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Becoming Someone Different: A Grounded Theory Study of How Nurses Integrate Pregnancy and Full Time Employment

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by

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A dissertation submitted to the Graduate Faculty in Nursing in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

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This manuscript has been read and accepted for the Graduate Faculty in Nursing in satisfaction of the

dissertation requirement for the degree of Doctor of Philosophy.

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Abstract

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by

Paul Gregory Quinn

Advisor: Dr. Barbara DiCicco-Bloom

In the United States, 40% of the contemporary nursing workforce is comprised of
women of childbearing age, 65% of whom are employed full-time. Hence, the likelihood of
pregnancy occurring for this population at some point in their employment is high. A holistic
exploration of how nurses integrate pregnancy and full-time employment has been lacking. The
purpose of this research was to explore how primiparous nurses managed pregnancy and full-
time employment. Using a grounded theory approach, nurses who were pregnant and delivered
their first baby, while employed full-time on 12-hour work shifts, provided a firsthand account of
how they incorporated pregnancy with employment.

Nurses, as social actors, experience many interactions in their workplace environment.
The basic social process, *becoming someone different*, emerged to explain those interactions and
allowed a substantive grounded theory to be developed. From that exploration, the researcher
will present the basic social process, *becoming someone different*, and the four core categories
that arose from the analysis:

1) *looking different, feeling different* – to explain how the physical and emotional changes of
pregnancy result in nurses looking and feeling differently about themselves as nurses;

2) *expectations while expecting* – where the nurse, with previous experiences and ideas about what is expected of her and what she expects from others, changes how she sees herself, based upon her interactions in the workplace with her peers and coworkers;

3) *connecting differently* – explains how the nurse, while pregnant, develops new relationships and interactions with the people in her environment, specifically her peers, coworkers and patients, and

4) *transitioning labor* – where, despite challenges from interactions within the workplace from coworkers or tasks, the participant nurses began to focus on their eventual maternity leave and working as long as possible up to the time of delivery in order to prolong that maternity leave.

Acknowledgments

"Believe…"

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Dedication

This work is dedicated to my mother, Eileen Guidice, RN. You have been my inspiration and mentor long before my career began. Your legacy to me will always be that taking care of the sick is an honor, and that becoming a nurse, and a midwife, was the most precious gift life would ever give me. If I can become half the nurse you are, my career will not have been in vain. The nurse I am, the work I do, the man I am and yet to become, are all because of you.

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Chapter 1: Introduction

According to the U.S. Department of Labor (2010c), there are approximately 1.7 million nurses in the United States, 40% of whom are women within the childbearing ages of 20-45 years; more than 65% are employed full-time. Pregnancy is thus a viable possibility for female nurses in this age range at some point in their employment. Despite an existing body of literature that explores the influence of pregnancy in the workplace, an exploration regarding how *nurses* integrate pregnancy and full-time employment is absent from the literature.

As related to pregnancy and employment, favorable and unfavorable findings are reported, e.g., workplace support or workplace accommodations (Bragger, Kutcher, & Morgan, 2002; M. Fried, 2000; Hebl, Glick, King, Singletary, & Kazama, 2007; Major, 2004) and workplace hostility or negative stereotypes toward pregnant employees (T. Brown, Ferrara, & Schley, 2002; Lyness, Thompson, Francesco, & Judiesch, 1999). Additionally, the literature has explored pregnancy and employment with regard to aspects that are physical (Brace, 2005; Pompeii, Evenson, & Delcros, 2011; M. W. Smith, Marcus, & Wertz, 2008) and emotional (Glynn, Dunkel-Shetter, Hobel, & Sandman, 2008; Stanton, Lobel, Sears, & Del Luca, 2002). Finally, nursing research has explored the workplace environment for nurses (Letvak, 2001; Lipscomb, Trinkoff, Geiger-Brown, & Brady, 2002; Tucker, Harris, Pipe, & Stevens, 2010), but no known studies have explored how nurses manage pregnancy and full-time employment with the contemporary 12-hour work shift.

Purpose

The purpose of this research was to explore how primiparous nurses integrate pregnancy with full-time employment. Based on a grounded theory approach, the phenomenon of primiparous registered professional nurses who were employed full-time while pregnant was explored with a systematically developed set of conceptual categories identified to form a theoretical framework (Glaser, 1978; Glaser & Strauss, 1967).

Research Question

This research was guided by the following question: How do primiparous nurses integrate pregnancy and full-time employment?

Inclusion Criteria

Primiparous: term used to describe a woman who has given birth to her first child (Cunningham et al., 2009; Varney, Krebs, & Gregor, 2003). The pregnancy is completed, and birth has occurred.

Nurse: a registered professional nurse possessing an associate's or a bachelor's degree who is employed in an acute care hospital and self-reporting employment on a medical-surgical, progressive care/stepdown, or critical care unit in the New York tri-state area.

Full-time: a work week as determined by the employer, typically 35-40 hours (Adams, 2010; U.S. Department of Labor, 2010a).

Background

Multiple theories have been posited to explain gender and role identity—specifically, how women are socialized to act "feminine" (Bem, 1981, 1993; Buss, 1995; Chodorow, 1989; Eagly, 1987; Eagly & Wood, 2002; Gergen, 1990, 2009; Hawkesworth, 1997; Shields, 1975). Culture and society influence the definition of femininity and prescribe what behaviors are acceptable and appropriate for women (Kane, 2006; Lawy, 2003). This prescription is pervasive, affecting how women behave in their homes and in social groups, with peers and with coworkers (Kane, 2006).

Despite roles being identified as "masculine" or "feminine," women have attained progressively higher levels of education and earnings compared to men (U.S. Department of Labor, 2010a). For example, in 2009 women aged 25-34 earned 89% of what men earned and for workers aged 16-24, women earned 93% of what men earned.. Women today are most likely to be employed in education and health services, followed by trade, transportation and utilities, and local government (U.S. Bureau of Labor, 2010c). Regardless of their employment role, only women can fill the biological role of bearing children. Pregnancy, then, is likely to influence how women are treated and how they act in the workplace (L. M. Brown, 2010). Workplace practices, policies, and behaviors reflect an organization's cultural norms and how women are perceived in the workplace (Padavic & Reskin, 2002).

Research between1990 and 2010 reported unfavorable findings for pregnant women in the workplace (Gueutal, Luciano, & Michaels, 1995; Gueutal & Taylor, 1991; Halpert & Burg, 1997; Halpert, Wilson, & Hickman, 1993; Pattison, Gross, & Cast, 1997) as well as favorable aspects (T. Brown et al., 2002; Farley-Lucas, 1997; Glass & Riley, 1998; Lyness et al., 1999).

For example, multiple physical discomforts, as well as the effects of workplace stress, have been identified with work and pregnancy (Brace, 2005; Pompeii et al., 2011; Smith et al., 2008;Glynn et al., 2008; Stanton et al., 2002). Additionally, the literature points out how women incorporate pregnancy into their work lives by accommodating their day-to-day needs and working around the challenges (Bochdering, 2009; Hamilton & Lobel, 2008). More recent trends indicate that employers are striving to make the workplace more "pregnancy-friendly" (Adams, 2010; Eichner, 2008). Entire industries, e.g., law enforcement, computer technology, massage therapy and various corporations have examined the needs and experiences of their pregnant employees and put forth an array of safety and workplace initiatives to support women during pregnancy. Their innovative policies and recommendations or incentives relate to integrating pregnancy and employment (Carlson, 2005; Lane, 2008). The nursing industry has made inroads in providing safety and preventive measures, for example, to protect nurses from exposure to toxic substances and radiation, before and during pregnancy (Draper, 2006).

Tucker et al. (2010) reported that nursing is a physically demanding and stressful profession. Studies on pregnant nurses in the workplace center primarily on safety and preventive measures to avoid exposure to toxic medications and substances, along with avoidance of specific teratogenic diseases (Hossain & Triche, 2007; Suarez-Varela et al., 2009). However, despite the fact that nurses are, for the most part, women of childbearing age (U.S. Department of Labor, 2010b), nursing literature lacks a holistic approach to integrating pregnancy and the contemporary 12-hour nursing shift.

Significance

Workplace challenges like stress and physically demanding environments have been implicated as causes of poor pregnancy outcomes, e.g., small size for gestational age, low birth weight, and preterm delivery (Glynn et al., 2008; Latendresse, 2009; Stanton et al., 2002; Yali & Lobel, 1999). Stress, including workplace stress, is cited as a contributing factor for complications during labor and delivery (Saunders, Lobel, Veloso, & Meyer, 2006). Studies demonstrate that supportive work environments successfully assist women in managing workplace stressors, including physical stressors, and increased their incidence of uncomplicated deliveries of healthy babies. Such support included social support from coworkers, and policies offering accommodations for pregnant workers: flexible scheduling, modified work hours, and change in job duties (Borcherding, 2009; Gurung, Dunkel-Shetter, Collins, Rini, & Hobel, 2005; March of Dimes, 2009b; Yali & Lobel, 2002). Although individual anecdotal experiences have been investigated, including stress and physically demanding employment (Tucker et al., 2010), no holistic exploration has been conducted of the social interactions of nurses employed full-time while pregnant. Therefore, little is known about what meaning or effects, favorable or unfavorable, the nurses attribute to the combination of pregnancy and full-time employment. This exploration into the phenomenon using a qualitative research method would contribute to nursing's substantive body of knowledge (Speziale & Carpenter, 2011).

Method

Qualitative research and its methods stem from the social sciences and can be used to describe and interpret complex phenomena that involve individuals' views, beliefs, preferences, and subjective responses to places and people (Rusinova, Pochard, Kentish-Barnes, Chaize, & Azoulay, 2009). Grounded theory is a systematic qualitative research method used to generate theory about how people deal with life situations, "grounded" in empirical data that describe the social processes by which people move through stages over time (Jeon, 2004). Grounded theory originated from the social sciences, wherein theory is generated from data (Charmaz, 2006). First described in the 1960s by two sociologists, Barney Glaser and Anselm Strauss, the method was intended to enable the discovery of theory from the data of social research (Glaser & Strauss, 1967). Using observations, conversations, or interviews, the researcher creates notes and memos about what he/she observes and then combines those with a line-by-line or incident-by-incident breakdown of the data into core categories (Dey, 1999). The hallmark of the method is a constant comparative analysis, where each line of text or each incident or observation is compared through repeated comparison to previous data (Hunter, Hari, Egbu, & Kelly, 2005). The data from the constant comparison steer the researcher toward additional informants (Glaser, 1978, 1992, 1998; Glaser & Strauss, 1967).

Informants in a grounded theory study are traditionally obtained through theoretical sampling. Initially, key informants are participants who the researcher believes will provide sufficient insight into a situation to begin a research exploration; however, theoretical sampling used the data obtained from the constant comparison to select who should be included next (Hunter et al., 2005). As the concepts emerged, the analysis continued, with the researcher reflecting on participants' stories and asking, "What is happening here? What does this mean?"

The participants had described the social processes and interactions in their work environment. From those descriptions and the analysis of data, core categories emerged. As new participants were interviewed, their stories were compared to the core categories that emerged, or new categories were identified. Further analyzing the data, the researcher created linkages between the information provided by the participants and the core categories.

Once there was consistency among the findings, and no new categories emerged, the researcher believed saturation was reached. (Glaser & Strauss, 1967).With saturation, the researcher established that the core categories reflected the meaning behind the social interactions of the participants and began to use them to describe the basic social process that was emerging. From this, a theory was developed (Glaser & Strauss, 1967; Jeon, 2004). Hence this theory emerged from the data and from the informants themselves (Dey, 1999). Further, this theory should be transferable, or replicable, to other people experiencing a similar phenomenon. Primiparous nurses employed full time in medical-surgical, critical care, or progressive care nursing specialties who did not participate in this study should be able to recognize similarities to their own experiences, as described by the stories that were told and by the theory that emerged from this study (Corbin & Strauss, 2008).

Grounded theory is used to discover dominant social and structural processes that explain the behaviors of participants as they progress through stages in the phenomenon under study (Wuest, Merrit-Gray, Berman, & Ford-Gilboe, 2002). It allows for an exploration of the interaction between a subjective experience and a social process. The researcher acknowledges that the experience of full time employment and first time pregnancy is not unique to nurses; there are women employed in different roles throughout health care organizations that could also experience pregnancy, physical tasks associated with work, and social interactions with peers

and coworkers. Themes that emerged from this study, then, may be applicable to women from other occupational groups. The researcher, however, as a registered professional nurse himself, opted to explore the experiences of nurses with the understanding that the findings of this study could be transferable to the other occupational groups employed within a similar context as the registered professional nurses in this study.

Implications for Nursing

The literature has demonstrated that nursing is physically demanding and stressful, but the experience of pregnant nurses in their workplace environment, favorable or unfavorable, has not been captured. Qualitative research outside of nursing has shown that when women are interviewed and their experiences are explored, practical solutions are elicited from from these experiences (Yali & Lobel, 1999). Given the high likelihood that pregnancy can occur for female nurses at any time during their childbearing years of employment, the phenomenon needs to be explored to ensure that the current workplace is attentive to the health and well-being of the nurse, her baby, and, possibly, her patients. Eichner (2008) identified supportive workplace policies that yield higher workplace satisfaction, such as extended maternity leave and accommodations for pregnant workers. The information gathered from a study of nurses who were employed full-time while pregnant would be useful: Not only could they contribute intimate knowledge of that experience to inform nurse administrators, nurse managers, occupational health nurses, and peers, but they could do so as staffing and care delivery models are planned and indicators for nurse satisfaction are explored.

Assumptions and Biases

The researcher assumed that nurses who were pregnant while they maintained full-time employment were willing to discuss their experiences, feelings, and actions in one-on-one interviews following the birth of their first baby. Furthermore, he assumed that meanings and assumptions existing behind the social interactions of the nurses in the workplace would be related through the telling of their stories. The literature informs that employees have a variety of good and bad interactions in the workplace with no two people having the same experiences (Carlopio & Gardner, 2011). The researcher assumed, then, that favorable and unfavorable aspects about integrating a first-time pregnancy and full-time employment would be described by the participants..

Summary

With a significant number of the current nursing workforce being comprised of women of childbearing age, pregnancy is a likely event at some point during those years of employment. Industries as diverse as massage therapy, computer technology, and law enforcement have examined the influence of pregnancy on their female workforce (Carlson, 2005; Lane, 2008), but no studies to date have explored how nurses incorporate pregnancy and full-time employment. Grounded theory is a qualitative research method, and it served as the basis for beginning an exploration into how primiparous nurses managed pregnancy and full-time employment. Gathering data through in-depth interviews and using a constant comparative method of data analysis produced a substantive theory that elucidated how nurses integrated pregnancy and full-time employment. Given the absence of research in this area, this original exploration contributed to nursing's substantive body of knowledge.

Chapter 2: Review of Literature

Recent statistics demonstrate that of the 122 million U.S. women aged 16 years and over, 72 million (52%) were labor force participants (U.S. Department of Labor, 2010b). Y. Fried, Shirom, Gilboa, and Cooper (2008) estimated that 80- 90% of women who work and are of childbearing age will become pregnant at some point during their employment. This chapter explores women in the workplace from various viewpoints and how gender influences the type of work that women choose and the actions and experiences they have in the workplace, including those that occur while pregnant. This chapter discusses the literature about the effect of work on pregnancy and its outcome, along with examples of organizations and practices that support the pregnant employee in the workplace. Finally, this chapter identifies the few studies that examined the unique situation of nurses in the workplace, and it advocates a holistic exploration of how nurses integrate pregnancy and full-time employment.

Gender

What defines a person as "masculine" or "feminine" translates to significant milestones in life, including the search for and attainment of employment and the behaviors that are associated with, and socialized within, the workplace (Liao & Cai, 1995). Society and culture play a major role in the development of a person's gender identity, and the process of socialization is the mechanism by which a person develops his or her ideas of being masculine or feminine, including ideas of how to act and behave in environments such as the workplace (Gergen, 2009). A person's sex relates to human biology; the term *gender* refers to various sociocultural constructions regarding behaviors and emotions as they relate to one's sex. Assumptions about gender often exaggerate the differences between men and women (Padavic &

Reskin, 2002), e.g., how different societies classify masculinity or femininity and what behavior or work is deemed "appropriate" for men and women. Researchers have posited that gender roles, i.e., public images connected with being male or female, form the basis for the development of gender identity—specifically, how appearance and behavior, based on one's culture, relate to being classified as masculine or feminine (Kane, 2006; Lawy, 2003). Children are socialized into their roles by their parents, extended families, and the norms of the society in which they live. Socialization is the ongoing process by which a person develops the knowledge, skills, and attitudes that help him or her fit into society (Cummings, 1995). An array of theories have attempted to explain how gender role and identity develop: evolutionary theory (Buss, 1995; Hawkesworth, 1997; Shields, 1975), object-relations theory (Chodorow, 1989; Fairbairn, 1952), gender schema theory (Bem, 1981, 1993), and theories of gender as a social role (Eagly & Wood, 2002) or a social norm or construct (Gergen, 2009). Evolutionary theory is predicated on biology and the genetic basis for the differences between men and women. Shields (1975) proposed a functionalist perspective, which explained that men and women evolved to fulfill their different yet complementary sexual functions that would promote the survival of the species. Hawkesworth (1997), reinforcing Garfinkel's work (1967) on the difference between sex and gender, stated that there are two invariant sexes: male and female, with the external genitalia being the essential differentiation. Because there are only two sexes, there are only two classifications of gender: masculine or feminine. Gender therefore occurs naturally and is not a matter of choice. Butler (1990, 2004) countered that gender is "performative" and is based on what one does, such as type of work. For example, people are not masculine or feminine; rather, gender is ascribed to the roles they perform and the work they do. Buss (1995) postulated that behavioral differences between men and women arise from their different sexual and

reproductive strategies, which evolved to ensure that men and women efficiently and effectively reproduce and pass on their genes for the continuation of the species. For example, the human female has a gestation period of 9 months and typically delivers one baby at a time, then takes several months or weeks before attempting to reproduce again. In contrast, the male human can inseminate multiple females and have multiple offspring at one time. As such, females are the primary caregivers, focused on the care and nurturing of offspring.

Following that offspring require a caregiver and that gender development does not happen simply because one is male or female, theorists in the field of psychology have posited that one becomes (i.e., is socialized as) masculine or feminine on the basis of the relationship that one develops as a child with caretakers (Chodorow, 1978; Fairbairn, 1952; Grusec, 1992; Sears, 1957, 1958). Object-relations theory, as proposed by Fairbairn (1952), states that interpersonal relationships with others are significant, especially between parent and child; through such relationships, a child learns how society expects a boy or a girl to act. Sears (1957, 1958) reinforced this approach, positing that children internalize the behaviors of the culture in which they are raised and that parents, as the primary caregivers, play a key role.(Grusec, 1992). Chodorow (1978) used feminist theory to explain that the close relationship between mothers and girls allows the latter to mimic the behaviors of the former and learn what behaviors are acceptable; those behaviors develop and become solidified later in life as girls become women.

Bem (1981) proposed that culture or society defines male and female roles and that children subsequently internalize this knowledge as gender schema, or unchallenged core beliefs, which organize later life experiences (Bem, 1993). Gender schema theory postulates that children incorporate self-concepts and assume traits and behaviors they deem suitable for their gender.

Kessler and McKenna (1978) proposed that being masculine or feminine is not a reflection of one's biological sex but rather a social construct that varies across cultures and is the impetus for women to accept their societal role. Biology and gender are both cultural. Eagly and Wood (2002) combined the notions of culture and gender with social role theory and postulated that division of labor and stereotypes (i.e., society's expectations) produced gender roles.

Eagly (1987) distinguished between two dimensions of gender-stereotyped characteristics: communal and agentic. Communal roles are characterized by attributes associated with domestic activities, such as nurturance and emotional expressiveness. These attributes are manifested primarily by women and associated with them. Agentic roles are characterized by attributes commonly associated with public activities, such as independence and assertiveness, and are associated with being male. Behavior, then, is influenced by gender roles when cultures support gender stereotypes that result in rigid expectations (Eagly & Wood, 2002). Similarly, K. Smith (1997) supported the idea that culture's impact on gender (i.e., gender as a community within a culture) stipulates what constitutes a male or female body, what norms of character and conduct are associated with each body, and who is a male or female. Gergen (1990, 2009) proposed that how a society or a community views each gender defines expected roles and behaviors as they relate to aging and reaching specific milestones, particularly for women.

Thus, just as society and culture play a critical role in the development of a person's gender identity, the process of socialization is the process by which a person learns and maintains the norms and values of a society, and develops ideas of being masculine or feminine. (Liao & Cai, 1995). The theories of gender role and identity presented here examine gender

development from various aspects: as a result of evolution, as a result of a child's identification with the parent of the same sex, as the end product of a child's incorporated self-concept, and as the fulfillment of society's expectations for how men and women should act. Although each theory is unique, each demonstrates how society or a culture shape a person's identity as a man or a woman and consequently what is masculine and feminine, and likely to be sustained throughout a person's lifetime. The development of this identity translates to significant milestones in life, including the search for and attainment of employment and the behaviors associated with, and socialized within, the workplace (Liao & Cai, 1995). Gender influences the type of work that women choose, defines how women are expected to act at work, and affects the experiences they have in the workplace.

Women in the Workplace

Workplace practices, policies, and behaviors reflect cultural norms within an organization and how women are perceived in the workplace (Padavic & Reskin, 2002). Historically, the workplace was described as an arena with cultural norms that affect how men and women work together and what roles they fulfill (Mills, 1992). The widespread idea of "family-primary women" and "career-primary men" continues to underpin organizations and determine what roles and functions are masculine and feminine (Weber & Williams, 2008). For example, employment that encompasses the public domain—including that in government and politics, mass media, academia, and organizational activity—is dominated by men and thus assumes a "male" character (Hodson & Sullivan, 2008). In contrast, roles that pertain primarily to the home—including childbearing and childrearing, familial relations, and home maintenance—are dominated by women and are thus ascribed a "female" character. Work within the home has been separated from work outside the home and therefore been ascribed gendered characteristics;

namely, any role related to nurturing, caretaking, raising children or maintaining a family is feminine, and any work outside the home is masculine (Weber & Williams, 2008). Thus, images and ideas of what employment roles are masculine and feminine within organizations not only reflect cultural norms but pervade organizational life.

Although culture influences the assignment of professional work roles as masculine or feminine, women, as females, are the only sex capable of fulfilling the biological role of childbearing. Evolution theory still holds, despite society's attempts to define the sexes otherwise. As such, pregnancy is likely to have an influence on how women are treated, or how they act, in the workplace (L. M. Brown, 2010).

Being Pregnant

Pregnancy is defined as the period of time from conception through the birth of a baby (Cunningham, Leveno, Bloom, Hauth, Rouse, & Spong, 2009). Pregnancy, however, can be viewed from different perspectives, or stages. From the societal perspective, pregnancy is a temporary condition that changes a woman's status from a woman without a child to "mother" (van Gennep, 1960). Pregnancy, then, is a transitional period divided into months or sections deemed important by society (van Gennep, 1960). In contrast, the physiologic perspective describes pregnancy through specific gestational points: trimesters, weeks of gestation, or months (Cote-Arsenault, et al, 2009). Inherent in both perspectives, are stages that provide points along a continuum from beginning to end, related to pregnancy. These stages constitute a transitional phase, referred to as *liminality.*

Turner (1967, 1987) viewed liminality as the state between two varying points in a social structure. This period is often accompanied by societally reinforced rituals and rites of passage

(Turner, 1967, 1987). Further, it is a period of becoming, or transition,that has fear and uncertainty contained within it. In this liminal phase, women change how they view themselves and how they believe others see them. Being treated differently, e.g., having peers or coworkers perform tasks for them or doing things for them without being asked, is a reminder of their new social status as *pregnant* women in the workplace. As they became more visibly pregnant, the pregnancy itself became the identifier of who they were in their workplace environment (Ladge, Clair & Greenberg, 2012). Body image, then, is determined by how the pregnant body is perceived by the pregnant woman herself and by the people in her environment.

