themes

This part of the second step in concept clarification involves the process of developing a system of observations and descriptions by identifying specific behaviors and factors that lead up to the phenomenon (Norris, 1982). The TPB defines attitude as an individual’s positive or negative evaluation of the self-performance of a particular behavior, the degree to which the behavior is positively or negatively valued, and the set of beliefs that link the behavior to outcomes. Patterns were sought relating nursing beliefs about birth, attitudes toward nursing care, support of vaginal birth, and beliefs about vaginal or cesarean birth. Before nursing interventions to reduce unwarranted cesarean births can be developed, the nursing attitudes that direct care must be identified.

The phenomenon of childbirth has been considered with different philosophical perspectives throughout history. Anthropologist Davis-Floyd (2001) developed and described the three current paradigms of childbirth: technocratic, humanistic, and holistic. Davis-Floyd developed 12 core tenets for each of these paradigms that she distilled from her program of research and from interviews with physicians, nurses, midwives, and mothers. Davis-Floyd believes that currently, the dominant paradigm is technocratic but that elements from all three paradigms should be combined to create a more effective obstetric healthcare system.

Several major themes and subthemes were noted in our review of the literature, particularly in two large
studies undertaken by Klein et al. (2009, 2010). In their first study, Klein et al. (2009) explored the attitudes of a variety of maternity care providers: obstetricians (OBs), registered midwives (RMs), family practice physicians (FPs), RNs, and doulas. In this study, Klein et al. (2009) identified groupwide attitude differences that represented a continuum of sorts. At one extreme were the OBs. The majority of these physicians described an attitude consistent with the biomedical model of care. On the other end of the spectrum, RMs and doulas had an attitude toward birth consistent with a holistic model of care. RNs and FPs fell roughly in the middle of the two extremes. These attitudes were described consistently across the literature.

Another pattern noted in the review was that few studies examined the attitudes of RNs. Klein et al. (2009) included RNs and found that as a group, nurse attitudes toward childbirth were in between OBs and RMs. In this study, Klein et al. (2009) identified groupwide attitude differences that represented a continuum of sorts. At one extreme were the OBs. The majority of these physicians described an attitude consistent with the biomedical model of care. On the other end of the spectrum, RMs and doulas had an attitude toward birth consistent with a holistic model of care. RNs and FPs fell roughly in the middle of the two extremes. These attitudes were described consistently across the literature.

Another pattern noted in the review was that few studies examined the attitudes of RNs. Klein et al. (2009) included RNs and found that as a group, nurse attitudes toward childbirth were in between OBs and RMs. One of the other relevant studies was Regan and Liaschenko’s (2007) exploration of nurse cognitive frames of childbirth. A cognitive frame is a way of interpreting a phenomenon and is very similar to the TPB definition of attitude. Regan and Liaschenko found that nurses fell into one of three different groups of cognitive frames, noting that these frames consisted of a system of beliefs that influenced how the nurses viewed vaginal or cesarean birth. The three groups were “birth as a normal process,” “birth as a lurking risk,” and “birth as a risky process.” Table 3 demonstrates the differences between these groups. Their data indicated that roughly two-thirds of labor/delivery nurses belonged to groups with an attitude of “birth as a risky process” or “birth as a lurking risk.” The authors hypothesized that these attitudes are largely preconscious and may influence how nurses provide care and support their laboring patients. This attitude toward birth as risky was a common thread among many of the reviewed articles (Callaghan, 1993; Davis, 2010; Davis-Floyd, 2001; Gagnon et al., 2007; Gould, 2000; Klein et al., 2009, 2010, 2011; Regan & Liaschenko, 2007; Sauls, 2007; Sleutel, 2000).

Table 4 provides an overview of categories, subcategories, and themes that were identified as significant aspects, antecedents, and consequences of the concept “nurse attitudes toward birth.” However, this concept can be broadly characterized into the following five major beliefs themes:

- How much intervention is needed in childbirth (some vs. none)?
- Who is the primary patient (the woman vs. the baby vs. mother/baby as an inseparable unit)?
- Is the use of childbirth technologies needed (necessary vs. unnecessary)?
- Is vaginal childbirth safe (vaginal birth safe vs. unsafe)?
- What is the laboring woman’s role in her birth (active vs. passive)?