Body image

The current literature informs that pregnant women are satisfied with their changing body shapes. Women accept that weight gain and body changes will occur during pregnancy (Duncombe, Wertheim, Skouteris, Paxton & Kelly, 2008). Increasing abdominal girth and weight gain associated with pregnancy are viewed as signs of a healthy pregnancy and a healthy baby (Clark, Skouteris, Wertheim, Paxton & Milgrom, 2009). However, when the social arena is considered, women's perceptions of their pregnant bodies change.

People in a pregnant woman's social environment have a significant impact on how she views, perceives, and interprets her body. Society overall holds an ideal of the feminine body as thin, physically toned and "in shape" (Harper & Rail, 2012). The implication, then, is that the pregnant body cannot be attractive and that weight gain, or being fat, further removes a woman from the ideal of attractiveness (Johnson, 2010). Comments about being "huge" or "getting bigger" become commonplace for women and soon they begin to describe themselves using the same language (Clark, Skouteris, Wertheim, Paxton & Milgrom, 2009; Johnson, 2010). Women,

overall, were found to derive inherent satisfaction in pregnancy and changes in their body enabling them to effectively navigate the social pressures to maintain a specific social body image (Loth, Bauer, Wall, Berg & Neumark-Sztainer, 2011). In the workplace, however, being visibly pregnant appeared less likely to result in a similar degree of satisfaction.

In the workplace, the pregnant body is seen as cumbersome, prone to injury, and disruptive (Gattrell, 2011c). The pregnant worker herself fears embarrassing situations such as physical instability; uncontrollable responses like sudden nausea, vomiting or crying; forgetfulness; or leaking (Gattrell, 2011c). Coworkers of pregnant women assume that pregnancy causes them to be physically and emotionally challenged and, in turn, interpret those characteristics to mean decreased attention span, lower productivity, and an overall reduced commitment to the organization or employer (Gattrell, 2011a). The result is workplace hostility and the perpetuation of negative stereotypes.

Pregnant Women in the Workplace

Research from 1990 to 2000 reported mostly unfavorable findings related to attitudes surrounding pregnant employees in the workplace, such as negative performance ratings and stereotypes (Guetal et al., 1995; Guetal & Taylor, 1991; Halpert & Burg, 1997; Halpert et al., 1993; Pattison et al., 1997). Research between 2000 and 2010 continued to demonstrate the persistence of unfavorable attitudes toward pregnant employees (Bragger et al., 2002; M. Fried, 2000; Hebl et al., 2007; Major, 2004). M. Fried (2000) and, later, Major (2004) reported that pregnant employees were subject to negative reactions from supervisors, lower performance appraisals, lost promotions, and pressure to take shortened maternity leaves, with penalties for

taking longer leaves. Bragger et al. (2002) demonstrated that bias existed in the workplace against pregnant women.

Exploring possible bias during the interview process, these researchers videotaped eight scenarios of a job interview, with each having the same applicant/actress but at a different stage of pregnancy. More than 200 undergraduate psychology students viewed the scenarios and then completed a questionnaire. The results revealed that regardless of the applicant's qualifications or stage of pregnancy, the participants consistently rated her as a poor candidate for hire, suggesting an overall bias against pregnant job applicants. Field study work by Hebl et al. (2007) investigated whether ambivalently sexist behaviors toward pregnant women spontaneously occurred in the workplace and whether that hostility could be generalized across different job types. In this study, 110 male and female participants (with some of the women at various stages of pregnancy) posed as job applicants in a large retail mall, and the research team asked random adults to pretend they were a placement agent and to complete a survey about their views toward hiring those applicants. The results revealed that women who appeared to be pregnant were more likely not to be chosen for hire. Additionally, the researchers identified a high potential for pregnant employees to be subject to hostile interpersonal discrimination when applying for sales jobs in retail stores. Thus, discrimination, biases, negative stereotypes, and poor performance evaluations persist for pregnant women.

The Pregnancy Discrimination Act of 1978 was enacted to protect the pregnant worker from discrimination and unequal treatment in the workplace (Baker, 2008; Barnard & Rapp, 2009; Eichner, 2009). However, research has demonstrated that employers are less likely to hire women who are pregnant or have small children at home, despite the presence of such legislation (Correll, Barnard, & Palik, 2007). The Family Medical Leave Act provides time off for

employees, male and female, for a period of up to 12 weeks to care for newborns or sick children (Eichner, 2008). The Americans with Disabilities Act allows for certain conditions of pregnancy to be classified as a disability, mandating that employers provide workplace accommodations for pregnant workers (Barnard & Rapp, 2009). Legislation can thus influence positive workplace attributes that support the pregnant employee.

Research during the latter part of the 1990s and into the current century (T. Brown et al., 2002; Farley-Lucas, 1997; Glass & Riley, 1998; Lyness et al., 1999) began to examine the effects of positive workplace attributes that support pregnant employees. In a doctoral dissertation, Farley-Lucas (1997) found that women, despite pregnancy or motherhood, do not want coworkers and supervisors to treat them any differently; most want to be seen as competent, dependable workers who expect to, and do, work hard. Following one-on-one in-depth interviews with 17 working mothers who had at least one child at home, Farley-Lucas found that these women wanted supportive relationships with their coworkers, through informal support groups that affirmed their identities as productive members of an organization while recognizing the high value they placed on raising children and creating a family. The idea of support for women who pursue building a family—namely, "family-friendly policies"—extended through the study by Glass and Riley (1998), who interviewed 324 pregnant working women at three points during their pregnancy. The researchers found that when controlling for the effects of wages, marital status, and number of existing children, several family-friendly policies (e.g., length of maternity leave, ability to avoid overtime) decreased job attrition following childbirth. The researchers also found that the pregnant women who were professionals and managers—and thus more likely to have access to family-friendly benefits at work—were less likely than nonprofessionals and non-managers to quit their jobs following childbirth. Glass and Riley

attributed the latter finding to a greater work commitment by professionals and managers, as well as a greater commitment by their employers to providing support that would encourage the retention of highly valued employees. Later, Lyness et al. (1999) and T. Brown et al. (2002) found that with a supportive work environment and generous maternity leave policies, pregnant employees reported higher job satisfaction.

Physical discomfort and stress.

Physical discomfort associated with pregnancy is well documented. Specific to the work environment, fatigue is the foremost physical complaint reported by women (Rosenthal, Majeroni, Pretorius, & Malik, 2008). Additionally, musculoskeletal strain related to frequent pulling, pushing, bending, or lifting has been reported (Brace, 2005; Pompeii et al., 2011; M. W. Smith et al., 2008). Changes in body posture attributed to an enlarged uterus and periods of prolonged standing have also been cited as sources of discomfort, particularly exacerbating pain in the lower back, often related to specific tasks (Brace, 2005; Cheng et al., 2006).

Stress during pregnancy and how women respond to the many physical, emotional, and social changes that occur has become a focal issue of recent research (Glynn et al., 2008; Stanton et al., 2002). Women's experience of pregnancy varies widely, depending on a range of factors, including age, health, socioeconomic status, social support, and previous experience of pregnancy and childbirth (Lobel, Cannella, et al., 2008). Issues that concern pregnant women include the physical problems, changes in appearance, changes in interpersonal relationships, the impact of pregnancy on household finances, concerns about labor and delivery, parenting, and the health of the baby (Stanton et al., 2002). How a woman appraises and responds to these concerns can trigger stress. Yali and Lobel (1999) reported that approximately 25% of women

reported emotional distress during pregnancy. Later research by Lobel, Hamilton, and Cannella (2008) suggested that a majority of women adapt well to pregnancy and experience related stress without any psychological complications. For women who do not adapt well to stressors, there is concern that the stress they experience can contribute to a poor pregnancy outcome (Dole et al., 2003).

Several studies have shown a consistent association between stress experienced in pregnancy and low birth weight, low gestational age, and preterm delivery (Lattendresse, 2009; Stanton et al., 2002). Dole et al. (2003) demonstrated that women who reported higher levels of stress had a higher incidence of preterm delivery of low birth weight babies. Earlier, Copper et al. (1996), in a study of 2,593 pregnant women, found that on examination of psychosocial characteristics, only stress—i.e., neither anxiety nor depression—was significantly associated with spontaneous preterm birth and low birth weight. Similarly, Dole et al. demonstrated pregnancy-related stress was significantly associated with an increased risk of preterm birth in a prospective cohort study of 1,962 pregnant women. Additionally, Lobel, Cannella, et al. (2008) studied perceived pregnancy-specific stress in 276 pregnant women and found a positive association with preterm delivery. Furthermore, the impact of stress on labor and delivery has been examined. Saunders et al. (2006) reported an association between prenatal maternal stress and an increased likelihood of undergoing an unplanned caesarean section. Da Costa, Larouche, Drista, and Brender (1999) examined the link between maternal stress during pregnancy and the incidence of complications during labor and delivery. They reported that women with higher levels of stress experienced more difficult labor and delivery; as such, stress response is therefore a critical determinant in the experience of labor and delivery.

Evidence suggests that a woman's response to stress changes during pregnancy. A study by Glynn, Wadhwa, Dunkel-Schetter, Chicz-Demet, and Sandman (2001) and, later, one by Glynn, Dunkel-Shetter, Wadhwa, and Sandman (2004) explored psychological responses to major life events during pregnancy. The findings of both studies indicated that events occurring early in pregnancy were perceived as being more stressful than those same events occurring later in pregnancy. These findings were supported by de Weerth and Buitelaar (2005), who suggested that the physiologic stress response is dampened as a result of pregnancy, with changes observed in the later part of the second trimester.

A later study by Glynn et al. (2008) demonstrated that the pattern of change in stress during the course of pregnancy is an important prediction of preterm birth. According to the researchers, whether or not a woman reported an increase in perceived stress during pregnancy was the best stress variable predictor of preterm birth, even when adjusted for obstetric risk, pregnancy-related anxiety, ethnicity, parity, and prenatal life events. Furthermore, Glynn et al. posited that as maternal investment increases with gestation, environmental sensitivity may decrease to ensure that environmental stress is less likely to result in an adverse birth outcome. Therefore, pregnant women who do not demonstrate effective coping with perceived stressors or an adaptive response to stressors remain sensitive to the effects of stress throughout pregnancy and, as a result, are at greater risk for preterm birth.

Day-to-day approaches.

Women approach pregnancy and the stressors associated with it in diverse ways. Hamilton and Lobel (2008), for example, found that pregnant women used spiritual coping behaviors, such as reading prayer books and performing religious rituals. Task-coping, which

focuses on the problem and how to solve it, was also frequently used. Similarly, Borcherding (2009) found that healthy pregnant women used a variety of coping styles, with prayer being the most frequent. Additionally, Borcherding reported that women from different social backgrounds and age groups tended to use different stress management strategies, with younger women utilizing preparation techniques, such as thinking about and planning for motherhood, along with distraction techniques, such as watching television or reading. Furthermore, women in Borcherding's study reported key stress-reducing activities by health care practitioners, such as providing timely practical suggestions on ways to alleviate the discomforts of pregnancy, offering support in managing health-impairing behaviors, and listening to a woman's feelings about pregnancy. This finding supports work by Lowenkron (1999) and Cotes-Arsenault (2007), who reported that healthy pregnant women relied on information from caregivers—especially medical professionals such as physicians and midwives—to allay anxiety about fears during pregnancy and subsequently reduce reported pregnancy-related stress.

The March of Dimes Foundation (2009b) published guidelines that advised women to reduce their stress levels during pregnancy in an effort to reduce the risk of preterm birth. Practical suggestions for reducing or managing stress included eating regularly, resting, meditating, listening to music, and employing various forms of social support, such as talking with friends, family, coworkers, and health care professionals.

Social support plays an important role in the psychological well-being of pregnant women (Gurung et al., 2005). Supportive relationships, including those with friends, family, and coworkers, benefit pregnant women because those offering support can provide information and assistance with daily tasks, along with caring about and understanding the stress faced by the pregnant woman (Yali & Lobel, 2002). Additionally, higher levels of social support correlate

with greater use of preparation-for-motherhood strategies. Giurgescu, Penckofer, Maurer, and Bryant (2006) found that women with complex pregnancies who reported high levels of social support reported low levels of uncertainty and distress, less use of avoidance coping strategies, and more use of preparation-for-motherhood strategies. Remarking on how women of different age groups use social support, Borcherding (2009) suggested that employed younger women utilize female coworkers as their source of social support, camaraderie, and empathy. Additionally, younger pregnant women seek out female coworkers for advice on managing pregnancy discomforts and preparing for motherhood, or *communitas*.

Communitas

Turner (1977, 1987) described a shared experience by a group of persons in similar transitional situations known as *communitas*. Support for people in transitional states such as pregnancy is obtained through communitas. For pregnant women, that support comes in the form of guidance, information-sharing, or advice-giving by other women who had lived through a similar experience or from women who have an understanding of what that experience could be like (Cote-Arsenault, Brody, & Dombeck, 2009). Through communitas, a pregnant woman receives necessary social support to prepare her for motherhood.

Social support, particularly in the workplace, plays an important role in the psychological and physical well-being of pregnant women (Gurung, Dunkel-Shetter, Collins, Rini & Hobel, 2005). Supportive relationships with peers and coworkers in the workplace are beneficial because they are believed to not only provide camaraderie, friendship, and information, but also assist with physical work tasks and a communal understanding and acknowledgment of workplace stressors (Aldarice & Lynn, 2009; Yali & Lobel, 2002). In addition to confirming

stressors and challenges in the workplace, social support from peers and coworkers, and the communitas established, assist pregnant women in the workplace to navigate the inherent changes and transitions during nine months of pregnancy.

Workplace accommodations

Literature addressing stress relief or management strategies for pregnant women is limited. Occupational health nurses have addressed pregnant women in the workplace and offered practical suggestions for managers who supervise or direct pregnant employees. For example, to address the myriad physiologic changes to the respiratory, cardiovascular, and renal systems associated with pregnancy, Draper (2006) recommended that supervisors provide pregnant women with extra time to complete work tasks, time to be in contact with occupational health nurses for frequent monitoring of vital signs, and ample time in and access to restrooms. Additionally, to manage the physical discomforts of pregnancy, Draper recommended that activities requiring pregnant women to bend over be avoided or adjusted and that pregnant women drink ample fluids during the day and take frequent rest breaks during a shift. Furthermore, Draper recommended that pregnant women take time during their workday to elevate their feet and change positions, while avoiding tight or improperly fitting clothes and uniforms. Although these interventions are useful, they can only be successful in a work environment that recognizes and supports the unique needs of pregnant workers (Banarjee, 2009).

Some employers embrace their pregnant employees and view them as valuable members of their work teams (Lane, 2008). The aforementioned areas—massage therapy, computer technology, corporate America, law enforcement—have various perks and incentives that make

balancing work and pregnancy easier on female employees (Carlson, 2005; Lane, 2008). There are current movements modeled after successful initiatives in Western Europe and Canada to make workplaces "pregnancy-friendly," especially for industries and corporations with a significant number of female employees (Banerjee, 2009; Canadian Centre for Occupational Health and Safety, n.d.).

Pregnancy-friendly

The term *pregnancy-friendly* denotes organizations, corporations, professions, and individual businesses that (a) recognize that pregnant women, though physically challenged, are vital members of the workforce and (b) make deliberate changes to work policies and structures to allow for more physically and emotionally accommodating work environments (Eichner, 2008). Certain professions carry inherent dangers, e.g., mining, heavy equipment operation, and police work (Baker, 2008). In these unique careers, pregnant women are immediately removed from any job function that proves dangerous to them and their fetuses and are reassigned to clerical, administrative, or light duty job tasks for the duration of the pregnancy (Baker, 2008). Despite being reassigned, the women still contribute to the initiatives and success of a business or industry.

Recent articles in business journals have highlighted and awarded companies that made deliberate strides to become pregnancy-friendly. Adams (2010) identified the top four consulting and accounting firms (Deloitte, Ernst & Young, Pricewaterhouse Coopers, KPMG) that continue to be innovative in their approaches to support employees who wish to pursue advanced employment opportunities balanced with the potential for motherhood. For example, WIN (Women's Initiative) is Deloitte's program to support and promote women. Utilizing the

business principle of mass career customization, WIN provides each female employee an opportunity to meet with a counselor at least twice per year or as requested by the employee to plan the direction of her career in four categories: pace, workload, location, and schedule. Cited as ideal for a woman planning a pregnancy, this program lets the employee decide to scale back her hours in certain categories, increase them in others, or decrease them altogether, depending on her current life circumstances. The key benefit is that her compensation is changed only if she scales her work hours back in any or all categories by 40% or more. *Business Week* ("Smashing the Clock," 2006) ran a cover story about Best Buy's ROWE program (Results-Only Women's Evaluation), developed on the premise of the clock-less work schedule. Women can flex their hours as needed to attend doctors' appointments, leave work when tired due to pregnancy or to meet child care or family needs. Women may work as needed and are evaluated only on specific job-related performance outcomes. Thus, industries have examined the needs of their pregnant employees, and how they combine pregnancy and employment, to put forth various safety and workplace initiatives to support women during pregnancy. As an industry, nursing has not explored how nurses integrate pregnancy and employment and is therefore an exception to this trend.

Nurses' Work

Nurses have identified their work as physically demanding and stressful. Tucker et al. (2010) cited the 2007 Canadian Institute for Health Information study, in which more than half the nurse respondents reported that their jobs were physically demanding and that injuries sustained on the job were due to a shortage of nurses, downsizing, and long working hours. Letvak (2001) found that nurses working in hospitals reported stress and fatigue while carrying excessive patient loads. Lipscomb et al. (2002) reported that nurses consistently worked more

than 40 hours per week and that two-thirds worked without a break, which contributed to reports of stress and illness. Additionally, two-thirds reported an increase in patient acuity with decreased availability of registered professional nurses, thereby increasing the reliance on unlicensed assistive personnel for support. Nurses were therefore at increased risk for musculoskeletal injuries and had a higher incidence of such when compared to construction workers, concrete block layers, and brick layers (Geiger-Brown et al., 2004). Wolf et al. (2006) concluded that the typical nurse's workday entails the physical demands of pulling, pushing, lifting, turning, and maneuvering heavy objects, such as beds and stretchers, several times.

Moreover, a time-motion study revealed that nurses walk an average of 2.6 to 3.0 miles in a given shift, between patient rooms and the medication room and in transporting patients on and off a unit. Furthermore, whereas a portion of nursing time is occupied in tasks such as planning care, administering medications, performing physical care (specific tasks not identified), and speaking with patients families and doctors, a significant portion of the nurse's day revolves around activities that have minimal direct impact on the patient but are concentrated within the work environment, e.g., housekeeping tasks, ordering and obtaining supplies, and performing administrative/clerical duties. Thus, the high demands of nursing work, especially in hospitals— including long hours, heavy lifting, insufficient staffing, and lack of support from coworkers or managers—increase the physical labor a nurse expends and increase one's risk of musculoskeletal injury. At the same time, nurses are prevented from addressing their personal needs for rest and stress reduction.

In addition to the physical demands of nursing work, the 12-hour work shift is a reality for a majority of nurses in the United States. It is the preferred number of work hours for contemporary nurses in order to meet the need to work while enabling a work-life balance

(Green, Fairchild, Kovner & Brewer, 2009; Nelson, 2012). Begun in the mid-1980's, the 12-hour shift was thought to be a formidable innovation to combat an increasing nursing shortage while providing significant periods of consistent, quality care to patients (Hughes & Stone, 2004; Nelson, 2012). Further, it was hoped that the shorter work week and increased flexibility with work schedules would entice nurses into the nursing profession and remain in the nursing workforce (Welton, 2011). Recent studies, however, have addressed the potential perils of a long 12-hour work shift, such as increased stress in the work environment, and fatigue or emotional and physical stress or discomfort, and have suggested that organizations remove the 12-hour shift and revert back to a traditional work week (Geiger-Brown & Trinkoff, 2010). Despite these findings, nurses continue to support and opt for the 12-hour work shift and actively seek to maintain employment in organizations that offer it (Hughes & Stone, 2004; Nelson, 2012).

Stress in the nursing work environment contributes to the physical, mental, and emotional work demands, in combination with rotating shifts, long work hours, and suboptimal relationships with peers, supervisors, and health care staff (Bourbonnais, Brisson, Malenfont, & Vezina, 2005; Letvak & Buck, 2008; Winwood & Lushington, 2006). Perceived stress is a consistent negative predictor of health behaviors and work environment ratings, with overall health and work environment ratings less favorable amid increased perceived stress (Tucker et al., 2010). Djukic, Kovner, Budin, and Norman (2010) found that nurses who reported dissatisfaction with the work environment—specifically, the physical setup and layout of the nursing unit—reported increased levels of job stress and job dissatisfaction. Strategies have been put forth to minimize workplace stress for nurses and promote overall health and well-being, such as workplace redesign, conflict management and mutual respect training, relaxation

techniques, easy access to fresh, healthy food, and quiet places for power naps (Tucker et al., 2010).

Pregnant Nurses in the Workplace

A paucity of literature has addressed pregnant nurses in the workplace. Older literature focused on nurses caring for patients with communicable diseases and how to prevent maternal-fetal transmission through work reassignment or protective barrier techniques (Bertin, 1999; Votra, Rutala, & Sarubbi, 1983). Additionally, Saurel-Cubizolles et al. (1985) studied hospital workers, including nurses, in France and recommended that any role within the hospital that involves arduous working conditions be avoided during pregnancy to prevent preterm labor—including prolonged standing, heavy load carrying, and heavy cleaning tasks not directly involved in direct patient care. Recent sources focused on the risks of radiation for pregnant health care workers who work in hospitals, including nurses, and recommended shielding and distancing for the prevention of fetal abnormalities (Hossain & Triche, 2007; Suarez-Varela et al., 2009). Additional literature (Lyerly et al., 2009) advised that pregnant hospital employees avoid exposure to tobacco smoke and toxic chemical agents, such as chemotherapy and cleaning solvents, within the hospital setting. Alex (2011) outlined recommendations for pregnant nurses that reinforced prior occupational safeguards, such as limiting exposure to infectious diseases through the use of personal protective equipment, avoiding inhalation of aerosolized drugs, shielding oneself from ionizing radiation, and minimizing long shifts and heavy workloads that can lead to musculoskeletal injury. In response to the need to safeguard pregnant employees in the workplace against birth defects and preterm delivery, the March of Dimes (2009a) created the "Healthy Babies, Healthy Business" campaign, which outlined 14 criteria for giving hospitals

an award for safeguarding pregnant women in the workplace. Only one hospital to date has received this award: Children's Hospital in Colorado in March 2011.

The research exploring pregnancy in nurses is clearly limited, and a holistic approach to how nurses integrate pregnancy and employment is lacking. The nursing profession continues to be largely composed of women who are of childbearing age (U.S. Department of Labor, 2010b). To date, nurse researchers have not undertaken a holistic exploration of how nurses integrate pregnancy with full-time employment.

Grounded Theory

A social process is defined as how people come together to form groups (Shore, Coyle-Shapiro, Chen, & Tetrick, 2009). Work is an example of a social process because people come together and adopt or assimilate specific behaviors for specific job functions to earn a wage (A. Brown, 1995). Nurses are a group of people who come together and engage in activities (e.g., patient care) that generate a wage and allow them to sustain a livelihood. To explore the social processes that nurses are involved in, grounded theory is a suitable research methodology for studying the behaviors and actions of nurses (Speziale & Carpenter, 2011). Grounded theory searches for social processes present in human interactions and aims to discover patterns and processes to understand how a group of people (e.g., nurses) progress through stages to define their reality through their social interactions (Chen & Boore, 2009; Cutcliffe, 2000).

Origin of grounded theory

Grounded theory emerged in the 1960s from the work of two Chicago-based sociologists: Barney Glaser and Anslem Strauss (Charmaz, 2000; Corbin & Strauss, 1990). The two later moved to San Francisco, California, and from their work with dying patients in

hospitals, they developed a method that allows researchers to systematically generate a theory "grounded" in data (Walker & Myrick, 2006). Together, Glaser and Strauss authored three key volumes: *Awareness of Dying* (1965), *Time for Dying* (1968) and *The Discovery of Grounded Theory* (1967).

As a qualitative method, grounded theory challenged the then-dominant quantitative approach of logico-deductive theorizing. Specifically, rather than develop a theory and then systematically find evidence to verify it, grounded theory researchers gather data from which to systematically develop a theory (Dey, 1999; McCann & Clark, 2003). Grounded theory emphasizes theory generation, not verification (Plummer & Young, 2010). Because of its different approach to social research, grounded theory gained popularity through the 1970s and 1980s (McCann & Clark, 2003).

In the 1980s, Glaser and Strauss went their separate ways, with Strauss remaining at the University of California, San Francisco. During the mid-1980s, Juliet Corbin, a nurse, began her doctoral research and her collaboration with Strauss (D. D. Meetoo, personal communication with J. Corbin, April 29, 2007). By this time, Glaser had independently written *Theoretical Sensitivity* (1978) as an adjunct to *The Discovery of Grounded Theory* (Glaser & Strauss, 1967), while Strauss produced *Qualitative Analysis for Social Scientists* (1987). Strauss and Corbin later coauthored *Basics of Qualitative Research* (1990) as an attempt to explain Strauss's version of the basic premises of grounded theory (McCann & Clark, 2003; Walker & Myrick, 2006). In 1992, Glaser authored *Basics of Grounded Theory Analysis: Emergence vs. Forcing*, where he critiqued Strauss and Corbin's version of grounded theory, thus beginning the split between Glaserian and Straussian models of grounded theory (Stern & Schrieber, 2001). Despite some differences between the two models, the conceptual framework remains the same for both.

Conceptual framework of grounded theory

Grounded theory as developed by Glaser and Strauss (1967) challenged the conventional method of developing theory "from the top down" by creating a way to develop it "from the bottom up" (Goulding, 1998). Since its inception through to the present, grounded theory has been used in fields such as sociology (Glaser, 1978, 1992, 1998; Glaser & Strauss, 1967; Strauss & Corbin 1990), organizational studies (A. Brown, 1994, 1995; Hunt & Ropo, 1995; Parry, 1998), consumer research (Goulding, 1998; Pettigrew, 2000), and nursing (Morse, 1994; Sandelowski, 2000). In relation to studying women and women's health care, Parratt and Fahy (2004) used grounded theory to explore the link between the birthing environment and woman's inner experience with the events of birthing. Maijala, Paavilainen, and Astedt-Kurki (2006) used grounded theory methodology to describe and explain the social interaction process between caregivers and expectant families when giving and receiving bad news, respectively, about the impending delivery of an impaired child. Siebold (2004) used grounded theory to explore pregnant women's experiences of embodiment, identity construction, and decision-making processes involving the patient-caregiver interaction. Additionally, Levy (2006) used grounded theory to describe how midwives assist women to make informed choices during pregnancy. Plummer and Young (2010) used grounded theory methodology to describe the experience of single motherhood, whereas Lipp (2010) employed the method to study nurses working in an abortion service. Furthermore, Shaho (2010) used grounded theory to study Kurdish women's experiences in Iran with pregnancy and childbirth. These diverse studies demonstrate the applicability and usefulness of grounded theory, particularly to nursing and issues surrounding women's health. Substantive theory was developed about each social process as grounded in data gathered from the participants.

Procedurally, the decision to study a social process on the basis of grounded theory leads to data collection about it (Henwood & Pidgeon, 2006; Rennie, 2006). These data may be in various forms: published reports, quantitative indicators, or verbal reports from the participants about particular experiences or actions (Corbin & Strauss, 2008; Glaser & Strauss, 1967). Traditionally, grounded theory data have been reports from either the observer's notes on the participants' conduct or the participants' observation of their own experience, whether in oral or written form (Glaser, 1978; Glaser & Strauss, 1967). The resulting text can then be broken down and analyzed in a variety of ways.

A key component of grounded theory is the constant comparative method of analyzing data (Glaser, 1978; Rennie, 2006). This method involves breaking down text into units of analysis (e.g., a line of text, a phrase, a paragraph) and interpreting their meanings, which in turn come together as categories (Henwood & Pidgeon, 2006). At this stage, it is the data that are constantly compared (Corbin & Strauss, 1990, 2008; Glaser & Strauss, 1967). As the number of categories increases, they are compared to one another, thereby leading to more abstract categories (Corbin & Strauss, 1990, 2008; Glaser, 1978; Glaser & Strauss, 1967). This abstracting continues until a central, or core, category is conceptualized (Glaser & Strauss, 1967; Jeon, 2004; Kelle, 2005). The core category organizes the theory (Kelle, 2005; Thomas & James, 2006). Based on the amount of abstracting and the interpretation of data, the method is interpretive (Kelle, 2005).

The interpretive nature encourages the researcher to subjectively engage in the data and make note of her or his reflections—what Glaser and Strauss (1967) referred to as *theoretical memos*. Such memos are ideas, intuitive insights, or projections about the data (Glaser, 1978). Once the main work of descriptive categorizing is completed, researchers are encouraged to

review their theoretical memos in search of insights that have proven to be grounded (Chen & Boore, 2009). Thus, the theoretical memos and the review of their content aid the researcher in the creation of abstract categories, including the core category (Glaser, 1978, 1992, 1998; Glaser & Strauss, 1967).

Data collection and data analysis are conducted concurrently (Corbin & Strauss, 2008). Data are initially drawn from a selection of homogeneous sources and analyzed to result in an initial set of categories (Dantas, Leite, Soares de Lima, & Stipp, 2009). This set guides theoretical sampling and the selection of other informants to provide data (Draucker, Martsolf, Ross, & Rusk, 2007). Theoretical sampling allows the data to determine the most appropriate participants to interview; it is not about the representativeness of groups or individuals but about those whose contributions can help to shed more light on, refute, or confirm emerging theoretical ideas (Parahoo, 2009). The concurrent collection and analysis of data continue until, in the researcher's judgment, the meanings of additional data are accounted for by the categories already developed (Corbin & Strauss, 2008; Rennie, 2006): in Glaser and Strauss's words (1967), at which point the data are "saturated." That is, seeking additional participants as sources of data can come to an end, and the study can come to a close.

The thrust of grounded theory is to develop an understanding of what is common among a set of data (Elliot & Jordan, 2010). In the case of those bearing on human experience and conduct, grounded theory first assumes that there are kinds of experiences or modes of conduct and then aims to conceptualize what they are (Corbin & Strauss, 1990; Glaser, 1978; Glaser & Strauss, 1967). Analysis of specific instances leads to an understanding of instances as a whole, as represented by a category (Corbin & Strauss, 1990; Glaser, 1978, 1992, 1998). It stands to reason, then, that if an understanding as represented by a category is grounded in data gathered

from participants, it will resonate with anyone sharing the culture of those under study (Thomas & James, 2006). It is this assumption that opposes the logic of sampling seen in quantitative research, which allows generalization to apply (Dey, 1999; Morse, 1994).

The hallmarks of grounded theory are (a) the concurrent collection and analysis of data, (b) the procedure of constant comparative analysis in the creation of categories, (c) the identification of additional informants for the study, and (d) the use of theoretical memos as an aid in objectifying and abstracting their relationships, in the interest of creating a grounded understanding of a social process. Furthermore, grounded theory can lead to the structure of a phenomenon, the process entailed in it, or both (Jeon, 2004; Morse, 1994). Where Glaser differs from Strauss (and, later, from Strauss and Corbin) is in their respective versions of the method, in terms of procedural differences as well as philosophical underpinnings (Kelle, 2005; Parahoo, 2009). Glaser, a post-positivist researcher, considered grounded theory based on an interpretive approach guided by critical realist ontology and a post-positivist paradigm. For Glaser, reality exists but can never be completely measured (Charmaz, 2000; McCann & Clark, 2003). Furthermore, the researcher and the participant are not fully able to understand the complexity of the study situation, so the researcher is independent from the participant (McCann & Clark, 2003). Conversely, Strauss (and eventually, Corbin and Strauss) drew from his affiliation with the Chicago School of American pragmatism (based on the works of John Dewey and George Mead), which allowed him to embrace symbolic interactionism (Blumer, 1969; Denzin, 2007; Jeon, 2004). As a postmodern researcher, Strauss emphasized that social life constitutes processes involving conditions, interactions, and consequences, where there are no absolutes (Corbin & Strauss, 2008). Whereas Glaser looked at symbols, interactions, and contexts in the socially constructed world, Corbin and Strauss observed a world comprised of ambiguities,

where multiple interpretations of data can exist (Jeon, 2004). Corbin and Strauss therefore viewed structural context, symbolic, and interaction influences within the cultural scene based on the framework of symbolic interactionism.

Symbolic interactionism

The aim of grounded theory research is to develop substantive or formal theory to explain a social process (Chenitz & Swanson, 1986; Robrecht, 1995). Symbolic interactionism is one interpretive perspective that underpins grounded theory and, according to Schwandt (1994), it is the theory and approach for the study of individuals' socio-psychological action and interaction, in order to understand the process of how meaning is created. The foundations of symbolic interactionism were laid by George Herbert Mead, a social psychologist from the Chicago School of sociology, who was influenced by the views of John Dewey (Morris, 1977; Strauss, 1993). According to Dewey, human beings go through a continual process of adaptation to the constantly changing social world; what makes this possible, in their view, is the existence of a mind that can continually contemplate this ever-changing world (Jeon, 2004). Symbolic interactionism was advanced through the work of Herbert Blumer, who elucidated on Mead's work and established symbolic interactionism as a research approach (Jeon, 2004).

Schwandt (1994) suggested that, according to symbolic interactionists, the researcher needs to analyze the process by which meaning is developed and the nature of meaning as represented in interactions between or among human beings. Furthermore, these meanings can be understood only through interpretation; therefore, to symbolic interactionists, "meaning" is one of the major elements in understanding human behavior, interactions, and social processes (Jeon, 2004). They claim that to reach a full understanding of a social process, the researcher must

understand the meanings as experienced by the participants within a particular context (Chenitz & Swanson, 1986; Morris, 1977). The concept of "self" arises as participants engage in that particular context (Schwandt, 1994).

According to Mead (1959), the notion of "self" is a uniquely human sense. In his book *Mind, Self, and Society*, Mead asserted that the self needs to be appreciated as being situated in interaction with the social world. The person and the world cannot be understood in isolation, because the self is being continually developed through interactions with other human beings (Jeon, 2004). The self is therefore developed through an ongoing process of interaction with society. For Mead, the self consists of (a) the subjective *I*, which is natural and not hampered by others, and (b) the objective *me*, which sees self as a reflection of what others see and what one sees when looking back on oneself. *I* and *me* are in constant communication through inner conversations, especially before creating an action or behavior. Morris (1977) stated that this ability to reflect on oneself allows the process of "taking on the role of the other" and creates a way to translate the other's symbols and develop the sense of the "social self." Symbolic interaction not only looks at the social selves of the participants but explores personal experiences and the meanings that these experiences hold.

Premises of symbolic interactionism

Blumer (1969) discussed the concepts of the actor, objects, human society, social interaction, action, and the interconnection of actions. The link among these concepts, according to Blumer, is rooted in Mead's basic tenets of *I*, *me*, and *self* and the inner conversations that occur among them within the context of social interaction. Both Mead (1959) and Blumer

believed that meaning is a social product made possible through social interaction with others. Blumer articulated the premise of symbolic interactionism as follows:

> Human beings act toward things on the basis of the meaning that things have for
>
> them. The meaning of such things, therefore, is derived from, or arises out of, the
>
> social interaction that one has with others. Meanings are handled in, and modified
>
> through, an interpretive process used by the person in dealing with things he or
>
> she encounters. (p. 2)

Additionally, Blumer stated that to understand the world, one must analyze it according to the participants' actions and interactions. The researcher must actively interact with the participants and see things from their points of view and in their natural contexts. The researcher aims to identify how the participants interpret their individual experiences and shared situations, what alternatives they use when acting in different situations, and under what conditions they choose those alternatives (Jeon, 2004).

Summary

Chapter 2 explored the phenomenon of women in the workplace from various viewpoints; how men and women are socialized to behave in a masculine or feminine manner; how gender in turn influences the types of employment that men or women seek; and how they act and behave in the workplace. This chapter reviewed literature that explored the effect of employment on pregnancy and its outcome, along with examples of organizations and practices that support pregnant employees in the workplace, to inform the researcher of the phenomenon under study and to provide a direction for the inquiry. Grounded theory methodology, and its philosophical underpinnings, were explored for their applicability that allowed an inquiry into

the unique situation of nurses in the workplace and how nurses, through social interactions in the

workplace and progression through stages, managed pregnancy while maintaining full-time

employment.

Chapter 3: Methodology

For nursing research, grounded theory provides an inductive methodology with the purpose of providing a theory that has the potential to explain or interpret a social process or phenomenon (Breckenridge & Jones, 2009; Speziale & Carpenter, 2011). This approach, focusing on social processes, requires the researcher to move past describing a specific domain of inquiry, toward a theoretical description of concepts and the relationships among them, using a specific method to analyze the data (Chen & Boore, 2007; Wuest, 2007). The current research used a grounded theory approach modeled after the methodology outlined by Glaser (1978). Grounded theory is rooted in the philosophy of symbolic interactionism. Symbolic interactionism describes how the world of social actors is constructed in the process of social interactions (Blumer, 1968). One can only study that world, then, by closely examining those social interactions. Symbolic interactionism, then, guided this research. Through social interaction between pregnant nurses and the people in their social work environment, meaning was generated and its significance explored.

According to Glaser (1978), the goal of grounded theory is to generate a theory that "accounts for a pattern of behavior which is relevant and problematic for those involved" (p. 93). Grounded theory is recognized as a desirable research method for nursing because it culminates in substantive or formal theory about situations that are pertinent to nurses (Field & Morse, 1995). It allows the analysis of social structures to explain human interactions in the social world (Clarke, 2003). Grounded theory is particularly suited to this study because full-time employment, and possibly pregnancy, is relevant to the nursing profession and nursing workforce. Grounded theories can explain phenomena and can be modified as new data is generated or recast to reflect new variations (Wuest, 2012). Grounded theory offers a viable

option to begin to theoretically discuss the interactions between pregnant nurses and the people in their work environment. Grounded theory, then, assumes to answer the questions about the experiences of nurses as a social group overcoming the challenges of the workplace as they engage in social process with those in their social environment. Using individual, semi-structured interviews as the tool of data collection, the researcher attempted to capture the nurses' experience of how they integrated pregnancy with full-time employment that involved a 12-hour work shift. The researcher begins by explaining his clinical and professional background in nursing and his experience of working with pregnant nurses. Following the chronology of this study the researcher describes the pilot phase and then the move to the more formal stages of data collection and analysis. Finally, this chapter ends by introducing the developing theory that emerged from the stories told by the nurses who experienced full-time employment while pregnant.

Researcher Profile

The qualitative researcher himself is the primary instrument for data collection. Thus, it is imperative that he identify his training, experience, and biases towards the problem (Charmaz, 2006; Lincoln & Guba, 1985). This researcher has been a registered professional nurse in New York State for over 20 years and a Certified Nurse Midwife for over a decade. The researcher has worked in acute care hospitals only and within the specialties of critical care, emergency medicine, and lastly maternal-child health. His basic education was obtained through a diploma nursing program in New York City, followed by a Bachelor of Science in Nursing and later a Master of Science in Nursing with an emphasis on Nursing Administration. In his clinical practice, this researcher rose from a staff nurse position through to senior nursing administrative positions within acute care hospitals that were on their Magnet journey or Magnet-designated by

the American Nurses Credentialing Center (ANCC). This diversity in experience allowed the

researcher to work with nurses who represented various cultural, racial, and ethnic backgrounds

and who were of various ages and states of health. From this diversity of clinical practice, the

researcher became accustomed to working with pregnant nurses but could only make

assumptions about the barriers or challenges they faced throughout a work day. Given that

pregnancy was a condition he would naturally never experience, he relied on insights provided

by the nurses experiencing pregnancy. Though their experiences related to the workplace were

numerous and frequent, the researcher observed that most nurses were silent about them.

As a nurse administrator responsible for the safe and optimal functioning of the

workplace, the researcher became concerned that within the silence of the nurses there might be

issues or situations that could impact patient care or the health and safety of the pregnant nurse

herself. Rounding on the nurses directly revealed that some nurses had difficulties both

physically and mentally, while others seemed to have no problems at all. No two situations,

however, were the same, and no conclusions could be made based upon the type of unit the nurse

was working on, the type of patients she cared for, or the peers with whom she was working.

In an effort to promote a better work environment for the nurses, the researcher searched

the extant literature for best practices related to pregnant nurses in the workplace and was

dismayed to find a paucity of literature on the subject. Few studies explored the experience of

pregnant nurses in the workplace, or addressed the unique issues of pregnant workers in general.

It is the intent, then, of this researcher to contribute useful information for other nurse leaders

about the workplace environment for pregnant nurses in acute care hospitals.

Pilot Study

The researcher was accustomed to speaking with pregnant women and pregnant nurses, but the breadth of conversations typically centered on work or clinical topics, or brief inquiries into how they were feeling. As a nurse midwife, interviewing pregnant women was a brief encounter and often yielded instant, clinical answers. Being inexperienced with full-length interviews that explored social issues and processes, the researcher developed a pilot study. The purposes of the pilot study were multiple: evaluate the effectiveness of the interview questions, test the reliability of the audio-recording device purchased by the researcher for use during the interviews, and provide experience for this novice researcher in interviewing research subjects.

The pilot study confirmed that the research questions were realistic, helped the researcher develop a research plan, and provided training for the researcher in elements of the research process (Watson, Atkinson, & Rose, 2007). Three nurses who were peers of the researcher and did not meet the specific inclusion criteria proposed for the formal study (i.e., all three were multiparous, worked outside of the medical-surgical, critical care or progressive care nursing specialties, and were known personally to the researcher) were asked to participate. All three nurses participated in a shortened version (approximately 30 minutes) of the actual interview. During the interview, the researcher found that his recording device was actually more sensitive to background noises and conversations, but that specific settings on the device could be used to minimize those noises and permit better clarity for transcribing the interview. Further, the opening question was changed from "How was it to work while you were pregnant with your first baby?" to a leading statement, "Tell me about working while you were pregnant." The results of the pilot interview were transcribed and shared with an expert qualitative nurse

researcher who provided additional feedback on interview style and on the subsequent questions for the researcher's interview guide.

Data Collection

The researcher's interest in exploring the experiences of nurses who had maintained full-time employment while pregnant led him to seek opportunities to speak with nurses who had recently delivered. For that purpose, the researcher sought to conduct individual, semi-structured interviews with nurses who had recently delivered their babies and were currently on maternity leave. Pregnancy lasts for approximately nine months; in order to gather a full range of the experiences that occur throughout a typical pregnancy, nurses who remained at work for the duration of their pregnancies and delivered a healthy, full-term infant, were chosen for this study. The reason for this specification was to capture the range of experiences across nine months of pregnancy; the researcher felt that nurses who left their full-time positions for medical reasons, or who delivered a pre-term infant, would have different experiences that were not within the focus of this study. By intentionally interviewing the nurses on maternity leave, the researcher assumed that during this time the nurses would have vivid memories of their pregnancies and therefore could talk about their experiences being pregnant while maintaining full-time employment. Further, while on maternity leave, the nurses would not have their recollections clouded by the evolving new experiences of being a new mother returning to work with an infant at home. Maternity leave in the United States ranges from eight to twelve weeks, so this seemed to be a good time frame to meet with nurses and talk with them about their experiences (U.S. Department of Labor, 2010d).

The qualitative interview is intended to be a personal and intimate encounter between the participant and the researcher in which open, direct questions are used to elicit detailed narratives and stories (DiCicco-Bloom & Crabtree, 2006). Planning the interviews, the researcher designed introductory statements and probing questions that would assist him in navigating the women's experiences of full-time employment and pregnancy. The leading statement, "Tell me about working full-time while you were pregnant" was a useful beginning to encourage the participant to begin to tell her story. It allowed her the opportunity to begin at whatever point in her pregnancy stuck out in her mind. Examples include physical symptoms, talking about coworkers, work load, or describing her workplace. As the interviews continued, each participant was asked to probe deeper into specific situations: cite specific examples, explain things that were not clear to the researcher, or discuss situations in deeper detail (Rubin & Rubin, 2011). As suggested by Ford-Gilboe, Wuest & Merritt-Gray (2005), the use of neutral, nondirective probes can elicit expansion and clarification of the respondent's comments. These probes included, "Can you tell me more about that?", "Can you give me examples?" and "Tell me more" (Munhall, 2012). Rather than asking questions in a strict order, the semi-structured nature of the interviews allowed the researcher to return to topics or statements for further explanation, ask additional questions, or seek clarity on specific words or phrases used. For the most part, the interviews were more conversational than the scientific question-and-answer format the researcher was accustomed to clinically.

Finding Participants

There are currently 184 hospitals in the New York tri-state area, 56 of which are classified as acute care hospitals that contain medical-surgical, critical care, and progressive care units (U.S. News & World Report, in press). Internet searches revealed that the 12-hour work

shift is prevalent in each of those organizations (www.careerbuilder.com or

www.nursingjobs.com). The research design, then, included recruitment of study participants

from acute care hospitals in the New York tri-state area. Further, nurses who were primiparous

were deliberately chosen. The researcher assumed that the experience of pregnancy, its stages,

and the transition through those stages would be captured in more vivid detail by women who

had experienced the phenomenon for the first time. Therefore, a recruitment flyer was created

(see Appendix A) that invited nurses who were RN's (registered professional nurses), employed

full-time on a medical-surgical, progressive care/stepdown, or critical care unit, and had recently

delivered their first babies to contact the researcher via email or by phone. The recruitment flyer

was printed in color and approved for use by the City University of New York Institutional

Review Board. A second recruitment strategy relied on the network of nurses working in the tri-

state area who either came across a copy of the recruitment flyer or knew the researcher

personally and who could refer friends, coworkers, peers, or classmates who met the study

criteria to the researcher for possible inclusion in this study. A convenience sample, described as

a sample of participants who could be suitable candidates for consideration to include in the

research study and readily available to the researcher, would be created and used to initiate the

study (Corbin & Strauss, 2008).

Both strategies were successful. A community hospital in the suburbs of New York City

was contacted first and the researcher was put in contact with the nursing representative from

that organization's Institutional Review Board (IRB). The researcher, through his role as a nurse

administrator, was familiar with this organization and recognized it as a hospital that supports a

program for nursing research. With an already established professional network within that

organization, he was permitted access. The recruitment flyer was reviewed by the IRB and

approved for posting on six medical-surgical units, two progressive care units, and in its one critical care unit.

A similar community hospital in suburban New Jersey was chosen at random from a list of acute care hospitals. The researcher contacted the Chief Nursing Officer (CNO) and was referred to her organization's nursing research council. The researcher made a formal presentation to this council to explain the research aim and the processes involved. A nursing representative from the nursing research council then presented the flyer to the organization's IRB, and approval for posting was granted. The flyer was then posted on five medical-surgical units, three stepdown units, and two critical care units by the nursing representative from the nursing research council.