(Aparicio, 2006; Callaghan, 1993; Davis, 2010; Davis-Floyd, 2001; Gagnon et al., 2007; Gould, 2000; Klein et al., 2009, 2010, 2011; Regan & Liaschenko, 2007; Sauls, 2007; Sleutel, 2000)
Step Three: Operational Definitions and Recognizing the Concept

The third step of concept clarification is to develop a means of identifying and measuring the concept (Norris, 1982). One way to create an operational definition is to use an existing theoretical framework. Paley (1996) argues that this is a critical step and strengthens concept development. The theory used as a foundation of this concept clarification was the TPB. Some of the key definitions of this theory are as follows (Ajzen, 2006):

1. The TPB evolved from the theory of reasoned action but adds the concept of social context (subjective norms). Subjective norm refers to a person’s
perception of how relevant others feel about the performance of the behavior.
2. Behavior is viewed on a continuum from total conscious control to completely unconscious control.
3. Perceived behavioral control evolved from Bandura's self-efficacy theory and refers to people’s perceptions of their ability to perform a behavior of interest.
4. Evidence from previous testing of the TPB supports that behavioral intentions are the best and most powerful predictor of a person’s future behavior.
5. Behavioral intentions are a function of three variables:
   • Attitude toward performing the behavior (individual beliefs toward behavior)
   • Subjective norm (social context and beliefs about behavior)
   • Perceived behavioral control (Can I control my behavior?)

Additionally, the TPB predicts that the more positive one's attitude, the greater the degree of approval by others, and the more behavioral control one perceives one has, the greater one’s intentions will be to perform the behavior (Ajzen, 2006). The TPB provides clear operationalizable definitions that are important for clarification of the concept of “nurse attitudes toward childbirth.”

**Step Four: Construct a Model, Including Relationships, and Other Related Concepts**

The fourth step in Norris' concept clarification is to construct a model. A proposed model was developed for the concept of “nurse attitudes toward childbirth” based on the TPB. In this model, the RN attitude was informed by their evaluative beliefs about the five themes noted in the literature. Nurse attitude is also influenced by the unit’s subjective norms. Nurse attitude, subjective norm, and perceived behavioral control then influence behavioral intention that determines the actual performance of the behavior (Figure 1).

**Step Five: Develop Hypotheses in Preparation for Experimentation**

The final step in Norris' method to clarify a concept is to develop hypotheses for future research. Nurses
have individual attitudes that evaluate whether childbirth is good or bad, and healthy or dangerous, and these direct the nurse’s patient care. These attitudes about birth are learned from prior professional and personal experiences with birth. Nurses will adjust their nursing actions according to their attitudes regarding the five key belief themes noted in the literature review: use of childbirth interventions, who the primary patient is, the use of childbirth technologies, whether vaginal birth is safe or not, and the laboring woman’s role in her labor and birth. Therefore, nursing attitudes predict whether the nurse’s care will support and promote vaginal birth, or contribute to the high cesarean birth rates.

Nurses may or may not be conscious of these evaluative beliefs. However, accurate measurement of nurse attitudes is the critical first step. Attitudes influence nursing care. Nursing care influences cesarean birth rates; therefore, nurse attitudes can influence cesarean birth rates. Once childbirth attitudes have been identified, research can proceed toward devising methods that support attitudes that promote vaginal birth and to potentially change attitudes that lead to care that hinders vaginal birth. This could lead to changes in the subjective norms of labor/delivery units in order to provide the best outcomes for mothers and babies.

Discussion

Attitudes are constructs of psychology. Hence, they are not directly observable, and their measurement is dependent upon truthful responses by the participants to psychometrically sound instruments. Attitude is difficult to measure, and some scholars feel that it may not even be possible to measure some aspects of attitude (Altmann, 2008). Attitudes are often not conscious, and individuals who are being studied may alter their responses based on what they feel is socially desirable. It has been suggested that attitude may be measured through inference by measuring its attributes. Then potential methods of influencing attitudes may be developed.

Conclusions

One of the limitations of this analysis was that so many articles were identified with the key words nurse attitude. It was simply not possible to analyze all of these articles, and therefore it is possible that some critical literature was inadvertently missed. Despite an extensive literature search, it also is possible that some synonyms were overlooked. Several articles were reviewed that used different terms synonymous with attitude, but it is a fair question to consider whether these were truly the same concept as “attitude.” However, the lack of theoretical frameworks used by nurse scientists supports the importance of this debate.

Nurses have the most patient contact of all health-care providers. While other providers (physicians or midwives) write orders that direct certain aspects of patient care, nurses have the freedom to implement independent nursing actions (e.g., continuous electronic fetal monitoring, activity, labor support, and maternal positioning). These nursing interventions place nurses in a position of great influence. Nursing research findings demonstrate that nursing care has the power to encourage, support, and nurture women toward the goal of a vaginal birth, or to hinder it, and contribute to a labor process that leads to eventual cesarean birth (Gagnon et al., 2007; Radin et al., 1993).

The TPB is an appropriate theoretical framework for future research involving this concept. Nurse researchers have demonstrated that attitudes can predict nurses’ intention to provide nursing care and nurse behavior. RN attitudes affect patient care and therefore patient outcomes. These nursing care actions may be a predictor of or protector against unnecessary cesarean birth. This concept analysis suggests a middle-range predictive nursing theory. Future theory development regarding “nurse attitudes toward childbirth” should include testing of the TPB for appropriateness in intrapartum nursing.

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References