Prospective participants voluntarily contacted the researcher if they wished to participate, leaving their name, preferred method of communication (e.g., telephone, e-mail), and a convenient time for speaking with the researcher. Communication with the researcher occurred by telephone, by e-mail to a dedicated address, or in person. The researcher monitored his voicemail three times a day and his e-mail several times a day for the presence of new messages from potential participants. The researcher generated communication back to the potential participant based on her preferred method and either planned a future time to speak directly with her or engaged her in immediate conversation if speaking on the telephone was more convenient for the participant. The researcher screened the potential participant to ensure that she met the delimitations for this study:

(1) A female registered professional nurse (RN). The researcher designed and titled this study to examine how "nurses" integrated pregnancy and full-time employment. In the United

States, however, nurses are defined not only as registered professional nurses but also as licensed

practical nurses (LPNs). While both levels of licensed professional nurses exist, the decision to

exclude LPNs was deliberate. In the New York tri-state area, RN's dominate the nursing

workforce and therefore the total number of nursing professionals; this is true of the overall

United States (U.S. Department of Labor, 2010c). Further, the New York tri-state area mirrors

the national trend where the number of LPN education programs, and the number of job

opportunities within hospitals, are declining and therefore do not represent the majority of the

current nursing workforce (Buerhaus & Staiger, 2011; Welton, 2011).

(2) Primiparous. Pregnancy is a significant life event for women. Women experiencing

pregnancy combined with full-time employment for the first time, as opposed to multiple, or

repeated experiences of pregnancy combined with employment, were assumed by the researcher

to provide more vivid details of the experience. The researcher relied on the newness of the

experience, and on the interactions that occurred in the workplace due to being pregnant for the

first time, to contribute to the development of this grounded theory.

(3) Employed full-time in an acute care hospital on a medical-surgical, critical care, or

progressive care unit. Acute care hospitals offer myriad services based upon the communities

they serve, but medical-surgical, critical care, and progressive care units or service lines are

common (American Hospital Association, in press). Further, these specialty areas in acute care

hospitals are frequently the most active related to nursing workload and with the largest number

of RN's staffed among them in full-time (i.e., greater than 35 hours worked per week)

employment positions (Buerhaus & Staiger, 2011; U.S. News & World Report, in press;

Welton, 2011). Therefore, to ensure the transferability, or the applicability of the research

findings in another context, (Leininger, 1994) these three specialty areas were deliberately chosen.

Once the participant was found to meet the initial criteria for inclusion in this study, the researcher obtained her mailing address to send her a hard copy of the consent form or, if preferred by the participant, her email address to receive a copy of the consent in PDF format. A tentative time to meet convenient to both the participant and the researcher was scheduled that would follow her review of the consent form and allow an interview to take place.

The consent form (see Appendix B) was sent via first-class mail to six of the participants to the addresses provided to the researcher. Twenty consents were sent electronically to the email address provided by participants per their requests. Included in the mailings were instructions for the participants to read through the consent form and to bring it to the interview and sign in front of the researcher. Additional time was allotted between the sending of the consent form and confirmation of an interview time to allow for questions and clarifications of the consent before the interview. For example, one participant asked if she would be needed for any follow up conversations after the interview while another asked if the printed transcripts would be included in the final document of the researcher's dissertation. Further, one participant wanted to confirm she could stop the interview if she needed to leave and, if that occurred, whether she could reschedule. A follow-up phone call, or email if requested by the participant, confirmed the interview time and location arranged at a place that was mutually convenient for the participant and the researcher.

This researcher found that scheduling to meet the participants was more challenging than anticipated. With potential subjects living throughout the New York-tri-state area, distance to

meet participants became a factor not considered by this researcher when developing this study. Specifically, suggesting locations to meet in areas the researcher was unfamiliar with that would be conducive to an interview was difficult due to his unfamiliarity with the local surroundings. Traffic, parking, and sufficient time to find the location were impediments that needed to be factored into the overall planning and scheduling of the interviews. Four of the participants scheduled appointments with the researcher and then did not show up for the interview and never contacted the researcher again. Two of the participants did not show up for the interview but rescheduled with the researcher; the same two did not show up for the rescheduled interview and did not contact the researcher again.

In total, 28 nurses contacted the researcher for participation in the study. Twenty nurses were interviewed and included in this study. Two nurses did not meet eligibility for inclusion (one was multiparous; the second was a nurse who was employed full-time in Psychiatry). The other six nurses met inclusion criteria but an interview never took place: four made appointments with the researcher and did not show up. As required by the Institutional Review Board, the researcher did not pursue the four nurses who did not keep their appointments with him and waited for them to contact him. No further communication occurred between the researcher and those four nurses. None of the nurses withdrew from the study.

As is appropriate for qualitative interviews, the first participants in this study were chosen through convenience sampling. Convenience sampling is a practical way to begin to gather data; the researcher uses subjects who agree to participate. It allows the researcher to make comparisons based upon the concepts that emerge during the analysis but limits choosing whom to interview next (Corbin & Strauss, 2008). The initial six participants were female nurses who were employed full-time in an acute care hospital, three from 12-hour day shifts (7 a.m to 7 p.m.)

and three from 12-hour night shifts (two 7 p.m. to 7 a.m., one 8 p.m. to 8 a.m.). All were within weeks of having delivered their first babies. Snowball sampling occurred as additional participants were referred to the researcher by other nurses. Snowball sampling is where the researcher, having already identified and interviewed members of the phenomenal group, relies on those members to identify other participants whom they feel would also contribute to the study. New participants, in turn, refer additional participants until the researcher feels saturation in themes has occurred (Crabtree & Miller, 1999; Creswell, 2012). In grounded theory research, theoretical sampling occurs as ongoing data analysis occurs. Theoretical sampling is a process by which the researcher seeks answers to questions or hypotheses that arise during data analysis by interviewing new participants who are likely to have relevant experiences, looking for comparisons in data already collected, and returning to participants to ask new questions (Munhall, 2012).

In this study, theoretical sampling was limited due to several factors. First, the specific criteria of full-time employment, recently primiparous, and working in an acute care hospital required the participants to self-identify or for peers to refer. Second, Institutional Review Boards of both acute care hospitals approached by the researcher required that any potential nurse participants be recruited or referred, as opposed to approached or solicited by the researcher directly. However, this sample was robust due to the large number and diversity of the respondents, which contributed to the credibility and rigor of the research findings (Creswell, 2012; Roy, 2012). Despite different clinical specialties, ethnicities, ages, education, and years of nursing experience, patterns emerged within the diverse sample of nurses (See Table 1-Participant Profile).

A total of 20 nurses met the specified criteria for inclusion in this research study. All were enthusiastic about participating and eager to share their stories. The participants were all employed full-time while they were pregnant with their first babies. The first 17 participants worked on specialty units defined in the inclusion criteria. However, by the thirteenth interview, thematic saturation was believed to have occurred but the researcher continued to interview additional participants to further confirm his findings. In order to test the transferability of the findings that emerged and to confirm that saturation had indeed occurred, the last three participant nurses interviewed represented specialties outside those defined in the inclusion criteria. These three nurses represented the specialty areas of the Post-Anesthesia Care Unit (PACU), Emergency Room (ER), and Operating Room, respectively. Seven of the participants identified their hospital as a Magnet-designated organization by the American Nurses Credentialing Center (ANCC); three reported that their hospital was on an active journey toward Magnet designation; and 10 worked in non-Magnet designated hospitals. All 20 participants worked 12-hour shifts, eleven on the day shift and nine on the night shift. The 12-hour day shift was primarily 7 a.m. to 7 p.m., although two of the nurses reported that they worked either 8 a.m. to 8 p.m. or 9 a.m. to 9 p.m. The 12-hour night shift was more consistent: the majority of the nurses reported their night shift as 7 p.m. to 7 a.m. with one reporting her shift was 8 p.m. to 8 a.m. Fourteen of the participants reported earning a Bachelor of Science in Nursing degree, with the remaining six earning an Associate's degree. The participants ranged in age from 25 to 35, with an average age of 27.9 years. Eighteen of the participants were married and two were engaged to be married. Each participant had delivered a well, full-term baby. Despite similarities in their social and economic situations, the researcher found that the diversity of the nurses' clinical experiences and environments, coupled with the unique interactions the nurses would

have with their peers and coworkers in the workplace, allowed for individual meanings of their interactions to be explored. Regardless of their work environment, the participants in this study provided stories that demonstrated consistency among the findings that emerged. A complete participant profile can be found in Table 1.

The interview process

Interview sites included the participant's home, a library conference room, or a quiet table at a restaurant. None of the interviews occurred at the participant's place of employment because, as per the study's inclusion criteria, the participant nurses spoke with the researcher while they were on maternity leave. Following introductions, the researcher reviewed the purpose of the study and the consent form with the participant. Two copies of the consent form were signed; the researcher kept one and the participant kept the other. Her consent to be audio recorded was obtained. Immediately before the start of the interview, the researcher asked the nurse's age, her educational preparation, the type of unit she worked on, the shift she worked, the number of years practicing as an RN, the number of years working on her current unit, and if her hospital was designated as a Magnet facility.

Individual semi-structured face-to-face interviews were used to collect data. The in-depth interview allowed participants to describe, in their own words, meanings and assumptions about situations and events in their own lives (Munhall, 2012). The researcher and participant are engaged in an active process: the participant as storyteller and the researcher as an active listener (Rubin & Rubin, 2011). The audio recorder was turned on and the researcher opened the interview with the leading statement, "Tell me about working while you were pregnant." The nurses began to talk about their experiences and began to describe a host of physical changes, the

workplace environment, their peers and coworkers, their patients, and their nursing care tasks. Over the course of the interview, the researcher would ask the nurses to clarify words and phrases, or to give specific examples or situations that would allow him to better understand the story the nurse was telling. For example, one nurse spoke about negativity in the workplace and the researcher asked her for a specific example. The nurse reported a story where she heard her peers and coworkers talking about her. She became reluctant to ask for help and would often perform all her work tasks alone. It was common for the nurses to present themselves as hard workers and "good nurses."

At the beginning of the study, the researcher focused on the physical aspects of nursing care and pregnancy and their impact on patient care. The majority of nurses described their pregnancy in two stages: "the beginning" or "the early part," and then "toward the end" or the final weeks when the most dramatic changes in appearance and physical symptoms occurred. Specific events, then, were reported by the participant nurses to have occurred during one of these two time periods with the most discussions and recollections about events occurring toward the end of their pregnancies. The researcher subsequently modified the questions he asked other participants to focus on events and interactions that occurred during those periods. From this perspective, the participants discussed their bodily changes and symptoms but also focused on their relationships with peers, coworkers, and patients in the workplace. It emerged that relationships and connections were essential to the nurses and that a sense of strength and empowerment followed the experience of full-time employment and pregnancy.

By the 13th interview, the researcher became convinced that he had reached saturation in the themes that were emerging. Saturation, as defined by Munhall (2012), is when no new data are emerging. To confirm that he was reaching saturation, he continued to interview participants.

Saturation, as defined by Corbin and Strauss (2008) is when no new data are emerging and there is delineation between concepts in the emerging theory. As he became assured of thematic saturation and wanting to confirm the transferability of the findings, the last three nurses interviewed were nurses who had contacted him from specialty areas not in the original study criteria. Transferability, according to Leininger (1994), refers to whether the findings of the study can be transferred to another similar context. Therefore, nurses from the Post Anesthesia Care Unit (PACU), Operating Room, and Emergency Department were interviewed and their stories confirmed previous findings. At this point the interview process stopped and data analysis began.

Data Analysis

For the purpose of clarity, the interview process and the data analysis are considered separately. However, the first part of the data analysis occurred following the first interviews. Immediately following each interview, the researcher wrote a memo reflecting on the interview and noting the highlights and major themes. He wrote notes in the margins and used different colored inks to write field notes to himself about the environment, the nurse's body language, or thoughts to keep in mind for the next interview. Each memo and the notes were reviewed when the audio recording was replayed. While listening to the audio recording, the researcher listened to the change in the nurse's tone of voice, or tried to single out periods of laughter or pauses in her story in order to elicit meaning about her interactions in the workplace. Key words were written both within the memo and along the margins of the memo to allow the researcher an opportunity to reflect on their meaning, or importance, as he reviewed the audio recording, as well as to prepare for future interviews. This process allowed the researcher to begin to identify themes early on as the phenomenon was explored and the basic social process was emerging.

Immediately following the interview and a review of the audio recording, the researcher transcribed the audio recording.

The audio recordings were converted into an MP3 file and saved to a flash drive that was secured in a locked drawer in the researcher's home office. These files were more portable in the MP3 format and could be played on a personal audio device such as an Apple iPod which permitted better sound quality and ease of transcription. The researcher opted to transcribe the audio recordings himself in order to enhance his own recollection of each interview and remain connected with his data and participants. Each transcript was typed into a Microsoft Word document and shared with the researcher's dissertation chairwoman, who is an expert qualitative nurse researcher, for feedback and guidance on emerging categories for future research. All transcripts were kept in an electronic file format, along with one hard copy to permit ease of review by the researcher. Each transcript was re-read twice: once alone, and a second time compared against the audio file to ensure all words and expressions were captured verbatim and important pauses or inflections captured. Memos written following the interview, along with key words highlighted in the margins and within the text, were reviewed to see if further meaning were gleaned from multiple hearings of the recording and the addition of printed text.

Upon completion of the transcription, the file was transferred and pasted into an Atlas ti-7 document as a hermeneutic unit for analysis and coding. Each transcript was thoroughly analyzed, line by line, using the Atlas ti-7 software and coded with substantive codes through the process of open coding. Where appropriate, codes were taken and labeled verbatim, or in vivo coding, according to the words of the participant. Coding involved breaking down the data into discrete parts, closely examining them, and comparing the parts for similarities and differences reflected in the data (Charmaz, 2009). As suggested by Glaser (1967), interview information was

coded into as many categories of analysis as possible. After the first seven transcripts were coded, multiple individual codes emerged. Review of the codes revealed multiple similarities and connections among them. Transcripts were re-read and some of the codes were combined or re-coded. For example, codes of *Nausea & Vomiting, Morning Sickness,* and *My Stomach's on Edge* were all recoded into *Physical Symptoms: GI.* Similarly, codes of *Doing nice things for me, Watched over me, Looked out for me,* and *Really cared about what happened to me* were combined into *Coworker Support.* Coding information was sorted using the ability to create, link, and connect coding families with Atlas ti-7. Additionally, the codes were listed and printed out as a Word document and the researcher used different ink colors to connect codes or re-code others as a visual reminder of how the study was evolving and to maintain clarity of the emerging categories. For example, the codes related to body image, body size, and commentary about body shape were grouped and renamed into the theme of *Looking Different, Feeling Different.* Under that theme, then, the supporting *in vivo* codes of *"I was huge!"* and *"Like a patient"* were grouped with sections of transcript from the nurses. Specific exemplars were chosen, then, that were the most illustrative of the theme based on the researcher's thematic analysis. Additional notes and memos were taken from this visual analysis that were not permitted with the Atlas ti-7 program for analyzing the next transcript.

As each transcript was coded, it was compared with the previous interview. As data analysis continued, new categories emerged. Review of the memos and journal notes, along with the use of open coding, allowed the creation of new categories. Open coding, and the constant comparison of newer data to older data and the use of memos and notes, allowed the data to be put back together and connections made between the category and its subcategories (Glaser, 1978, 1992). With repeated review of the data and the use of the constant comparative method of

analysis, four categories emerged that led to the emergence of a core category as the basic social process.

Trustworthiness

Trustworthiness refers to how reliable, consistent, transferable, and confirmable the study findings are in qualitative research (Lincoln & Guba, 1985). Most qualitative research studies are evaluated for rigor according to a set of broad criteria that is similar to criteria for quantitative studies of reliability and validity (Carcary, 2009; Munhall, 2012). Lincoln and Guba's (1985) criteria provide direction for ensuring trustworthiness, while doing grounded theory as opposed to an evaluation of the finished product. Trustworthiness, then, can be enhanced through a variety of ways. These include the use of rich descriptions, peer review by experts, prolonged engagement, member checks, triangulation, an audit trail, and a statement of researcher bias (Cooney, 2011; Williams & Morrow, 2009). Most of these were used by the researcher throughout this study:

1) To enhance the credibility of the findings, along with the consistency of the meanings ascribed by the nurses to their social interactions within the workplace, nurses from different clinical settings, nursing educational preparation, years of nursing experience, and shift worked were all taken into account in this study. A highly variable sample of nurses resulted. Nurses of different ages and races who had recently delivered their first baby and were on maternity leave were interviewed. The nurses worked within different specialty units of medical-surgical, progressive care, or critical care nursing. Some were employed at Magnet-designated hospitals, hospitals on a Magnet journey toward designation, and hospitals without Magnet

designation. This allowed for capturing different perspectives, as the workflow and work processes differ among unit types and within specialty areas. Further, interviewing only nurses on maternity leave allowed for isolating the work experience while pregnant and not be overshadowed or influenced by current working conditions, e.g., being a new mother or having a newborn at home while working. Participants were sought who had either a BSN or Associate's degree in nursing; these reflect the current educational preparation of the modern nursing workforce.

2)   To ensure objectivity, a review of the literature and use of memos and journal notes brought additional insight and information.

3)   As the theory evolved, the findings of this study were found to apply not only to the nurses who participated in this study, but also to nurses who worked in other specialty areas. Nurses, for example, from the Emergency Department, the Post Anesthesia Care Unit, and the Operating Room were interviewed to confirm the transferability of findings.

The study was conducted over a one-year period. This enabled the researcher to thoroughly review and reflect upon transcripts, journal entries, and memo notes to code and re-code interview transcripts as the theory emerged. This extended length of time was necessary to allow the researcher to thoroughly review each of the interview transcripts, interview new participants, analyze the data, and ensure saturation, or the point in the research when all concepts are well defined and explained (Corbin & Strauss, 2008, p. 145). The researcher's dissertation chair, an expert in qualitative research, reviewed the interview transcripts and provided feedback for future interviews along with commentary on the emerging theory.

It is the obligation of the researcher to present the data honestly (Munhall, 2012). Interviews were recorded until the participant ended the interview. The recordings were reviewed before transcription began. In order to maintain intimacy with his data, the researcher transcribed the interviews himself. Multiple times during transcription the recording was stopped, replayed, and reviewed in order for memos or notes to be made. Following transcription, the researcher read the transcript against the audio recording to ensure that the interview was fully captured. Participants were asked to contact the researcher if additional thoughts or ideas surfaced following the interview.

Reflexivity

To document rigor in qualitative research, the researchers engage in reading and reflecting on field notes, transcribed interviews, documents and memos (Lincoln & Guba, 1985). Reflexivity, then, is the process by which researchers recognize that the researchers themselves are an integral part of the research, the awareness that their role in the interpretation of the data, and their sensitivity to the meanings and patterns that emerge (Munhall, 2012). In this study, the researcher identified, and engaged in, activities to provide rigor through reflexivity.

The researcher is a certified nurse midwife, and he identified potential biases from his clinical experiences and range of understanding about pregnancy and the common discomforts and complications that can arise from being pregnant. For example, during the interviews, the participants often spoke of their physical discomfort at specific stages of their pregnancy. In one interview, the participant described an incident at work where she experienced cramping, fatigue, and increased leg swelling. The researcher instantly realized, within the context of the story she was telling, what that could signify clinically. He needed to step out of his clinical role, remain

quiet, and allow the participant to explain what was happening in her own words, and identify what *she* believed the causes, meaning or consequences were.

As a staff nurse who worked with coworkers who were pregnant, and then as a nurse leader directly supervising pregnant nurses in various clinical specialties, the researcher recalled his own experience working with pregnant nurses. For example, he had worked with pregnant nurses on the night shift who needed a longer break during their shift. He recalled the animosity he felt toward their taking a longer break and automatically attributed the cause of needing a longer break to his peer being pregnant. He negated the possibility of any other factors that could have contributed to her fatigue, such as no sleep prior to work or that this was a particularly busy shift. The researcher admits that he has referred to a pregnant coworker as the "Pregnant One" and took part in jokes about her being "ready to pop."

As a nurse administrator, the researcher was surprised to hear the stories of how the pregnant nurses were treated by their coworkers in different situations. For example, he was dismayed to hear from one participant about how badly she was treated while pregnant by her peers and coworkers. Conversely, he was surprised in another situation by the positive feelings and emotions the participant nurses conveyed about their connections with patients and their families. The researcher, however, had to learn while conducting the interviews to remove his own personal feelings from the situation and let the participants tell their stories. Further, in his role as a nurse administrator, the researcher was very familiar with the typical structure and environments of the medical-surgical, critical care, and progressive care units that the participants in this study were employed full time in. He needed, again, to step out of his role and let the nurses describe their environment in their own words and not assume that the units, the types of patients they treated, or the amount of staffing they had, were all similar.

Limitations

Limitations are factors that may have an effect on the interpretation of the findings or the generalizability of the results and are not under the control of the researcher (Lunenberg & Irby, 2008). The researcher, therefore, acknowledges the following limitations to this study:

(1) Limited theoretical sampling. Theoretical sampling in grounded theory is the process by which the researcher seeks answers to questions or hypotheses that arise during data analysis by interviewing new participants who are likely to have relevant experiences, looking for comparisons in data already collected, and returning to participants to ask new questions (Munhall, 2012). In this study, theoretical sampling was limited due to several factors. First, the specific criteria of full-time employment, recently primiparous, and working in an acute care hospital required the participants to self-identify or for peers to refer. Second, the Institutional Review Boards of both acute care hospitals approached by the researcher required that any potential nurse participants be recruited or referred as opposed to approached or solicited by the researcher directly. Corbin and Strauss (2008) remarked that researchers often need to rely on systematic data gathering and sampling through convenience sampling, described as a sample that is available to the researcher at the time. Further, they remarked that researchers should accept what subjects are available to them because, even with true theoretical sampling, rarely will a researcher find two or more participants with identical events or incidents (Corbin & Strauss, 2008, p. 155). Additionally, Corbin and Strauss (2008, p. 155) elaborated that if the researcher is comparing incidents and events on the basis of the concepts rather than looking at data in a descriptive sense, then the researcher is doing theoretical sampling regardless of how the data was actually gathered. Ultimately, this sample was robust due to the number and

diversity of the respondents, which contributed to the credibility and rigor of the research findings (Creswell, 2012; Roy, 2012). Patterns emerged with the diverse sample of nurses despite different clinical specialties, ethnicities, ages, education, and years of nursing experience

(2) Only registered professional nurses (RN's) participated in this study. In the United States, "nurses" include not only registered professional nurses but also licensed practical nurses (LPN's). The decision to exclude LPN's was deliberate. The New York tri-state area reflects the trend throughout the United States where RN's comprise the majority of nursing professionals (U.S. Department of Labor, 2010d). Further, the New York tri-state area also reflects a national trend where LPN education programs, and the number of job opportunities within acute care hospitals, are declining (Buerhuas & Staiger, 2011; Welton, 2011).

(3) All of the nurses in this study worked a 12-hour shift. The 12-hour work shift is a national trend for, and preferred by, the majority of registered professional nurses (Green, Fairchild, Kovner & Brewer, 2009; Nelson, 2012). While a national search of RN employment opportunities revealed the existence of an 8-hour work shift, the 12-hour shift predominates, especially in the New York tri-state area (www.nytimes.com/pages/jobs/index/html or www.RNjobs.monster.com). The findings of this study represent nurses who only worked a 12-hour day shift (e.g. 7 a.m. to 7 p.m., 8 a.m. to 8 p.m., or 9 a.m. to 9 p.m.) or a 12-hour night shift (e.g. 7 p.m. to 7 a.m. or 8 p.m. to 8 a.m.) and would thus limit the generalizability of those findings to registered professional nurses who are employed on an 8-hour work shift.

(4) Only the medical-surgical, critical care, and progressive care nursing specialties were

represented. In acute care hospitals, these nursing specialties predominate and are

common service lines offered (American Hospital Association, in press). While other

service lines or nursing specialties can exist within acute care hospitals (e.g. obstetrics,

radiology, or psychiatry), the three specialties (medical-surgical, critical care, and

progressive care) represent services accessed by the largest number of patients and where

the largest number of nurses are apt to be employed in the acute care setting (Buerhaus &

Staiger, 2011; Welton, 2011). Despite this limitation, however, the researcher observed

no difference in the findings that emerged and the findings were consistent among the

participants. Three additional participants were included who validated the consistency

of, and add weight to, the findings and represented the specialties of emergency nursing,

post anesthesia care and the operating room.

(5)   The participants in this study were interviewed only when their

pregnancies were completed and maternity leave had begun. Rather than observing and

interviewing nurses during their pregnancies, the researcher chose to recruit and

interview participants whose pregnancies had concluded in order to capture the

experience of pregnancy and full-time employment as a completed entity to be reflected

on as a whole. This resulted in the nurses describing their experiences in phases, for

example, "early" or "in the beginning" and then "later on" or "toward the end," with the

most dramatic and memorable events and recollections occurring at the end, or the later

phase. The events of pregnancy become more pronounced as it nears completion, and

most likely those events were the most recent and therefore most memorable. While some

findings related to the early phase of pregnancy, the majority of the research findings

focused on events and interactions that occurred toward the end, or later phase, of

pregnancy.

Summary

Nurses, as social actors, experience many social interactions in their environment, the

workplace. The basic social process, *becoming someone different*, emerged to explain those

interactions and allowed a substantive grounded theory to be developed. From that exploration,

the researcher will present the basic social process, *becoming someone different*, and the four

major themes that arose from the analysis: 1) *looking different, feeling different* to explain how

the physical and emotional changes of pregnancy lead nurses to look different and feel

differently about themselves as nurses; 2) *expectations while expecting* where the nurse, with

previous experiences and ideas about what is expected of her and what she expects from others,

changes who she sees herself as, based upon her interactions in the workplace with her peers and

coworkers; 3) *connecting differently* explains how the nurse, while pregnant, develops new

relationships and interactions with the people in her environment, specifically her peers,

coworkers and patients, and 4) that despite challenges from her interactions within the workplace

from coworkers or tasks, the participant nurses began *transitioning labor* to shift their focus to

their eventual maternity leave and working as long as possible to the time of delivery in order to

prolong that maternity leave.

Chapter 4: Findings

Becoming someone different emerged as the basic social process of how registered professional nurses integrate full-time employment and pregnancy. The nurses interact within their social environment: the workplace. Nurses communicate constantly with peers, coworkers, and patients. Social interaction, then, is common and the work environment is created based upon those interactions. The behaviors and actions of the nurses who maintained full time employment while pregnant were based on the interactions they had with peers, coworkers, and patients. The findings of this study suggest that nurses, regardless of the type of hospital (e.g., an academic medical center or a community hospital), clinical specialty (e.g., medical-surgical, critical care, or progressive care), shift worked (e.g., 12-hour day shift, 7 a.m.-7 p.m., 8 a.m.-8 p.m., 9 a.m. to 9 p.m. or 12-hour night shift, 7 p.m.-7 a.m. or 8 p.m. to 8 a.m.), or years of nursing experience (i.e., 3-11 years), responded to become someone different based upon their interactions with others in their environment, and how they morphed during pregnancy.

Grounded theory provided an inductive methodology that allowed the researcher to develop a theory to explain or interpret the social process or phenomenon of how nurses integrated full-time employment and first-time pregnancy. Grounded theory, then, focuses on social processes and the interactions of people, as actors, within their environment (Chen & Boore, 2007). The actions, behaviors, and responses of the nurses were based in large part on social interactions with peers, coworkers, and patients. The emphasis, then, of the data analysis was to find meaning about the assumptions the nurses felt were made about them through the course of their first pregnancies, and to describe how the nurses changed and others changed towards them. Using the constant comparative approach of grounded theory with data collection, open coding, and data analysis, themes emerged from the stories of the nurses.

Through their interactions with coworkers and peers in the workplace the nurses moved through stages and their identities as pregnant women were formed. The nurses recounted how interactions and events in their pregnancies occurred in two unique stages: an "early" or "in the beginning" stage and then a "later," "toward the end" or "at the end" stage. What divided those stages varied among the nurses: some described it as a specific period (e.g., "when I was 28 weeks") or as a specific month (e.g., "when I hit six months") or on a point they recalled when their physical appearance changed (e.g., "once I was showing" or "when you could tell I was pregnant"). For example, the experience of physical symptoms was frequently described in the "early" stage, whereas the dramatic physical changes to their bodies were described in the "later" stage. Once the participant nurses' identities as pregnant women were formed, for the remainder of their pregnancies, the nurses, *looking different, feeling different*, become known, or marked, on their units as "the Pregnant One" and their abilities as nurses were judged, or perceived, by their peers and coworkers based on their being pregnant. The nurse, having *expectations when expecting*, navigates the expectations she holds of herself combined with the expectations of her actions and behaviors by her peers. The nurse *connecting differently* with the people in her workplace environment, forms alliances and new relationships based upon interactions in her work environment. By *transitioning labor*, then, the nurse balances expectations, challenges, and relationships to not only complete work tasks but also finish the limited time of pregnancy to deliver her baby and advance to motherhood.

This chapter begins with descriptions of workplace settings according to the nurses participating in this study. Within those settings, participant nurses ascribe meaning to the impact of their bodily changes. Next is a discussion of how physical changes and expectations of themselves, and those of their coworkers, alter the pregnant nurses' interactions with their peers

and coworkers – with subsequent changes in their behaviors within the work environment. Third, a description of how the new connections the nurses developed with their peers, coworkers, and patients during the limited time of their pregnancy is explored. Last, how the nurses manage the interactions to balance workplace and personal demands and expectations throughout the duration of their pregnancies is introduced. *In vivo* codes are used often in section headings to capture the precise words of the nurses who participated in this study. Specific narratives are used to enrich the interpretations and enhance the qualitative context in which these findings exist.

The workplace setting

The nurses in this study reported working in two types of health care organizations: large, academic medical centers and non-academic, acute care community hospitals. An academic medical center was typically "a big place" with "lots of different specialties" and "interesting cases." Specifically, the academic medical center was a "teaching hospital" where residents and interns worked alongside attending physicians as part of their training.. The novice physicians would often be present on the nursing units and "rounded often" with the nursing staff during a work shift. In contrast, the community hospital was a "non-teaching" facility that was "run by the attendings" and "without residents or interns." In the community hospitals, the nurses reported interacting with physicians "only when they rounded". Despite different statuses of physicians working within the hospitals, each hospital contained the same three types of specialty units of interest to this study: medical-surgical, critical care, and progressive care, which were described consistently by each nurse who participated in this study.

Medical-surgical units, often referred to by the participant nurses as simply "Med-Surg" or "the Floor," were units that cared for patients with a host of medical or surgical diagnoses. The units were geographically "bigger" compared to critical care or progressive care units and the patient locations "spread out" among the available rooms on the unit. The amount of patient care tasks, combined with the physical layout of "the Floor," required the nurses to move frequently around the unit in order to accomplish work tasks. The workload on these units, then, was described as "busy." The nurses explained that their work environment consisted of several other registered nurses or assistive personnel, such as nurses' aides, nursing assistants, or patient care technicians. Communication, or interaction, with other staff working on "the Floor" was frequent and necessary in order to accomplish patient care tasks.

In contrast, critical care units, or the "ICU" or simply "the Unit", were described as places for the "sickest of the sick" and the "most critically ill" patients. These units were consistently described as "heavy" or "intense" by the nurses as they related stories of the typical workload or treatment modalities. The participant nurses from critical care described their "Unit" based on its specialty or focus, e.g., surgical intensive care (SICU), medical intensive care (MICU), cardio-thoracic intensive care (CTICU or CSICU), or the coronary care unit (CCU). The participant nurses representing the critical care units reported frequent, sustained contact with patients or their families and that they spent "a lot of time at the bedside." The nurses further explained that the clinical instability of these patients and multiple types of treatments meant their assignments were "typically one nurse with two or three patients." The nurses, further, reported a lack of assistive personnel employed in their units and that there was a high reliance on, and frequent communication and interaction with, other nurses for assistance with patient care tasks.

Progressive care, also called "stepdown" or "Tele", units were described by the participant nurses as the units "in between Med-Surg and ICU." Patients in these units required targeted monitoring and treatments but the severity of their illness was "not sick enough to be in the ICU" but "too sick to be on Med-Surg." The ratio of nurses to patients was consistent: one nurse was assigned to four to five patients. Unique to this setting, as described by the nurses, was the frequent "turnover" or "in and out" of the patients; patients were often admitted to these units for short, well-defined time periods and then transferred to higher or lower levels of care. In turn, the nurses reported the need to "push beds all the time" or "constantly take patients off the floor." Assistive personnel, similar to the medical-surgical units, were available but seemingly not in sufficient supply on these units, according to the nurses. As with the medical-surgical and critical care units, the nurses reported relying on their fellow nurses to assist them with patient care tasks.

Each of the nurses in this study worked a 12-hour shift. Despite the long hours, the nurses reported that they "preferred 12's" and that they "couldn't imagine ever working an 8- hour shift five days a week." The day shift was described as 7 a.m. to 7 p.m., 8 a.m. to 8 p.m., or 9 a.m. to 9 p.m. The night shift was 7 p.m. to 7 a.m. or 8 p.m. to 8 a.m. The ability to change or "flex" those hours was determined by the nurse manager.

The nurse manager was the leader of the nursing unit, described as the nurse with the "authority" to do things. He or she was responsible for "running the unit," "making the schedule," "staffing," and the "hiring and firing" of nurses. Communication or interaction with the nurse manager was sporadic and "depended on how many units they covered" and could sometimes occur daily. To assist with the operations of the unit, then, charge nurses were utilized.

The charge nurse's role was described as the nurse on the unit who "managed the unit during a shift." Communication and interaction with the charge nurse was frequent. The charge nurse created the patient care assignment and could alter that assignment by adding or deleting the number of patients at any time during a shift. The charge nurses also "assigned breaks" or "relieved people for lunch" as part of their daily routine. Regardless of the breadth of their role, during a specific shift the charge nurse was the "go to person" when issues or problems arose, either clinically or professionally..

Seven of the nurses in this study reported that they were employed in a hospital that was Magnet-designated by the American Nurses Credentialing Center (ANCC). Further, three reported being employed in hospitals that were actively seeking Magnet designation while 10 reported being employed in non-Magnet hospitals. The ANCC Magnet model (2005) proposes that structures and processes in place within a nursing division to promote nursing autonomy and professional development would produce a well-engaged nursing staff with high job satisfaction, low nursing turnover, and quality patient outcomes. Magnet designation, then, confirms that hospitals have demonstrated commitment and success with their implementation and application of the Magnet model. For this study, Magnet designation, or lack thereof, was found to not be a factor in the nurses' experiences of pregnancy and full-time employment. The overall findings of this study were consistent among all the participant nurses.

Looking Different, Feeling Different

Physical changes are inherent with pregnancy. The nurses knew that their bodies would change but believed that the impact of those changes would be minimal. However, the nurses would come to realize that the changes in their bodies, plus the physical symptoms experienced,

would affect their work processes and physically set them apart from their peers and coworkers. This section describes the nurses' physical and emotional changes, specifically, how the nurses interpreted the actions and behaviors of those in their work environment and the impact those actions had on each nurse's perception and identity of herself as a pregnant woman.

Looking different, feeling different: "I was huge!"

The nurses anticipated physical changes to their bodies during pregnancy. Most felt that because they were in "great shape" and "physically fit" prior to becoming pregnant there would be "minimal" to "no disruption" in their routines or work practices. While the nurses understood that their growing abdomen signified a "growing baby" and the normal progression of pregnancy, they were not prepared for the physical discomforts that followed or "being singled-out," "labeled," or nicknamed "the Pregnant One," "Preggo," or "Preggers." They soon begin to compare themselves to their coworkers, or "the in-shape girls" or the "skinny ones" who are like "the Energizer Bunny" on the floor. The nurses realize that their growing abdomens make them stand out, or different, than the other women they work with. The nurses accept that "I was the Pregnant One" or call themselves "the one with the baby" on the floor. The pregnant belly, then, became the focal point for the nurses that impacted both how they worked, the symptoms they experienced, and how they were perceived by those around them.

The nurses were enthusiastic about being pregnant. They herald their increasing abdomen as "normal," and any weight gain or distortion of their bodies, during this time, was to be expected. As their pregnancies became more apparent, however, the nurses become the recipients of "comments about their size" or their weight. These comments led the nurses to reflexively use similar language when describing themselves as they compared the shape and

condition of their bodies to those of their peers and coworkers. For example, Eileen, a

Progressive Care Unit RN, recalled:

> I was huge! Everyone kept telling me things like, "Wow! Look at you! You're huge!" Or
> "You're as big as a house" or even like, "You look like you're ready to pop!" I was
> looking at my reflection in the patient's window and I thought to myself, "Yeah, they're
> right. I'm huge! I'm gross."

Comments about their increased body size would often precede comments about their

"abilities to work" or "questions about how long they intended to remain working." The

nurses, in turn, would realize daily that having a pregnant belly would be judged by those in

their environment as a gauge of the likelihood of being an active, contributing member of

the nursing team and of the likelihood of accomplishing nursing care tasks for assigned

patients.

The pregnant belly, then, was perceived by the participant nurses as a "barrier" to

patient care. The nurses become unable to maintain a physical closeness with their patients,

and a majority of patient care tasks involve close contact with patients. The pregnant belly,

then, separated the nurse from her patient and that separation steadily increased as she came

nearer to the time of delivery. The more she could not do, the more negatively she described

her body shape and her "dissatisfaction with not providing the type of care she envisioned."

Further, the more she could not do, the more she felt others would notice and perceive her as

"lazy" or "not a team player."

> I mean, the belly just gets in the way! You have this watermelon in front of you and it
> totally messes up your routine. I remember when I wasn't pregnant I used to just lean
> over the bed rail or even lean on it and talk to the patients, and since the beds need to be
> leveled at a certain height for the vent or for the A-lines and stuff it was just easier to
> come into the room and either squeeze myself between the spot where the rails split or
> just lean over the rail to like flip the pillow or something. Then when I was pregnant, I
> didn't fit in that spot anymore and one time I did squeeze myself in there and then
> panicked because I was totally stuck. The distance between the patient in the middle of
> the bed and me on the side was huge because my belly was in the way and I couldn't

> reach over it to touch the patient without practically crawling into bed with them. I felt like I couldn't do what I needed…like, I couldn't care. I couldn't do my nursing because my, well, "self," got in the way. (Kelly, Medical ICU RN)

The nurses begin to question the "possibilities of performing their work tasks" and, week by week, the tasks were described by the participant nurses as becoming more challenging. The pregnant belly becomes a source of potential "embarrassment" as it causes the nurses to become physically "slower and awkward" or that it could be a potential source of "jokes" and "comments from the girls on the unit." "Fear of tipping over" when bending down, squatting to the floor and not being able to return to standing, "being too out of breath" to converse with patients, or "dribbling urine" while rendering care are real concerns. The pregnant belly, as it becomes more pronounced and prominent in the nurses' midsections, often bumps into or brushes against patients, knocks over items or into equipment. For example, Tara, a Medical-Surgical RN, recalled:

> You name it, I crashed into it: computer, patients, the supply cart, everything. If I could spill it or make a mess, I did it by hitting into it with my belly. Guaranteed. I just could never, like, grasp, my own space in front of me and like daily I sent water pitchers flying off over bed tables or containers of juice onto patients' laps.

Grounded theory helped explain what was occurring for Tara in the work environment. She believes those in her work environment, including her patients, see her discomfort and her incidents of minor physical mishaps. In turn, Tara believes herself to be awkward and clumsy based on what she perceives her patients and coworkers to be thinking and she believes that these embarrassing situations will keep occurring. She perceives then, that regardless of her abilities, she will be seen as physically intrusive or uncoordinated for the remainder of her pregnancy.

Looking different, feeling different: "Like a patient"

The advancing pregnancy, hallmarked by the characteristic enlarging abdomen, was accompanied by additional physical symptoms that also impacted the nurses' work experiences.

Fatigue, leg swelling, body aches, nausea, and vomiting, blurred the boundaries between the nurses and their patients, i.e., the increasing physical problems made the nurses more like the patients in their care and, coupled with morning sickness, these symptoms had a profound effect on the nurses' abilities at work.

Fatigue, one of the most common physical symptoms of pregnancy, is exacerbated by the 12-hour shift and "intense work environment." The nurses report this as the most "troublesome symptom" due in large part to their wish to perform tasks. However, frequently, their bodies are "unable to carry out what their minds envision." Further, fatigue was the one symptom that, once experienced, was not easy to recover from and became increasingly pervasive, with peers and coworkers noticing also. Katie, an ICU RN, recalled a time when:

> The girls [her coworkers] were like, "Katie, go home! We'll manage. Go home!" and I went but felt like shit leaving them with the unit so busy. I just remember getting into my car and just crying, like the tears began and I was just crying and crying and crying because I literally had no idea how I walked to my car because I was so tired. Then I was literally too tired to pick up my arms to turn on the ignition. I was like, "I just want to go home," but after working like I had I had no strength to even think or even drive so I just sat there and cried. My body hurt more than I could ever imagine and each day it seemed like my body hurt more and more.

Coupled with fatigue were often complaints of body aches that intensify and persist as pregnancies progressed. All of the nurses in this study worked a 12-hour shift that was cited as the key factor that added to, or accentuated, the "muscular aches" and "discomforts experienced," especially of the lower back, legs, and feet. Body aches were one of the preliminary symptoms that first impacted work performance; nurses could not physically lift, pull, turn, or push patients due to the discomfort experienced when the tasks were attempted. Kimberley, a Medical-Surgical RN, recounted:

> The 12-hour shift killed me. The 12-hour shift, you know, it's tiring and when they say "back breaking," you know, they might be on to something there because nursing when I was pregnant totally broke mine. God…everything, just like, hurt. I mean, soreness like I

have never experienced before and even just like standing there just made me ache all over. I could be like pouring meds or like charting or something and I would just hurt. If I even tried to do patient care, I would always like invariably hurt myself. I turned wrong, I bent wrong, I did everything wrong, or I must have because I was always sore. It had to be something I did but I know it just had to also be part of me working so many hours and so many rough hours at that. It's a long day. I was sore, I was tired, I was swollen from literally the waist down. Everything just hurt.

While the feelings of fatigue and sometimes the body aches might not be noticeable to

peers and coworkers, leg swelling was one symptom the nurses often could not "disguise" that

added to their physical and emotional discomfort. Swollen calves, ankles, or feet could be easily

seen through scrub pants or overflowing past the tops of sneakers or clogs. Similar to the

pregnant belly, the leg swelling was a "source of commentary" by observers. For the nurses, the

leg swelling further slowed their pace, affected their gait, and their ability to turn, pivot or stand

for prolonged periods of time. The nurse feels distant from her peers and coworkers because she

is unable to perform at a pace she is accustomed to and feels different, or embarrassed. For

example, Ella, a stepdown unit RN, remarked:

> My legs were just like tree trunks. I couldn't move. I mean, I had to like ask the girls I worked with to help me out of the chairs, to help me in the patients' rooms, and even to like help me measure the output in my Foleys or my chest tubes. Anything that involved me moving, bending, or whatever, I needed help. How embarrassing…and my legs looked like the old ladies on our floor with CHF. My legs were I think even bigger than theirs at one point. People had to help me just move around. Between my big legs, and…the nausea and the morning sickness? I was done.

Nausea, vomiting, and morning sickness interrupted the nurses' routines, including how

they started their work days, commuted to work, and their schedule of patient care tasks

throughout a work day. Work routines became planned around the likely possibility that "sights

or smells in the workplace" could induce sudden, unpredictable nausea and the subsequent

embarrassing, uncontrollable need to vomit. Despite the intensity of the symptoms, the nurses

feared vomiting uncontrollably while performing patient care, or in front of their coworkers, so

all precautions are taken to avoid those situations. Lettie, a Medical-Surgical RN, described how

she managed her work day to avoid such instances:

> I think it was anything to do with food, and if I even hung up a new bottle of tube feeding the whiff of that like fake- formula stuff or like the Ensure supplements? I'd be done. The chocolate one was the worst and I love chocolate but somehow smelling that stuff just set me over the edge. I'd be in a room and I learned that I had to be sure I kicked the garbage can over to whatever side of the bed I was on. Like I could empty a bedpan full of you-know-what and be fine, but I'd literally open the can of tube feed, or like the bottle of Kayexcelate, or, oh God, the clamp off an ileostomy and I'd just like hurl in the next second. I knew I had to keep something close by or pray that I was near the "A" bed by the door. Or I learned to carry those little plastic patient bags? You know, the ones they put used tissues in? Or specimen bags, or have a water pitcher liner close by so I could just, you know, discreetly heave and then just like, ever so quietly, toss it. Can you imagine? I mean, if the patients saw me puke? Oh God I'd die. Literally I'd be so mortified. So I prayed that if I went in the room I remembered to put all the necessary stuff near me so that sort of thing didn't happen.

A new, "distressing symptom" that affected the nurses was the experience of "Baby

Brain." Baby Brain was described as "memory loss," "forgetfulness," or "uncertainty about

simple tasks" during pregnancy. While the nurses had heard of the phenomenon of "Baby Brain"

prior to pregnancy, all the participants in this study were "amazed that it could happen" to them

or were surprised at the degree to which it occurred in their daily practice. Further, the nurses

were particularly concerned about medication dosage calculations, feared a miscalculation,

administering medication incorrectly, or omitting an important nursing task entirely. The periods

of confusion or forgetfulness in conjunction with the physical discomforts experienced

throughout their pregnancies resulted in feelings of "frustration," "anger," "annoyance," or

"being totally embarrassed." Like a patient in their care, then, the participant nurses were

experiencing, and responding to, similar feelings, emotions, and physical discomforts that often

accompany illness or disease. The nurses needed to rely on their coworkers to not only ensure

patient safety with such critical tasks but also assist and support them to complete tasks and

perform nursing functions properly.

> Like trying to calculate drips and trying to like anticipate each next thing was becoming a struggle and I felt like I was constantly writing myself notes to remember things and to keep myself on track I started making like a checklist—like, labs sent, check. 2nd liter of fluid, check -- stuff like that because I was so forgetful and just, honestly, wiped out. I was constantly asking my coworkers to check my math, check my drugs, check my notes…I was so afraid I would mess up. Then I'd like bring them in the room with me to be with me when I hung up drips, or even do a fingerstick. I didn't want to make a mistake. I was so frustrated with the whole thing. (Renee, Surgical ICU RN)

"Emotional lability" during pregnancy was another new experience for the nurses. The nurses reported significant changes in their personalities ranging from "short-temperedness" to episodes of "tearful outbursts" or "prolonged crying." Most of the nurses blamed their "hormones," but the majority did not know at the time that they were feeling, or responding, in the manner they were. They relied on retrospection or the observations of coworkers, spouses, or family members to inform them of their behavior. The nurses felt a sense of embarrassment or surprise that they exhibited such a wide range of emotions. For example:

> And that's the thing, like I was so emotional when I was pregnant and stuff like that just made me cry. But I could cry on like demand, especially with my patients because, what do they say? Your hormones or something are so out of control and you're like sobbing at every song or TV commercial? That was me. It was so embarrassing. (Denise, Coronary Care Unit RN)

Each nurse spoke of the "unpredictability of their emotions" and that was the most worrisome to them. Not being able to feel a "rising tide of emotions" approaching, they were unprepared for the resultant "tears," "anger," "verbal outburst," or lack of action on their part that followed. For example, Kristine, a Medical-Surgical RN, recalled:

> The kind of patients I work with, you know, were for me mostly oncology patients and then I got the ones who were on hospice at [Hospital name] and I don't know if that was maybe more difficult for me because your hormones are crazy and you're a little more emotional. Um, so I tried to keep that intact and keep it together and not break down in front of a patient, you know, because they have their own issues and such that they have to deal with. But it always just snuck up on me. I didn't know it was coming. It freaked me out because the last thing I wanted to do was be crying in front of the

patients. I'd never been like that before. I needed support, that was it. I needed people to tell me it was OK, that I was normal, and that this would pass. I felt like my patients, you know? Like I get it now why they're so moody and emotional because I was just like them.

Kristine's experience, and those of the other nurses, demonstrate that, like the patients in their care, they too experienced new physical discomforts and limitations. What began as a desire to work at the same pace and rigor as before they were pregnant dissolves slowly into the realization that, due to their increasing size and physical limitations, there are specific tasks and routines they can no longer perform. Further, their peers and coworkers judge them based on their pregnancies; they become marked as "the Pregnant One" on the unit and therefore it is assumed their work abilities and contributions to the nursing team are diminished. They come to understand that, "similar to the patients" in their care, they "need assistance," additional resources, and "new skills" to achieve goals. Becoming someone different by looking different and feeling different, and then balancing the expectations of themselves and others in the workplace, is essential to the nurses.

Expectations when Expecting

The nurses held expectations throughout their pregnancies. They placed high expectations on themselves as they focused on working until the end of their pregnancies. They felt there were expectations of them from their peers and coworkers, and they, in turn, had expectations of their peers and coworkers as a team. They recalled their prior experience working with pregnant nurses and compared their experiences to their predecessors. Ultimately they assessed their work environment, their coworkers' willingness to help, and their own expectations for "how nurses are to act" as key factors in asking for and receiving help -- or whether they relied on their own "innovation" and "stamina" to find a way to get tasks

accomplished. This section describes the expectations of the nurses: what they assumed their peers and coworkers expected of them, what the nurses expected of themselves, and what the nurses expected of their peers and coworkers.

"Asking for help" and "receiving help" were new for the nurses. Their decisions to seek help with many, if not all, of the physical tasks of their patient assignments were predicated on their experiences working with pregnant coworkers in the past. Their experiences were twofold: 1) how the nurses themselves felt about working with a pregnant coworker in the past and 2) how they witnessed the pregnant nurse being treated by her other coworkers on the nursing unit.

Expectations when Expecting: Them of me

The participant nurses described how their peers' and coworkers' expectations (i.e., "them") of how the pregnant nurse (i.e., "of me") would act or behave in the workplace often stemmed from previous experiences working with pregnant staff members. The nurses in this study surmised that, in the past, their pregnant peers "used their pregnancies as an excuse" to not do specific tasks or to not take certain patient assignments. The nurses felt overall that pregnant coworkers they worked with previously could have functioned within their normal capacity but refused to. Pregnancy was used as a "medical condition" that required "attention" or "protection versus a temporary condition" that slightly limited the nurse's abilities. Requests for help from pregnant coworkers were seen as "whining," "being a wimp," or "complaining." Some of the nurses in this study reported that in the past they willingly helped their pregnant peers, anticipated their needs, or took on extra work because they felt it was the "right thing to do" for a coworker. The majority, however, felt at the time that they were "dumped on" because a pregnant coworker could not perform all the required patient care tasks, leaving the other nurses on the unit to bear the workload.

The participant nurses, then, witnessed and recalled how their pregnant coworker was treated by the group of nurses working on the floor. Often the group of nurses "resented" that their pregnant coworker was "relieved of certain work tasks" or a specific patient assignment. A sense of "imbalance" or "unfairness" was talked about among the group and the pregnant nurse was the identified cause. Negative "gossip" and "sidebar conversations" were heard about the pregnant nurse being "lazy," "useless," and "milking it" or a "bad nurse,". Renee, a Surgical ICU RN, recalled her previous job with pregnant coworkers:

> Yeah, most of the time I was the one who got dumped on. It's so annoying. I mean, we all have equal share of the patients, we're all busy, and now I got her work on top of my work and there is only one of me to go around. Like if it was my Buddy that was different because it's more like "our" work, but I got stuck with doing everyone's stuff. At one point like 3 of them were like at different stages of pregnancy and it was awful when all 3 were on and here I was the newlywed who was the most fit of that group. God, I think one day I like pushed 10 beds upstairs and back and cleaned and bathed every patient in the unit that day. See? It's so annoying! And this one girl was annoying because she'd be behind the desk rubbing her stomach complaining about how miserable she was and I was like, "Seriously?" I tried to tell her that if she got off her butt maybe she wouldn't think about how miserable she felt but that only went so far. Everyone talked about her too. God, they were brutal. They talked about her behind her back and would like talk about how lazy she was and that they couldn't wait til she went out on Maternity leave.

Some of the participant nurses recalled how, in the past, they felt "sorry for thinking badly about the other girl" or for "making fun of her," yet held onto the belief that their coworker was actually "milking the system" and using their pregnancy to deliberately avoid work or specific work situations. The nurses in this study, in turn, assumed that their peers and coworkers expected the same scenario or situation to repeat itself. To the nurses, being a "good nurse" meant that, regardless of your physical condition, one "came to work and performed" at their best.

Expectations while Expecting: Me of me

The nurses, having experienced working with a pregnant peer and having experienced how that coworker was "treated and talked about by other nurses," resolved to be different if, and when, they became pregnant. The nurses, then, developed expectations of what they envision a "good nurse" to be. A "good nurse," regardless of her specialty, is constantly in action. Periods of downtime or inactivity are frowned upon by peers and superiors. "Good nurses," then, are always "doing": lifting, bathing, medicating, moving, lifting, transporting, documenting or caring. Further, a "good nurse" is "constantly attentive" to her patient's needs, "quick to intervene," "adept with her clinical skills," and "responsive to changes in her patient's condition," The nurses, then, believed they were inherently "good nurses" but when pregnant, their abilities were somewhat limited and they were and in need of help themselves. The definition, then, of being a "good nurse" was challenged.

Expectations when Expecting: Me of them

The decision to ask for help was based largely on the nurses' perceptions of their overall work environment, the expectations in the nursing unit of how the staff are expected to perform, and with whom the pregnant nurse worked. If the nurses witnessed a supportive, nurturing work environment when other coworkers were pregnant, they readily asked for, and received, help. In contrast, if an unfavorable work environment existed they were reluctant to ask for help and often created "short cuts" or "work-arounds." Having witnessed the way pregnant nurses were treated in the past, and the behaviors of other nurses toward those they felt did not "pull their weight" or regarded as "not a team player," the nurses therefore tailored their actions to demonstrate they were contributing, reliable members of the nursing team.

The majority of nurses experienced working with a "good team." A "good team" was described as nurses who were "sympathetic," "genuine, caring people" that anticipated the pregnant nurse's needs and readily "stepped in to help." Assignments were altered to accommodate the pregnant nurse and tasks that involved repeated physical exertion such as pulling patients up in bed, repositioning patients, transferring out of bed to a chair, or pushing beds and stretchers were all done for her without her having to ask. The nurses felt that their peers "understood the discomforts and limitations" pregnancy imposed and, by having tasks completed for pregnant coworkers in advance, spared her the "burden," or "embarrassment, of asking for help." Siobain, an ICU RN, recalled how her coworkers supported her:

> I worked with such great people. They would go in and turn all my patients, position, them, clean them up, pull them up, whatever. I never, ever had to ask. They just took it upon themselves to do what needed to be done. I don't think I would have asked them though. I was too embarrassed to be like, "Oh I'm pregnant and I need help to pull these heavy people up" but honestly? I was. I was just not able to do it alone like I used to. They did it for me and I not having to ask was a Godsend. It was something I don't think I'll ever forget because it made a world of difference to me. I still felt like I was one of them, you know? Even though they were doing my heavy stuff, I still felt like I was part of their team.

The nurses "felt guilty" or "that I didn't deserve to be treated so nicely" when their peers and coworkers were doing their work for them. It becomes important, then, for the nurses to remain looked upon by their coworkers as a "good nurse." This often involved a self-imposed "barter system" where the pregnant nurse would try to substitute performing a task she was capable of doing for her coworker who was performing a task for her. The need to "reciprocate the favor" and, more importantly, "look like she was still actively working" in some capacity, became paramount. Sitting still or watching others work was not an option. Further, not being perceived or talked about as a "slacker" or the "useless one" became equally as important. Kristine, a Medical-Surgical RN, recalled:

Seeing someone else do my stuff, like cleaning my patient or doing my dressings or emptying my Hemo Vacs or my JP's, I felt guilty so I tried to compensate by like doing their orders, or updating their care plans, or doing whatever other boring task I could to make it even. It was only right. Or I'd like fill their water pitchers, or feed their patients or flush their lines or something. Whatever I could do to sort of like, you know, repay them for all the help they were giving me. That way all of us were working and it hopefully worked out in the end. It was definitely not one of those bad places, or a bad way, to work.

Kristine, like the other nurses, held expectations of herself as a nurse, and of her coworkers as a team. Each of the nurses acknowledged that, in turn, their peers and coworkers, had expectations of them. Past experiences, and the connections with coworkers, were integral to the formation of expectations. To meet those expectations, then, the formation of new connections in the social environment of the workplace became important.

Connecting Differently

Regardless of whether the nurses felt they were a burden to their peers, angry at the way they were treated, or guilty because their peers and coworkers were doing their work for them, the nurses move on and connect differently with the people in their social environment. The nurses' pregnancies became an unavoidable physical characteristic that set them apart from their peers and coworkers, but being pregnant drew people's attention to them and new relationships were established. Most of the nurses in this study experienced peers and coworkers who supported them not only through completing work tasks but also through advice-giving and kind gestures. Unexpected hostility and maltreatment, however, occurred also. The nurses developed a new relationship with, and respect for, their nurse manager and charge nurse over the shared experience of pregnancy and motherhood. They learned to connect differently with their patients and their patients' families. They come to perceive the patient as similar to themselves: humans in need and together they discovered new ways to cope with problems and self-care.

Connecting differently: The unexpected

Unfavorable work environments were a reality for some of nurses in this study. "Hostile coworkers," "difficult working conditions," and "vindictive behavior from coworkers" occurred within some environments. The nurses, in response to the actions of their peers and coworkers, were forced to persevere through these situations, which overshadowed their overall recollection of their experience working while pregnant.

Coworkers were overtly hostile toward the nurses. The nurses endured "negative comments made about her physical size" or about her "abilities to complete work tasks," "argumentative behavior," and felt a "lack of concern" about them from their peers. For example, Alexandra, a Stepdown Unit RN, remembered:

> My staff was just out and out mean to me. And I worked…God, I worked but no one would even like say "Hello" to me or even ask me how I felt…no one really spoke to me. All they asked me was, "What do I get stuck doing today?" and that hurt. I didn't ask them for a thing because I knew they'd probably jump down my throat if I did. One nurse even told me, "I can't wait till you go out because you're making our lives miserable. And don't come back. You're useless." I swear! All I could do was just cry. I felt the tears coming and the burning feeling right before you cry and then I knew once I started I just wouldn't stop. They were just mean. I never felt so…so…unwanted in my whole life.

The hostility experienced by Alexandra was similar in critical care. Katie, an ICU RN, recalled:

> One of my coworkers was on the phone with the nursing supervisor asking her for more help. I counted and we were four RN's like we're supposed to have. I gave her this look like, "Why are you asking for more help?" and she shot me this look and looked me straight in the face and told me, "Yeah, having you here is like working as 3. You don't do much. I was stunned.

Further, on her Medical-Surgical floor, Linda remembered:

> I worked with the meanest women. They hated me. No, I'm serious, they hated me. They totally ignored me, and they gave me an assignment I had no business taking and they put me in rooms I shouldn't have been in.

The work assignment, and the work conditions, were problematic for some of the nurses.

Assignments with "combative" or "infectious patients," or one with "high acuity" and a "large

total number of patients" in an assigned district or team were cited as examples. Overall, the

nurses working in these environments felt the assignment was "created deliberately" as a way to

force the nurse to work harder, or as a "test" to see if the nurse would meet the challenges or step

back and ask for the other staff to do her work. For example, Roxanne, a Stepdown Unit RN,

recalled:

> I got the same rotten assignment night after night. Isolation rooms, a patient with herpes, two totally demented old people, and one guy who was kicking and biting. I went up to the Charge Nurse and asked, you know, if there was a reason why I was getting all these patients because at that time I was really big and showing and there was no way you couldn't tell I was pregnant. She practically jumped all over me and was like, "What? Are you refusing? I'll call supervision. You have to work too, you know, we all work here. All our assignments stink so if you can't do it then go home." I should have left but I needed my job. I was so embarrassed and I never brought it up again. I just did my best and couldn't wait to deliver so I could get away from those girls.

"Vindictive" or "malicious behavior" occurred also. Deliberate acts were "perpetrated" upon the

pregnant nurse that disrupted the nurse's work routine or distracted her established coping

mechanisms. For example, Kelly, a Medical ICU RN, described some of her coworkers's

actions:

> They threw out my water bottles. I'd fill them up, hide them, and sure enough, they dumped them. I mean, everyone knows pregnant women are supposed to drink lots and lots of water and these girls would go out of their way to get rid of my water. The lounge was on the total opposite side of the unit so I had to have water close by my rooms. I caught one once and tried to stop her and know what she did? She held my water bottle over the garbage and said, "We don't drink at the nurses' station. Joint Commission rule" and dropped it, like let it go like a water balloon, right into the garbage can. Then another one went and threw out all my snacks. Like I kept carrots and crackers in the pocket of my scrub jacket and when I took it off to gown up for isolation I'd come back and my little packs were stolen out of my pockets. I didn't dare ask them for help because when I did they turned around and said, "If we have time we'll try." It wasn't worth my breath to ask again so I just figured out ways to do things by myself.

Tara, a Medical-Surgical RN, recalled this incident with her coworkers:

> They gave me a guy with shingles only I didn't find out about it until almost eight hours into my shift. I was running around busy and never got to look through his chart and they didn't tell me about it in Report. When I found out I went right to the Charge Nurse and told her, "Do you know this guy has shingles? I'm pregnant, remember?" and she just glared at me and said, "You can gown and mask but you need to take whatever the rest of us take. I knew he had shingles but we have protection equipment here. Problem solved." I was stunned. I knew telling someone, you know, like my supervisor or even my Nurse Manager would be useless. They'd think I was complaining. So, I just was super careful. I figured out a way around it and did what I could do to get through.

The nurses, feeling as if they had been labeled a "burden" and that they were not part of the nursing team on the floor, began to sense "resentment" from their coworkers and an underlying fear of "sabotage." Realizing a lack of support from their coworkers, the nurses stopped asking for help or assistance with any nursing tasks and attempted to do their work to the best of their abilities. The nurses in these hostile environments were convinced that any request for help would go "unanswered" or that there would be "unfavorable repercussions" from repeated requests for help. Determined to get their work tasks accomplished, the pregnant nurses "devised new ways to get their work done." Often requiring a deviation from established best practices, these "short cuts" and "work arounds" succeed in accomplishing nursing work tasks without the assistance of coworkers. These short cuts, however, could result in patient harm or worsening their condition. For example, Mindy, a Medical ICU RN, recalled:

> There was just no way these people were going to help me so what was I to do? I had to do it myself or it wouldn't get done. It's not my patient's fault they were sick. So, you know, you learn. Like you really can pull a patient up alone. I dropped the head of the bed into a really low Trendelenburg and put my back against the wall and sort of grabbed the patient under his armpits and pulled him up. Then I put the bed back and I grabbed the bottom sheet and pulled up tight on one side, then sort of went to the other side and grabbed the other corner of the sheet and pulled it up over there. He looked good and I was happy with myself that I did it. But when I went to fix the blankets I saw all this blood at the foot of the bed and it was fresh, and I was thinking, "Where did this come from?" So I pulled back the covers and saw both his heels were a bloody mess. I couldn't believe what I had done. From pulling him up that way I totally sheared his heels along the mattress. I did this to him and now he has these two open wounds on his feet. I should

have known it would happen because he was so debilitated but I didn't think. I just didn't think and now look what I did to this poor man.

Despite any untoward outcome, and regardless of whether the work environment is perceived as favorable or unfavorable by the nurses, it became important for the nurses to demonstrate their independence and that they are seen and perceived by their coworkers as "reliable," "contributing" members of the nursing team. The nurses began to do more than they physically should and made overt attempts to demonstrate their independence and competence to their peers. When in patient rooms, the nurses devised new ways to coordinate their care so as not to rely on their coworkers for assistance or learned new ways of "consolidating tasks" to shorten the amount of time they needed to dedicate to accomplishing tasks. For example, Lettie, a Medical-Surgical RN, recalled:

> I mean the biggest thing we did on our floor was clean patients, whether it was a bath or to clean up incontinence or something and it just got harder and harder each day. I had to, you know, again, be creative with what I could do, like maybe getting all the sheets rolled up into one so that when I flipped the patient all I had to do was tuck the clean linen underneath the patient, or if it was really bad diarrhea or something I'd like wash the hips, the legs, and the rest of the patient and save the butt and back for when I could hold up their back with my one arm while I wiped them down with the wet cloth in the other. Or like with Foley catheters or like a CBI? There was a lot of up and down and bending but I learned to use my knees for strength and to hold onto the bed rail or the bed frame while I was crouching down and then to like stabilize myself while I was emptying it so I didn't tip over or something and then use it to climb back up to a standing position, you know, like how babies use to stand up in a crib? And then I'd hold onto it for a few seconds while I got my bearings back, you know, stuff like that. Don't get me wrong, though. If someone wanted to help me, I'd be all over it and indebted to them forever.

Connecting Differently: *"Cared about"*

Supportive relationships with peers and coworkers were valued. More than the physical support peers and coworkers provided, "emotional support," "advice," and "camaraderie" were appreciated. As the nurses' pregnancies became apparent, peers and coworkers began to check in

with the pregnant nurse to ask "How was I feeling?" or "Can I help?" Break times and scheduled

lunch times were honored and accommodated. Patient care assignments were modified

depending upon patient acuity and the pregnant nurses' physical abilities. Gestures of kindness

were welcomed, accepted, and never questioned.

The pregnant nurses also recognized those peers and coworkers were "mothers

themselves" and had gone through similar experiences. Advice on nutrition, infant care, and

suggestions about ways to manage pregnancy were freely offered. The pregnant nurses came to

view their peers and coworkers as "mentors for motherhood" and developed a new sense of

"closeness," "loyalty," and "a sort of kinship" with them. Their peers and coworkers had "done

this before" and "knew what I was going through." They shared important rituals, such as

celebrating gestational milestones like "When I felt him kick" or "When I dropped," baby

showers, maternity leave, and visits when hospitalized after delivery. The shared experiences of

working while pregnant and eventual motherhood created a familial connection between the

pregnant nurses and their peers that "solidified" as their pregnancies progressed and contributed

to the pregnant nurses' resolve to return to work, and her unit, after delivery. Ella, a Stepdown

Unit RN, recalled:

> I truly worked with the nicest group of people. I guess that since they'd all gone through
> the same thing they knew what I was feeling and went out of their way to help me. They
> were just so smart because, you know, I like knew nothing about any of this stuff. Like,
> I'd never done this before. They made sure I ate, that I drank my water, and that I even
> took time to go to the bathroom. They were constantly asking me if I needed help. Then
> they went and threw me this huge baby shower on the unit and even like our secretary
> and our security guards came. I got all sorts of nice gifts from them and they all pitched
> in and bought me my stroller, then they all came to see me in the hospital after I
> delivered. And they're even still emailing me or texting me to see how I'm doing. I miss
> them. It was like having a bunch of Moms and big sisters looking out and caring about
> me.

Charge nurses and nurse managers became support people for the pregnant nurses also. Most nurse leaders were considered to have a "higher status" or were "bosses" compared to the role of the staff nurse, but the favors and the kindnesses they imparted to their pregnant staff nurses strengthened the bond of "loyalty for my manager." Additionally, leaders gave precedence to the well-being of the pregnant nurses over the logistics of managing their units; this set the tone for, and defined, the culture of the nursing unit. Kristine, a Medical-Surgical RN, recalled:

> I think my manager set that whole tone—like from the beginning at staff meetings when I was letting people know I was pregnant she said, "You know, Kristine is pregnant so thank you everybody for helping her out as best you can during these next couple of months" and I knew she was expecting that kind of participation from people which I got. Like everyone was OK with it and in that one simple statement I knew my Manager was supporting me and that it was OK.

Further, the charge nurse or nurse manager was often the person who identified alternatives related to work schedules or work processes and used their experience to guide and protect the pregnant nurses. Kimberley, a Medical-Surgical RN, remembered about her nurse manager:

> Really, really, looked out for me and got what I was going through. She was the first one who said, like, "Kim, I know you want to work to the end, but I want you to be healthy to the end. So, if you need to switch things up a bit I am fine with you working 8's, 10's, or 12's but it's up to you. I'll use you wherever you can work and with whatever you can give me, but it's up to you to tell me when you're done and you've had enough but I'll keep you working until you tell me not to anymore" and I loved that about her. She literally told me that taking care of Me was the most important thing and that to do what I needed to do to be sure I was OK.

Connecting Differently: All about me

"Self care" became an important skill that the pregnant nurses acquired. Often dictated by the physical changes in their bodies, the pregnant nurses learned to identify cues from their physical symptoms or from the movements of the baby. The pregnant nurses began to listen to an "inner voice" that told when it was time to rest, elevate their feet, stretch, or drink water. Prayer, meditation, and exercise and yoga were attempted and then practiced regularly.

Spiritual practices became shared, especially with spouses or close family members. The pregnant nurses began to converse regularly with a God-figure, regardless of their religious origin, and felt that by doing so they ensured a healthy baby and a safe pregnancy. The pregnant nurse and her partner or spouse began to pray together or attend religious services regularly, spent more time together, and made plans for their baby's future. As the pregnant nurses' times for delivery approached, they began to utilize prayer as a way to manage workplace stressors. Mary, a Surgical ICU RN, spoke about she used prayer:

> I used to pray a lot when I was younger and I guess my life got busy when I was an adult. But when I knew I was pregnant I began to pray again, you know, just like talking to God a lot more and stuff. But it helped. I prayed going into work and right after my prayers I felt strength. I believed He would send me strength to handle anything. Even if I woke up feeling like crap I knew He would send me the strength to overcome that and do good that day and be successful. I literally could feel my prayers working—they relieved my stress, and I felt God's presence with me, beside me, right there along with me and my patient. Sometimes I'd get so focused on what I was doing and I would be sitting at the computer doing my notes that I'd remind myself to stop, say prayer, thank God for being with me, or I'd pray with my patients. I'd feel this warmth and surge of energy come through me that literally energized me for the next hour or so. It was a nice thing to do, especially with my patients.

Connecting Differently: Looking at patients differently

The pregnant nurses savored the personal connection that developed with their patients and their patients' families. Patients began to notice the nurses' pregnancies and their enlarging abdomen became "open territory for anyone to touch" and a "conversation piece." Patients would "just reach out and touch" the nurses' abdomens while "relaying stories about their own children or grandchildren." Questions such as "What are you having?" or "When are you due?" became common. Patients, especially women, related their own birth experiences or birth stories and voiced concern and amazement for the pregnant nurses' "stamina" or "chutzpah" to work while pregnant. The patients became "protective" of the nurses and attempted to perform as many tasks as possible on their own, including repositioning, toileting, or transferring themselves

to shield the nurse from physical injury if she performed them herself. The nurses developed a

"new connection" with their patients through conversations that shifted away from clinical topics

and onto "life and birth stories." The nurses recognized "joy" in their conversations - as most

patients recounted happy stories related to children and grandchildren. This joy would be

understood following delivery for most of the nurses. Mary, a Surgical ICU RN, recalled:

> There was such joy in people that I didn't experience until I was really showing. People would literally get tears in their eyes when they talked about me being pregnant, like "what a wonderful experience" and people, strangers really, who looked at me with such joy and were just so genuinely happy for me. I think I didn't understand it when I was pregnant, but after I had the baby and held her for the first time and felt that complete utter joy myself that I realized they were reliving a better time or memory sort of through me, and I was able to bring that to them even though I didn't know it at the time. It was sweet. Like one old lady, she just reached out each time I was in and would like tap my stomach and smile a toothless smile and I finally get it what she was so happy about.

A first for many, the nurses allowed patients, their families, or on some occasions,

strangers, to touch their abdomens. This act felt "right" and "natural" and "seemed to be just

what people do around pregnant women," serving as a conduit between the nurse and another

human being.

Often the nurses saw their patients, especially women, differently. When their pregnant

bellies were touched, the nurses felt like they shared similar life experiences as women with their

patients: "first time mothers," "unsure of the outcome," "the scary truth about birth" and the

"excitement of motherhood." A connection outside the nurse-patient relationship occurred that

was "deeper," "more meaningful" and "new to me." Lettie, a Medical-Surgical RN, cared for a

combative patient with advanced dementia and revealed an incident on her unit:

> We went in the room and I remember we had to turn her and she always used to fight us when we did nursing care on her. So I helped [name] turn her, and she's screaming and yelling practically in my ear and I couldn't wait till we were done. Then, as I pull her over onto her side, I feel her touch my belly and I like jumped because I thought she was trying to hit me. I looked and her hand was different—like not in a fist or a slap mode or

anything like that, but it was outstretched like she was reaching. Don't ask me why, but I knew she was touching my belly and for some weird reason I took one small step back in toward her and sure enough she put her hand right on my belly. And she was so gentle about it—like she was sort of caressing my belly. She wasn't even screaming anymore, but just there, holding her hand on my belly, and then, I swear to God, she looked right at me, and I think for the first time I looked at her and realized she had the bluest blue eyes.

I mean, I'd seen her before, but in that one moment she and I connected on some other level. She wasn't that demented old lady anymore. To me she was a woman, too, who had been pregnant with her own kids, and had gone through what I was going through. I could cry thinking about it because I was so wrapped up in doing my work that I never stopped to see "her" in all that screaming and crazy behavior. Her eyes were so blue and I saw her smile…she actually smiled. I had never seen this lady smile. She just kept her hand there and I was like, "[name], look! Look at what she's doing!" and [name] looked over and she was like stunned because for the first time we weren't wrestling with her to change her and she was so calm. And she just kept her hand there, and then the baby kicked and I knew she felt it and she smiled again. I think that was something I won't forget about this whole experience. She and I shared something there at that moment, and each time after that I swear she looked directly at my belly and would stare at it each time I was there.

Kristine, on her Medical-Surgical unit, recalled:

It was special to me because in a way I was able to bring some joy to them for a few minutes, even if it was something so simple like when they'd ask "Can I feel your belly?" and I'd let them and they would look at me with such a light in their eyes and say "Oh this baby is big!" or "I bet it's a boy!" and we'd share that. I was happy that I could do something so easy that meant so much and it was like I had one special gift for a little while to offer people.

Mindy, a Medical ICU RN, told of a time when she cared for a young woman with cystic fibrosis whose prognosis was uncertain. The patient noticed she was pregnant, asked Mindy if she could touch her, and Mindy recalled:

…Saw she had a tear in her eye and I was shocked because we were doing fine and like we were joking and talking and getting along great, like I didn't pick up on any sadness or anything and she looked at me and said, "Can I touch it?" and she was looking at my baby and without a second's hesitation I said, "Sure!" So she turned to me and she put her hand right on the top, like up here by my ribs, and he was moving all over the place and I think he even kicked her and she like, her eyes were like huge and she looked at me with such like amazement and then was asking me about, you know, what does that feel like? Does it hurt? Does it tickle? And I was so touched and I had absolutely no qualms or anything about letting her touch me.

I honestly was totally OK with her touching my belly. I felt bad because, like with her disease and stuff, she'd never, ever get to be pregnant, and she was so sick that she probably wouldn't make it through the rest of the week. It was OK, and then for the rest of the nights that I had her she would touch me throughout the night, or pat my belly when I came in or before I left in the morning, so yeah, stuff like that I was glad I did and I would have that belly for a short time so I might as well use it for something good for someone else, you know? Like, hey, if it made her smile and maybe make her feel something she'd never felt before, then what's the harm, you know? I was OK with it and she got a rush from it and I think it was overall a good thing. And to be honest her rubbing my belly felt so nice and it was actually soothing to me so I gained in the deal too. She was such a fighter and she was determined to get better. She had amazing strength that I think rubbed off on me a little too.

Transitioning Labor

Despite the physical or professional challenges in their work environment, the pregnant nurses pushed past their pain or discomforts in order to accomplish patient care tasks. The pregnant nurses analyzed their tasks that needed to be done and determined ways to complete them. They developed a goal: "the end." The "end," or ultimate delivery and going out on maternity leave, became the focus. Staying at work meant longer time for maternity leave and working up to "the end" took on a new meaning. To get to "the end," the pregnant nurses needed to get through each shift and each day. To get to the "end," the nurse had to endure the continuous cycle of being judged by her peers and coworkers and having her physical limitations become more apparent as the time of delivery drew closer. In response to the behaviors and perceptions of her coworkers, then, physical and mental strategies were employed to help the pregnant nurses "push through" and get to "the end."

Transitioning Labor: The end is near

Pregnancy is a limited duration of time. The pregnant nurses described the later stage of pregnancy where they realized that any discomforts or inconveniences would "eventually pass" and that they "wouldn't be pregnant forever." The end of their pregnancies, then, was acknowledged and they began to anticipate maternity leave and motherhood. The pregnant

nurses delineated the timing of pregnancy: it had a beginning (i.e., the "early" stage) and a calculable end (i.e., the "later" stage). The "end" became the goal and for the pregnant nurses the ultimate end point was "when work stops," "I delivered," and "maternity leave starts."

While the end point was delivery, most nurses focused on maternity leave. The pregnant nurses became acutely aware of their amounts of sick time and how much paid vacation time they had accrued, and became knowledgeable of their hospitals' maternity leave policies. Most, if not all, of the nurses anticipated "working until the end" of their pregnancies in order to prolong their maternity leaves. Calling in sick, taking vacation time, or "going out early" were not options; time taken while pregnant impacted the amount of time allowed for maternity leave. "Staying at work," then, became the key tactic to achieve the goal of maternity leave.

"Staying at work" meant different things for each nurse. For example, Eileen, a Progressive Care Unit RN, "Came to work and did my job. I did what I had to do and hope I did it well." Tara, a Medical-Surgical RN, recalled that, "There were days I should not have come to work because I was feeling so lousy, but I didn't want to waste my sick time." Siobain, an ICU RN, admitted, "Like, what's the point going out early and sitting home without a baby? I'd rather tough it out and go out at least when I know I'm going to be at home with my baby." Some of the nurses admitted that they were "burdening the people I worked with" as their abilities to "do what was expected of me got less and less." The majority of the nurses admitted there were multiple instances where they felt they should not have been at work but went to work anyway in order to lengthen their maternity leave.

Transitioning Labor: "*Learning to just do it*"

All of the nurses admitted that their 12-hour work shifts are "a long day," "grueling," "exhausting," and "the hardest work." The physical discomforts experienced, especially fatigue,

body aches, back pain, and leg swelling, were aggravated by the long work day. Most reported

that "right around lunch" or "at the six hour mark" their physical discomforts were most

noticeable and a time when strategies needed to be implemented to complete the remaining hours

of the work day. Physical symptoms were ignored. The nurses admitted to "working even though

my body was telling me otherwise" and "doing what I had to just to get it done." Physical

exertion past pain or discomforts became routine as a way for the nurses to accomplish their

patient care tasks. Renee, a Surgical ICU RN, recalled:

> Like the last three hours, like I said, I'm completely exhausted and I was like, "I can't
> take care of another patient today" and I was just wiped and tired. So I think it was like in
> those last three hours or so that I had to push through and push myself to finish because
> there was a goal for me which was the end of my shift and going home. Ignore the back
> pain, ignore the cramps, just do it. Get it done. I honestly didn't think I'd hurt myself but
> now that I look back I really could have. I ignored everything my body was probably
> telling me. I just had to get stuff done.

Transitioning Labor: A new perspective

The pregnant nurses could only accomplish the physical patient care tasks if they

mentally were in a state of mind to do so. Most recalled that "keeping positive thoughts,"

"staying focused," and "realizing just how strong I am" were the guiding affirmations that

allowed them to push past their physical limitations or discomforts and complete patient care

tasks. Kimberley, a Medical-Surgical RN, remembered:

> It's totally a mental thing…it wasn't like I was literally pushing anything, well, maybe
> Myself, but not like that cartoon where you see the little caveman pushing his boulder up
> the hill or anything like that -- it was more like mentally prepping and reassuring myself
> that I was strong, strong and capable to do whatever tasks I had and that I could tell
> myself that things were not bad even though deep down I was a little nervous that there
> would be a point where I would just have to suddenly give up and stop all my work.

Further, Kristine, another Medical-Surgical RN, recalled:

> Like I knew my mind was going to be the best asset for this, and I just had to keep telling
> myself this was unique, no shift lasts forever, take it minute by minute, hour by hour and

do what I could when I could do it. It didn't make me a bad nurse or anything, but it might have meant that I needed to be a little more creative in what I did at one time and what I put off to do later. Like who says all your dressings and baths have to be done by lunch? Some patients would be OK with having that done later and if is q. day, who cares? You know? So yeah, you just refocus your thoughts to the positive—always stay in the positive—and tell yourself you can do this, nothing is too much, and if you're desperate get help.

Regardless of any personal gains from working through the entire duration of their

pregnancies, the nurses worked "because the patients needed me," or "because I love what I do

and as a nurse I'm always there for my patients." Additionally, "it's not the patient's fault that

I'm going through this." The patients, and patient care, remained predominant. Work, and

patient care tasks, was accomplished because the nurses realized, for the patients, it had to be

done. Tina, an ICU RN, remarked:

> You just focus yourself on you and the minute you're in, you know? You don't think past yourself or what you can't do, but you sort of give yourself positive reinforcement that you can do anything and if you're sore, tired, aching, mad, whatever you just look at the patient and know what you're charged with doing. You're the nurse, the RN, and that's a special role that only certain people get entrusted to have. I saw that. I knew what my work was and no matter how bad I may have been feeling or how ticked off I was, that patient was in a worse scenario than I was. They needed me and I was going to do what I could for them regardless.

Eileen, a Progressive Care Unit RN, summarized:

> Being pregnant was like a new challenge for me and looking back it was a good challenge but I couldn't have done it alone and I had to realize that there are times when help is OK to get and OK to ask for, but I didn't learn that lesson until later on. The physical challenge was new for me and like I said, you just push past whatever you're feeling and push through the negative thoughts and just get the job done. You do what you can do and do the best you can do and when you have to, you get help to keep doing the right thing for your patients. And their families…and each other. At the end of the day you have to go home and be proud because you're a nurse. You did it. That's all that really matters.

Summary

The findings of this grounded theory study indicate that pregnant nurses become someone different and progress through stages as they manage full-time employment and first time pregnancy. Through an exploration of the nurses' interactions within the social environment of the workplace, it was found that pregnant nurses, in the early stage of being pregnant and employed full-time, have expectations of their work environment and of themselves. Through their social interactions with peers, coworkers, and patients in the workplace, they make assumptions about what others think of them and act according to those assumptions. The nurses, then, change, and others change towards them. While looking different and feeling different, the nurses perceive being judged by their peers and coworkers based upon their pregnancies and not on their abilities as nurses. In the later stage, the reality of new physical and professional challenges in the work environment becomes apparent and leads pregnant nurses to act by developing new relationships, alliances, and connections with peers, coworkers and patients. Regardless of challenges or relationships in the workplace, in this last stage the nurses remain focused on staying at work as long as possible in order to lengthen their maternity leaves; and they employ new ways of thinking and reacting in order to accomplish work or patient care tasks. *Becoming someone different,* then, represents the basic social process of how registered professional nurses integrate full-time employment and pregnancy.

Chapter 5: Discussion, Implications for Nursing, & Future Research

Women are employed in various roles within the acute care hospital setting. Combining pregnancy with full time employment is a potential reality, then, for any woman currently working in acute care hospitals in the New York tri-state area. The findings of this study, then, are transferable to other occupational groups employed in a similar context as the registered professional nurse participants in this study. This emergent grounded theory study revealed that, for nurses who maintained full-time employment and a 12-hour work shift while pregnant with their first babies, becoming someone different was the basic social process that emerged. This emergent grounded theory study revealed that, for *nurses* who maintained full-time employment and a 12-hour work shift while pregnant with their first babies, *becoming someone different* was the basic social process that emerged. Themes that support the basic social process, and the stages the participant nurses progressed through, surrounded the nurses *becoming someone different*. The purpose of this chapter is to return to the literature to support the findings of this grounded theory study. First, the sociologic perspective and nursing framework that support this emergent grounded theory are identified. Following is an exploration of how the nurses in this study described their experiences working while pregnant, and of the workplace environment, in stages: the early stage and a later stage. Within the early stage, *looking different, feeling different* and *expectations when expecting* emerged that are supported by the extant literature related to body image in pregnancy and workplace hostility. The later stage was the most dominant and dramatic stage recalled by the nurses in this study, and where the themes of *connecting differently* and *transitioning labor* emerged, which were supported by the extant literature related to workplace support, liminality, and presenteeism. The literature, and the findings of this study, then, form a foundation for future nursing research and suggest implications for nursing leaders.

Symbolic Interactionism

The interactivist perspective, with roots in Darwinism and pragmatism, assumes that 1) any knowledge is evolutionary; 2) interactions with the environment are important for understanding one's potential; and 3) "truth" is socially constructed (Oliver, 2012). The main premise, then, of the interactivist perspective is that humans simultaneously create their environment and are shaped by it (Ritzer, 2000). The works of Cooley (1922) and Mead (1934) embody these assumptions.

Both Cooley and Mead sought to understand the relationship between social actors and the role that the social interactions played in forming the individual and his or her environment. The actions of individuals are transformed into meaningful acts under the influence of their social environment. Described as the "looking-glass self" by Cooley (1922), this transformation is only due to a person's ability to observe others and imagine their perspective. For example, with the category *looking different, feeling different*, Eileen, a progressive care unit nurse, changed the way she described herself physically. She began using the same language and terminology that her peers and coworkers used to describe her and referred to herself as "big" or "huge." The process of transformation, then, involves 1) the ability to imagine ourselves as we are seen by others; 2) imagining the judgment of this appearance; and 3) reflecting back on the meaning of this judgment for ourselves (Cooley, 1922).

Individuals develop a sense of self by interpreting the expectations of others regarding behavior that would be appropriate to a particular situation. The development of self, then, is the ability to perceive oneself as an object which, in turn, can only be developed through communication. For example, the category of *expectations when expecting* emerged and Renee,

a Surgical ICU nurse, described her past experiences working with a pregnant coworker. Renee observed how her peer was treated by the other nurses on the floor and, through her own interpretation of those behaviors, developed a set of expectations about how pregnant nurses were expected to act in the workplace. When Renee herself became pregnant, she went into the workplace knowing that certain behaviors and attitudes were expected of her. Renee, in turn, developed expectations of herself working while pregnant and of her peers and coworkers also.

Symbolic interactionism pictures individuals who are meaningful, and responsive, to their social world. Individuals can only develop, physically and mentally, through interactions with their social world. Symbolic interactionism, then, is a perspective used in this research to explain what goes on between pregnant nurses in the social environment of the workplace that translates into the meaning of those experiences (Schwandt, 1994).

This research relied heavily on the interpretive tradition. Generation of meaning which nurses attached to their pregnancies, their interpretive process of full-time employment, and the contextualization of these experiences in the social reality of the workplace which was, simultaneously, constructed and reconstructed by the nurses, combine to make the interpretivist perspective essential for this analysis (Jeon, 2004). Going to work, becoming visibly pregnant to their peers, coworkers, and patients, and participating in encounters with them, the nurses reflected on what others thought about their pregnancies, their bodies, and their abilities as nurses. These interpretations were reflected in their personal views of their experience of a first-time pregnancy and full-time employment and the meaning the nurses attached to that experience.

Focusing on the nurses' actions in response to interpretations they gave to being pregnant while maintaining full-time employment, this study emphasized the stages of the process *becoming someone different* within the social environment of the hospital workplace. The stages described by the nurses in this study as the "early" and the "later" stage of pregnancy provide a unique interpretation to describe how a pregnant nurse changes over time through the course of her pregnancy.

Stages of Pregnancy

Pregnancy can be viewed from different perspectives, or stages. The extant literature informs of two perspectives: the societal perspective where pregnancy is viewed as a temporary condition that changes a woman's status from a woman without a child to "Mother" (van Gennep, 1960), and the physiologic perspective, based upon specific gestational points such as trimesters (e.g., first trimester, second trimester), weeks of gestation (e.g., 26 "week'er", 32 weeks pregnant), or number of months pregnant (e.g., 6 months pregnant) (Cote-Arsenault, et al, 2009). The nurses participating in this study, however, described their pregnancies from a new perspective: the "early" stage and a "later" stage.

Based upon the findings of this study, the nurses described the early stage, which included the categories of looking different, feeling different and expectations when expecting. In this early stage, the pregnant nurse progressed through the physical changes of pregnancy and experiencing the physical symptoms of pregnancy, such as morning sickness and fatigue, to the realization that expectations from her peers and coworkers exist about her. It is also in this early stage that the pregnant nurses developed and interpreted expectations for their own behavior, and expectations of the behaviors of her peers and coworkers. The later stage was where the most

dramatic physical, professional, and emotional events occurred and, as the most recently experienced, were therefore the most easily recalled, or most talked-about, events of the pregnancy. For the purpose of clarity, a line is drawn between the early stage and the later stage of pregnancy as described by the nurses. Events during both stages, such as body changes or physical symptoms, occurred during both stages. The vividness of those experiences, however, and the meaning of those experiences, is demarcated into one of two stages. This section will explore the emergent grounded theory of *becoming someone different* by exploring how the nurses in this study changed and progressed through the early and later stages of pregnancy they described. First, the "early" stage of pregnancy, and its supporting literature, where the core category *looking different, feeling different* and the introduction of *expectations while expecting* emerged will be explored. Next, the later stage of pregnancy and its supporting literature are explored, where the subsequent core categories surrounding *becoming someone different* such as *connecting differently* and *transitioning labor*, are discussed.

The Early Stage: *Looking Different, Feeling Different*

Body Image

The nurses that participated in this study heard commentary and interpreted meaning about their body sizes and shapes related to their pregnancies. Rogers' Science of Unitary Human Beings (1970;1992) informs from the nursing science perspective that the human energy field is unique and has pattern. Pregnant nurses, then*, looking different, feeling different*, have a unique human energy field pattern that changes as their bodies morph through the stages of pregnancy. The human energy pattern has helicy; it is unpredictable, innovative, and becomes increasing diverse as it changes (Rogers, 1992). The human-energy field has integrality, or a

mutual process with the environment. (Rogers, 1992). Pregnant nurses, then, are human energy fields that are interacting with, and are influenced by, their social environment of the workplace. Those interactions were therefore interpreted by the nurses and meaning was found. With open energy fields, meaning could be changed or modified with new interactions. For example, Eileen, a progressive care unit RN, described the changes in her physical body due to pregnancy by comparing her body to those of her non-pregnant peers and coworkers in her work environment. She recalled how her pre-pregnant body was in "good shape," "thin", and "physically fit" but, comparing herself to her non-pregnant coworkers, she saw herself as "huge," "big," or "fat." Coupled with those in her social work environment calling her "the Pregnant One," or the one on the nursing unit "carrying a baby" and changing daily, Eileen assumed a new identity, and a changing human energy field pattern, as a pregnant nurse, a pregnant woman, and mother-to-be on the nursing unit. While pleased with what this new identity represented, being pregnant set Eileen, and the other nurses in this study, apart from their peers and coworkers and changing the human-environment interactions that occurred.

Current psychology literature informs that pregnant women are satisfied with their changing body shapes. Women accept that weight gain and body changes will occur during pregnancy (Duncombe, Wertheim, Skouteris,Paxton & Kelly, 2008). The increasing abdominal girth and the subsequent weight gain associated with pregnancy are seen as signs of a healthy pregnancy and a healthy baby (Clark, Skouteris, Wertheim, Paxton & Milgrom, 2009). However, when the social arena is considered, women's perceptions of their pregnant bodies change.

People in a pregnant woman's social environment, being part of the human-environment energy field, have a significant impact on how the nurses in this study viewed, perceived, and interpreted their bodies while pregnant. Society overall holds an ideal of the feminine body as

thin, physically toned and "in shape" (Harper & Rail, 2012). The implication, then, is that the pregnant body cannot be attractive and that weight gain, or being fat, takes the woman further away from the ideal of attractiveness (Johnson, 2010). Commentary about being "huge," or "getting bigger," become commonplace for women and soon they begin to describe themselves using the same language (Clark, Skouteris, Wertheim, Paxton & Milgrom, 2009; Johnson, 2010).

Women, overall, were found to derive inherent satisfaction with pregnancy and changes in their body enabling them to effectively navigate social pressures to maintain a specific body image (Loth, Bauer, Wall, Berg & Neumark-Sztainer, 2011). For example, Kelly, a medical ICU RN, described how she viewed her pregnant abdomen as an "obstacle," a "barrier," and "something that got in the way" because it impeded her abilities to deliver patient care and was "so noticeable" to the patient when she walked into a room. There was "no way to hide it." Similarly, Tara, a medical-surgical RN, described her physical appearance related to the size of her pregnant abdomen that "got bigger and bigger every day." As she began having small workplace mishaps, e.g., her pregnant abdomen knocked into carts or frequently bumped into things, she began to describe herself as she perceived others in the workplace were regarding her: "clumsy" and "awkward." In the workplace, therefore, being visibly pregnant, took on a different meaning.

The pregnant body in the workplace, including in the acute care hospital environment during the early stage of pregnancy, is seen as ineffective, cumbersome, prone to injury, and disruptive (Gattrell, 2011c). The pregnant worker herself, like the participant nurses in this study, fears embarrassing situations such as physical instability, uncontrollable responses like sudden nausea, vomiting or crying, forgetfulness, or leaking (Gattrell, 2011b; 2011c). For example, Lettie, a medical-surgical RN, was fearful that the aromas and sights in the hospital would bring

on sudden nausea and that she would suddenly have to vomit. She feared the embarrassment that would follow if she vomited in front of her patients or her coworkers so she took precautions and extra steps, such as carrying plastic bags or staying as close as she could to the patient's bathroom.

Coworkers of pregnant women assume that pregnancy causes them to be physically and emotionally challenged and, in turn, interpret that to mean decreased attention span, productivity, and commitment to the organization or employer overall (Gattrell, 2011d). For example, Denise, a coronary care unit RN, admitted that she was more emotional during her pregnancy and prone to prolonged episodes of crying and tearfulness. She felt embarrassed that she seemed to be able to "cry on demand" but was worried more that her peers and coworkers would think less of her, that she was "too emotional" and therefore unable to carry out her assigned tasks. As the participant nurses navigate *looking different, feeling different*, their pregnancies became more visible to those in their social work environment. The nurses in this study make assumptions about what their peers and coworkers think about them, and began to interpret the meaning behind the actions of their peers and coworkers. The participant nurses developed expectations of their peers and coworkers and assumed that their peers and coworkers had expectations of them. It is within those expectations, while expecting in this early stage of pregnancy, that the participant nurses experience negative stereotypes and workplace hostility.

The Early Stage: Expectations when Expecting

Workplace Hostility

The organizational and managerial literature informs that workplace hostility is a possibility for pregnant women in the workplace (Bragger et al., 2002; M. Fried, 2000; Guetal et

al., 1995; Guetal & Taylor, 1991; Halpert & Burg, 1997; Halpert et al., 1993; Hebl et al., 2007; Major, 2004; Pattison et al., 1997). Rogers' Science of Unitary Human Beings illustrated that the human energy field, interacting and changing with the environment, exchanges energy and creates a human-environment field pattern (Rogers, 1992). The people on the work environment, then, responded and reacted toward the pregnant nurses, which could take the form, or pattern, of favorable and unfavorable actions, remarks, or comments.

This study revealed that workplace hostility was indeed a reality during the early stage of pregnancy for first-time pregnant nurses employed in acute care hospitals in the New York tri-state areas. The majority of participant nurses in this study reported unfavorable actions ranging from derogatory comments about their body shape and work abilities to overt gestures such as hiding needed snacks, not providing breaks, or not providing assistance with work tasks. Negative stereotypes of the pregnant nurses, e.g., lazy, ineffective, and burdening their coworkers, were pervasive. For example, Alexandra, a stepdown unit RN, remembered how one of her peers and coworkers called her "useless" and vividly recalled a time at work when someone said "I can't wait till you go out because you're making our lives miserable." Roxanne, a stepdown unit RN, told how the charge nurse on her unit purposely assigned her patients on isolation. When Roxanne tried to have her assignment changed to prevent exposure to any potentially communicable diseases, she and the charge nurse got into an argument. The charge nurse thought Roxanne was refusing an assignment and threatened to call the nursing supervisor to report her behavior. Tara, a medical-surgical RN, recalled a situation similar to Roxanne's where she was assigned a patient with shingles and neither the charge nurse nor her peers would switch her assignment. Tara feared telling her supervisor "would make them hate me even more." Based on the actions of their peers and coworkers, and the pregnant nurses perceiving

negative opinions of them by those in the social work environment, the nurses in this study were determined to be seen as "good nurses," often pushing themselves to accomplish work tasks in the same manner and speed as before they were pregnant.

Hostility in the workplace has been explored in the literature. Extant organizational and human resource literature identified that pregnant women are targets of unfavorable workplace experiences and judgments, social rejection, and hostility from coworkers (Hebl, King, Gluck, Kazama & Singletary, 2007; King & Botsford, 2009; Masser, Grass & Nesic, 2007). Stereotypes toward women are enhanced when they outwardly embody femininity in a pregnant state and therefore increase the perception among coworkers that being pregnant does not fit with the demands of most jobs (Hebl, et al, 2007). Further, as pregnancy progresses, the pregnant worker begins to be seen more as a mother focused on impending commitments to her home and family and a waning commitment to the workplace (King, 2008). For example, Kelly, a medical ICU RN, described how the nurses in her critical care unit threw out her water bottles, discarded her snacks and food, and refused to help her because she felt they were angry with her for being pregnant and that her maternity leave would "leave them working short." Resentment, distrust, and frustration among her coworkers, then, follow.

Physical aggression toward pregnant coworkers is rare in the workplace. Separation, silence, segregation and avoidance, however, were reported by pregnant female workers as subtle forms of hostility that contributed to unfavorable workplace experiences (Guetal & Taylor, 1991; Hebl, et al, 2007). For example, Linda, a medical-surgical RN, had minimal interactions or social conversations with her peers and coworkers. She interpreted their silence to be "hatred" and "intolerance" of her condition.

The nurses in this study identified early who their allies and support people would be. As they are *looking different, feeling different*, they acknowledge their *expectations when expecting* and begin to find sources of support within the workplace. Social support, then, could come from numerous sources; during the later stage of pregnancy, the nurses in this study began connecting differently and found workplace support from peers, coworkers, and their patients. Social support and unity, then, were reported to add to favorable workplace experiences.

The Later Stage: *Connecting Differently*

Workplace Support

The nurses in this study reported myriad actions and gestures of support from peers and coworkers in the workplace environment. Actions included performing patient care tasks for the pregnant nurse, e.g., Ella, a progressive care unit RN, recalled how her coworkers went and repositioned her patients without her having to ask them to do so; and Linda, a medical-surgical RN, recalled how her fellow staff would push beds and stretchers for her. Additionally, Kimberley, another medical-surgical RN, remembered how her charge nurses would change the patient care assignments to accommodate Kimberley's needs. Other gestures included Ella describing the baby shower her coworkers held on the unit for her, and Kristine recalling how the other nurses on the unit would inquire daily about how she was feeling or offered advice and reassurances to her throughout her pregnancy. When these were provided, the nurses felt a sense of camaraderie, belonging, and closeness with their peers and coworkers. These feelings, in turn, were often predictive of the nurses' intention to return to their units and assigned shifts when maternity leaves ended. For example, Tina, an ICU RN, described how she was enjoying her maternity leave and the time with her baby but that she missed the people she worked with and

was "really looking forward to going back." Through sharing their experiences of pregnancy with peers and coworkers, the nurses perceived support and acceptance of their impending transition to a new role, motherhood.

Turner (1977, 1987) described a shared experience by a group of persons in similar transitional situations known as *communitas*. Support for people in transitional state such as pregnancy is obtained through communitas. For pregnant women, that support comes in the form of guidance, information-sharing, or advice-giving from other women who had lived through a similar experience or from women who have an understanding of what that experience could be like (Cote-Arsenault, Brody, & Dombeck, 2009). Through communitas, pregnant women receive necessary social support to prepare them for motherhood.

Social support, particularly in the workplace, plays an important role in the psychological and physical well-being of pregnant women (Gurung, Dunkel-Shetter, Collins, Rini & Hobel, 2005). Supportive relationships, and social interactions with peers, coworkers, and their patients in the workplace, as perceived by the nurses in this study, are beneficial because they are believed to not only provide camaraderie, friendship, and information, but also assist with physical work tasks and a communal understanding and acknowledgment of workplace stressors (Aldarice & Lynn, 2009; Yali & Lobel, 2002). In addition to validating stressors and challenges in the workplace, social support from peers and coworkers, and the communitas established within the nursing unit, assisted the nurses in this study to navigate the inherent changes and transitions during nine months of pregnancy. For example, Mary, a Surgical ICU RN, recalled how her patients were happy and excited to see her each day and that they would offer her advice and suggestions about how to be a good parent. Kimberley, a medical-surgical RN, recalled how her coworkers "looked out for her" and made sure she took breaks, got rest, and assisted her with

her patient care tasks such as lifting or repositioning patients. Kristine, a medical-surgical RN, recalled how her nurse manager created a flexible schedule for her and allowed her to work different hours while she was pregnant. Mindy, a Medical ICU RN, recalled how some of the older women she took care of would be "amazed" that she was working toward the end of her pregnancy and comment that she must be a "strong" and "energetic" woman. It is during the later stage, then, that the nurses begin *transitioning labor* and shift their focus to their impending delivery and their eventual maternity leave.

The Later Stage: Transitioning Labor

Liminality

The findings of this study provide a new perspective on the transitional period of pregnancy for nurses as they progressed through stages to becoming someone different. Becoming someone different enhances the understanding of what occurs during this transition period and of the interactions that occur in both an early and a later stage. Pregnancy is a defined period of time from conception through the birth of a baby (Cunningham, Leveno, Bloom, Hauth, Rouse, & Spong, 2009). Pregnancy, however, can be viewed from different perspectives. From the societal perspective, pregnancy is a temporary condition that changes a woman's status from a woman without a child to "Mother" (van Gennep, 1960). Pregnancy, then, is a transitional period divided into months or sections deemed significant by society (van Gennep, 1960). In contrast, the physiologic perspective describes pregnancy through specific gestational points: trimesters, weeks of gestation, or months (Cote-Arsenault, et al, 2009). Inherent in both perspectives, however, is an aspect of a transitional phase between a beginning and an end point. This transitional phase, then, is referred to as *liminality*.

Turner (1967, 1987) viewed liminality as the state between two varying points in a social structure. This period is often accompanied by societally reinforced rituals and rites of passage (Turner, 1967, 1987). Further, it is a period of becoming, or transition that has fear and uncertainty contained within it. Liminality, then, explains the data from this study because pregnancy is indeed a time of transition. The nurses in this study were in a liminal state through their entire pregnancies. Rogers' Science of Unitary Human Beings (1992) describes the human energy field as pandimensional. With the human energy field being pandimensional, one is therefore aware of one's personal wholeness as a human being and looks to integrate the past, present, and future (Ring, 2009). For the nurses in this study, as unitary human beings with a human energy field, with an ability therefore to conceive the reality of time and space, liminality, was two-fold: a period of transition from being women without children (past) to mothers (future), and a time of *transitioning labor* from being an employee who was pregnant and working (present) to an employee who would leave her peers and coworkers when she began her maternity leave (future). It is during this liminal period, then, that the nurses in this study truly *become someone different* and where they progress through the stages, early and later, of pregnancy.

In this liminal phase, the nurses in this study changed how they viewed themselves and how they believed others saw them. Being treated differently, such as having peers or coworkers perform tasks for them or do things for them without being asked, was a reminder to them of their new social status as *pregnant* nurses in the workplace. As they became more visibly pregnant, or *looking different, feeling different*, the pregnancy itself became the identifier of who they were in their social environment of the workplace (e.g. the "Pregnant One") and where *expectations while expecting* develop (Ladge, Clair & Greenberg, 2012). Their progress through

the stages while *connecting differently* was hallmarked by the scheduled and unscheduled rituals that occurred on the nursing unit: being seen and identified as being pregnant, having the on-unit baby shower, changing work assignments, celebrating the "last day" at work, the official "start day" of maternity leave, and being visited by coworkers immediately after delivery. The nurses, *transitioning labor*, recognized changes in both their inner selves and their social selves and accepted that there was no going back to the state they were in previously. Delivery was inevitable and becoming mothers was approaching. Communitas, then, played a key role during this liminal phase for the nurses to accept the reality of becoming mothers and support during this transitional period. The end point of this period for the nurses in this study was delivery of their baby.

Similar to labor, transition is the most dramatic and powerful period of the labor process. A physical transition occurs within this liminal period as well. The nurses in this study experienced dramatic physical changes to their bodies and accompanying physical symptoms or discomforts. Especially in this later stage, at the end of pregnancy, the nurses were *transitioning labor*; they were out of energy, and while it was becoming harder to physically come to work each day, they had a job to do and duties to perform. The feelings, memories, and emotions were most intense during this later stage, and the participant nurses "push through" the physical discomfort and remain active and working as long as possible. Maternity leave awaited them, but it was not the end point of this transitional period. Maternity leave commencing, then, was a ritual within this liminal phase. For example, Kimberley, a medical-surgical RN, recalled how she would mentally prepare and reassure herself that she was "strong," "capable," and could "do what needed to be done" as she neared the end of her pregnancy where work tasks became harder to complete. Kristine, also a medical-surgical RN, recognized during the later stage of

pregnancy that she was becoming fatigued more frequently during the middle of her 12-hour night shift. She would "push through" and keep herself focused on getting her work done and not thinking about the number of hours between the middle of her night shift and the end of her shift at 7 a.m. Tina, an ICU RN, would focus her attention on her patients and the care they needed to take her mind off how she was feeling or how long she felt her shift was. Similarly, Eileen, a progressive care unit RN, purposely pushed past her negative thoughts and feelings and tried to stay focused on each hour of her shift and not let her thoughts creep toward thinking of the impending birth of her baby. Making it to the end, however, posed unique challenges, especially ones related to work and the workplace.

Presenteeism

A unique finding of this study was that the nurses, despite acknowledging a decrease in their work performance and a desire to not go to work, while *transitioning labor* refused to use sick time or other benefit time. The nurses in this study reported multiple physical discomforts and symptoms. Whether experienced alone or in combination, the symptoms, such as fatigue, nausea, or back pain, caused physical distress for the nurses and impeded their abilities to independently carry out specific job tasks. Using sick time would cut into their allotted maternity leaves and was, therefore, not an option. For example, Siobain, an ICU RN, admitted that she saw no point in going out early on maternity to "be home without a baby." Instead, she opted to bank her benefit time to "stay out as long as I can when the baby comes." Eileen, a progressive care unit RN, admitted there were times she forced herself to come to work because she "felt bad leaving the floor short [staffed]." The nurses reported that they forced themselves to go to work and perform as best they could in order to prolong the amount of time available for maternity

leave. For example, Tara, a medical-surgical RN, recalled times when she knew she was feeling ill but came in to work anyway to not "waste" her sick time.

Organizational, medical, and nursing literature have explored the idea of *presenteeism.* The opposite of absenteeism, presenteeism is purposely going to work, or remaining in the workplace, when employees are ill or know that they are not functioning up to the full expectations required of their role or by their employer (Landy & Miller, 2010; Middaugh, 2006; Pillette, 2005). Specific to nursing, presenteeism is a threat to quality and safe patient care and also contributes to costly productivity loss (Pillette, 2005). With pregnancy, the need to remain actively working for financial reasons is often overshadowed by the need to remain at work so peers and coworkers see the pregnant worker as healthy and reliable (Gattrell, 2011b). Feeling under pressure to downplay their impending maternity and not disrupt unit routines, nurses often feel guilty if they call in sick and leave their units short-staffed, causing peers and coworkers to have to work harder (Middaugh, 2006). Being seen as a member of the team and contributing whatever they can to the work environment, then, outweighed any personal distress or discomfort related to physical symptoms for the nurses in this study.

Implications for nursing

The intent of this study was to explore the experiences of pregnant nurses in the workplace and inform nursing leaders about those experiences. As a nurse midwife, the researcher subscribed to the slogan of the American College of Nurse Midwives: "Listen to Women"; the researcher, however, by undertaking this study, realized that interviewing women, including nurses, required more than merely "listening" to women, but rather required he "hear" the message, or meaning, contained in what they were saying. This study revealed that there

were implications for nursing leaders based upon the experiences, and the meanings of those experiences, of registered professional nurses from three distinct specialty areas within acute care hospitals: medical-surgical, critical care, and progressive care. The findings of this study, then, suggest actions on the micro, or unit, level by nurse managers, and on the macro, or organizational, level by nurse administrators.

From this study, it was demonstrated that the words and actions of peers and coworkers have an impact on the pregnant nurse and are determined by the culture of the nursing unit. That tone of that culture, according to the nurses, was set and defined by the nurse manager of the unit. It becomes imperative, then, for nurse managers to assess and evaluate the existing culture of their nursing units. Specific suggestions include observing how pregnant nurses are treated by their peers and coworkers on the nursing unit, regularly checking in with pregnant staff, and being vigilant regarding gossip or sidebar conversations among staff about their pregnant coworkers. Monitoring work flow and work processes with pregnant staff is essential to validate that required tasks are performed and that the patients and the pregnant nurse are safe. Innovation, flexibility, and communication by the nurse manager related to staff scheduling and assignments could enhance safety for both the pregnant nurse and her patients.

Communication with the nurse manager was identified by the participant nurses in this study as helpful toward supporting them in the workplace. Nurse managers who remain approachable and visible on the nursing unit allow pregnant nurses the opportunity to verbalize concerns about the workplace. In turn, this provides the nurse manager an opportunity to convey support or empathy for the pregnant nurse. Issues that arise, e.g., a need to change work hours or a shift, can then be communicated by the nurse manager to his or her nurse administrator.

Nurse administrators are in a key position within health care organizations to assess the culture of the workplace environment and a nursing division overall. Understanding that a significant portion of the current nursing workforce is women of childbearing age, the nurse administrator can explore the landscape for pregnant nurses within an organization. To begin that exploration, nurse administrators need a clear understanding of the Pregnancy Discrimination Act (PDA) in order to be cognizant of its nuances and able to identify potential areas of vulnerability within an organization. Further, knowledge of the Family Medical Leave Act (FMLA) and human resources policies surrounding the use of sick time and maternity leave is essential. Fiscal accountability for the nurse administrator requires innovative use of staffing resources in order to ensure adequate coverage and the delivery of safe care on nursing units when a maternity leave occurs.

Nationally, nurse leaders can use their political influence to re-evaluate existing maternity leave policies. A unique theme that was resonant with each of the participant nurses in this study was the need to remain at work despite physical or mental inability related to pregnancy. The nurses in this study, fearing a decrease in maternity leave by using sick or benefit time prior to delivery, present a glaring challenge to patient safety and the delivery of quality care. If the current policies related to maternity leave were revisited, and the amount of maternity leave available or the amount of benefits improved, safety for both the pregnant nurse and her patients could be maintained as nurses would be allowed to leave the workplace sooner and more capable staff would assume those temporarily vacant roles. Given that the nurses in this study represent various hospital employers in the New York tri-state area but with similar concerns related to maternity leave, the issue, then, can only be explored at the federal level through the collective voice of the nursing profession.

Future research

This study explored the experiences of nurses who had delivered their first babies only. Future studies could explore the experiences of nurses who maintained full-time employment with subsequent pregnancies and use data from both studies to compare consistency among themes that emerge. While not discussed explicitly by the nurses in this study, the experiences of nurses who were pregnant with multiples (e.g., twins or triplets) could provide another unique viewpoint that would be informative of social interactions among pregnant nurses in the workplace.

The nurses in this study represented only medical-surgical, critical care, and progressive care nursing specialties. Other nursing specialties exist, for example ambulatory care, psychiatry, or the operating room, which have unique workplace cultures where this study could be replicated and findings compared. Further, academic and non-academic organizations were included but each type of organization could be explored separately.

This study only explored the experiences of nurses who were pregnant and their social interactions with the work environment during that time. A useful study would be to explore the experiences of the other nurses, ancillary staff, nurse managers, or possibly physicians who worked with pregnant nurses. Exploring the actors in the social environment could confirm the assumptions made by the nurses in this study or identify other social processes not uncovered by this study for further exploration.

Table 1:

Participant Profile

Table 1 - Participant Profile

Name	Age	Education Preparation	Years of Nursing	Unit Type	Shift	Years on Current Unit	Magnet Designation
Eileen	26	BSN	4	SD	Days	4	Journey
Tina	28	BSN	6	ICU	Days	4	No
Lettie	31	BSN	8	Med-Surg	Nights	8	Yes
Denise	33	ADN	9	CCU	Nights	6	No
Mary	27	BSN	4	SICU	Nights	2	No
Kelly	25	ADN	4	MICU	Days	3	Yes
Kristine	28	ADN	6	Med-Surg	Nights	6	No
Katie	31	BSN	8	ICU	Days	5	Yes
Mindy	25	BSN	3	MICU	Nights	3	Journey
Ella	34	BSN	10	SD	Days	8	No
Kimberley	29	BSN	7	Med-Surg	Days	7	No
Renee	30	ADN	8	SICU	Days	5	Yes
Linda	33	BSN	10	Med-Surg	Nights	10	Yes
Siobain	28	BSN	4	ICU	Days	4	No
Alexandra	35	ADN	11	SD	Nights	10	Journey
Roxanne	32	BSN	8	SD	Nights	8	No
Tara	29	BSN	6	Med-Surg	Days	6	No
Gladys	28	BSN	5	PACU	Days	2	Yes
Ann	27	ADN	4	ER	Days	2	Yes
Giovanna	26	BSN	4	O.R.	Days	4	No

Notes: Magnet Status

Yes= Hospital is Magnet-designated

No= Hospital is not on a Magnet journey nor Magnet-designated

Journey= Hospital is in process of obtaining Magnet Designation

Appendix A

Recruitment Flyer

Attention R.N.'s!
Research Participants Wanted

1) Are You an RN or know a fellow RN who:

- Just delivered her first baby or is going on Maternity leave?
- Was employed Full Time while Pregnant?
- Worked on a Med-Surg, Telemetry/Stepdown or Critical Care unit?

2) Are you willing to share your story with a doctoral student about working full-time while pregnant?

- Confidential, anonymous interview
- 60-90 minutes
- $25 gift card to Babies-R-Us

If YES to all the above, Contact:

Paul Quinn

Nurseresearcher2012@gmail.com

(201) 476– 5697

CUNY UI - Institutional Review Board	
Approval Date:	March 15, 2012
Expiration Date:	March 14, 2013
Coordinator Initials:	T.M.P

Appendix B

Informed Consent

City University of New York, Graduate Center, Department of Nursing

Consent to Participate in a Research Project

Project Title: How Nurses Integrate Pregnancy and Full-Time Employment: A Grounded Theory Approach

Principal Investigator: Paul Quinn, Doctoral Student, Graduate Center, 365 Fifth Avenue– Room 3317, New York, NY 10016; (845) 480–1685

Faculty Advisor: Barbara DiCicco-Bloom, PhD, RN, Distinguished Lecturer, Lehman College, Department of Nursing, 250 Bedford Park West, Bronx, New York 10468; (212) 817-7985

Study Site: Multiple: Locations may include, but are not limited to, her home, a coffee shop, a restaurant, a park, or other public place where an interview can occur.

Introduction/Purpose: You ("the research participant") are invited to participate in a research study. The study is conducted under the direction of Paul Quinn ("the principal investigator"), doctoral student at the Graduate Center. The purpose of this research is to explore how nurses who were pregnant and delivered their first baby integrated pregnancy with full-time employment. The results of this study are intended to provide a holistic explanation of the experience of nurses who worked full-time while pregnant. The interview between you and

the principal investigator will be audio recorded so that it can be transcribed and analyzed. All identifying information will be removed from the audio recording and the transcript.

Procedures: Approximately 20 individuals are expected to participate in this study. Each will participate in a face-to-face interview with the principal investigator. The time commitment of each participant is expected to be no longer than 60 to 90 minutes. Each session will take place at location convenient to you and the principal investigator but not at your place of employment. Each interview will be audio-recorded to capture the participant's story in total for later transcription into an electronic data file.

Possible Discomforts and Risks: Your participation in this study may involve a minimal risk, including potential discomfort, stress, or anxiety of recounting your experiences of working full-time while pregnant, as well as a remote chance of a breach of confidentiality. No physical discomforts are associated with participating in this research study. To minimize the risk of breaching your confidentiality, any identifying information about the participant, including her name and place of employment, will be removed from any notes or transcripts. Pseudonyms will be randomly assigned to each participant for the purpose of discussing the data. Furthermore, the interview is being audio recorded into an electronic data file (MP3) and then transcribed into an electronic data file; as such, there will be no physical audio recording to secure. The electronic transcripts, however, will remain in a file on the principal investigator's personal computer, which is password protected. Additionally, a duplicate file will be made and secured in a locked file in the researcher's home office. If you are troubled or upset as a result of this study, you should contact Joan Caruana, MS, RN, Psychiatric Nurse Practitioner, 80 Eighth Avenue, New York, New York 10011, (212) 645–5793.

Benefits: There are no direct benefits to participating in the study. However, there is a chance that by participating in this proposed research, you will contributing to the overall body of knowledge surrounding the work environment and practice of registered professional nurses, which could benefit the profession of nursing overall.

Alternatives: You may opt to not participate in this study or to stop your participation at any time.

Voluntary Participation: Your participation in this study is *voluntary*, and you may decide not to participate without prejudice, penalty, or loss of benefits to which you are otherwise entitled. If you decide to leave the study, please contact the principal investigator, Paul Quinn, to inform him of your decision.

Financial Considerations: Participation in this study will involve no cost to you. For your participation, you will receive a $25 gift card to Buy-Buy-Baby, which will be given to you at the end of the interview session—whether at its scheduled conclusion or when you choose to end it.

Confidentiality: The data obtained from you will be accessible to (a) Paul Quinn, the principal investigator; (b) Barbara DiCicco-Bloom, PhD, a full-time faculty member from the City University of New York; and (c) Kevan Schultz, a research specialist from the University of Pittsburgh Qualitative Data Analysis Program (for transcribing the audio recordings into a transcribed data file). The researcher will protect your confidentiality by removing all identifying information, assigning a pseudonym for the purpose of discussing the data, and storing it in an encrypted file. A duplicate file will be made and secured in a locked file. Consent forms will be kept separate from the data.

Contact Questions/Persons: If you have any questions about the research now or in the future, contact the principal investigator, Paul Quinn. If you have any questions concerning your rights as a participant in this study, you may contact Tara Prairie, HRPP Administrator of the Lehman College, City University of New York, (718) 960-8717, hrpp.administrator@lehmancuny.edu.

Statement of Consent: "I have read the above description of this research and I understand it. I have been informed of the risks and benefits involved, and all my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions that I may have will also be answered by the principal investigator of the research study. I

voluntary agree to participate in this study. By signing this form I have not waived any of my legal rights to which I would otherwise be entitled. I will be given a copy of this statement."

I agree to have this interview audio-recorded. Please circle one: YES   NO

_____   _____   _____

Printed Name: Participant   **Signed Name: Participant**   **Date**

_____   _____   _____

Printed Name: Person Explaining   **Signed Name: Person Explaining**   **Date**
   Consent Form   **Consent Form**

_____   _____   _____

Printed Name: Investigator   **Signed Name: Investigator**   **Date**

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