Spring 5-12-2022

Perceptions of Perinatal Nurses Caring for Perceived Stigmatized Patients During the COVID-19 Pandemic in Perinatal Settings: A Qualitative Study

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PERCEPTIONS OF PERINATAL NURSES CARING FOR PERCEIVED STIGMATIZED PATIENTS DURING THE COVID-19 PANDEMIC IN PERINATAL SETTINGS: A QUALITATIVE STUDY

by

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A Dissertation
Submitted to the Graduate School,
the College of Nursing and Health Professions
and the School of Leadership and Advanced Nursing Practice
at The University of Southern Mississippi
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Philosophy

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May 2022

Published by the Graduate School

THE UNIVERSITY OF SOUTHERN MISSISSIPPI®

ABSTRACT

Perinatal nursing consists of caring for women before, during, and shortly after the birth experience, providing a unique opportunity for nurses to care for women and families in a fundamental moment of life (Simpson et al., 2020). This qualitative descriptive study design allows for straight descriptions of phenomena to evaluate perceptions of nurses caring for perceived stigmatized patients in the perinatal setting during the SARS-CoV-2 (COVID-19) pandemic. As research gaps were identified, the following research questions were developed and used to guide this study:

1. What are the perceptions of caring in perinatal nurses who deliver care to perceived stigmatized patients in the perinatal patient population?
2. What are the perceptions of caring in perinatal nurses as they deliver care to perinatal patients during the COVID-19 pandemic?

Swanson's theory of caring serves as the guiding conceptual framework for this study as perceptions of caring are evaluated in perinatal nurses. The purpose of this study was to extend Swanson's theory of caring and further describe how perceptions of stigma among perinatal patients alter perceptions of caring during the COVID-19 pandemic. A descriptive, qualitative design was used for this study, and 15 Zoom interviews were conducted with perinatal nurses in the Southeastern United States to provide a further description of nurses' perceptions of caring as they deliver care to perceived stigmatized patients during the COVID-19 pandemic. Purposive sampling methods were used to recruit participants. Hsieh and Shannon's (2005) directed content analysis method was used for data analysis, to enable systematic coding of interview data.

The study findings indicated alterations in the level of nurses caring for perceived stigmatized patients. Nurses described negative maintaining beliefs of perceived stigmatized patients and shared a lack of desire to be emotionally present with them. Among caring categories of desiring to know perceived stigmatized patients and do for and enable them, most nurses reported an equal or greater occurrence with perceived stigmatized patients compared to traditional ones. Nurses provided suggestions for growth in nursing education and the entire nursing culture and environment as a means of improving caring care and patient outcomes when perceived stigma exists.

ACKNOWLEDGMENTS

There are numerous to thank for the support and guidance that has led to the completion of this journey. I recognize that the closing of the book on my doctoral degree will only open doors to many other opportunities for growth and learning. I would like to thank Dr. Debra Copeland, Dr. Bonnie Harbaugh, Dr. Marti Jordan, and Dr. Lachel Story for your commitment to my research, my education, and my dissertation success. Your patience, direction, and encouragement throughout this entire process was my driving force for pressing on toward the goal that once felt so impossibly far away.

I would like to say a special thanks to Dr. Story for presenting the Ph.D. program details to me in early 2019. I never would have considered following the doctoral path without your encouragement and faith in my interests, dedication, and abilities. Dr. Copeland, I cannot thank you enough for coming alongside me as my dissertation committee chair and thoroughly answering every one of my many questions. Without our constant communication throughout this last year, I am certain that I would not have had as seamless of a dissertation and Ph.D. experience. You are gifted at research and writing, and I am beyond thankful to have worked so closely with you during this experience. I have learned more than I could have imagined on this journey, and I know this is only the beginning of many great things to come.

DEDICATION

This dissertation is dedicated to my family and friends who have patiently forgiven me for canceled plans and a limited schedule these last three years. Also, to my parents for laying the disciplined educational, financial, mental, and most of all spiritual foundation for me to reach all of my goals, including my Ph.D. Above all, this dissertation is dedicated to my loving husband, Zack Tucker. You have loved me through many rough periods, pushed me when I felt like giving up, and encouraged me to do my best, always. Without you and the Lord's enabling hand to guide me, I could not have accomplished a thing. Not only has your steady love and devotion to me supported me as a nurse over the years, but you have also empowered me to challenge myself and reach for goals beyond what I ever thought possible.

Zack Tucker, you have poured yourself out as the source for all the strength, endurance, and support that I have needed to succeed. I am able to love, serve, and take risks because I am so filled and secure in my role as your wife and life partner. Zack, thank you for upholding me throughout my Ph.D. journey and never allowing me to simmer in doubt. You are my pillar of strength, fun, and rest, and my earthly example of God's steadfastness and grace. I will spend all my days striving to love and cherish you the way you faithfully do me. I hope you can one day comprehend the magnitude of your influence on my life. The Lord has showered abundant blessings and abilities on our family, and I pray we continue to make an impact for His glory.

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CDC	Center for Disease Control
COVID-19	SARS-CoV-2; Coronavirus
IRB	Institutional Review Board
PPE	Personal Protective Equipment
PTSD	Posttraumatic Stress Disorder
STD	Sexually Transmitted Disease
UDS	Urine Drug Screen
USM	The University of Southern Mississippi

CHAPTER I - INTRODUCTION

Perinatal nurses have the unique opportunity to care for women in a pivotal moment of their lives, whether it be before, during, or shortly after their labor and delivery experience. Depending on the perinatal nurse's perceptions of the patient, their level of caring toward certain patients may be adjusted based on personal bias or differences (Link & Phelan, 2001). The past experiences of nurses may cause them to perceive a patient as possessing a stigmatizing quality, altering the level of care the nurse is willing or intending to provide. The definition of stigmatizing characteristics varies from person to person, providing evidence for the need to allow individuals to define what they perceive as stigmatizing (Hatzenbuehler & Link, 2014; Lee & Lee, 2006).

To explore and explain the dimensions of stigma and caring, the perceptions of caring in perinatal nurses who deliver care to perceived stigmatized patients during the SARS-CoV-2 or Coronavirus (COVID-19) pandemic in perinatal settings will be explored. COVID-19 is a rapidly spreading virus that transmits through airborne droplets and can cause serious respiratory compromise leading to numerous complications (Centers for Disease Control [CDC], 2021). This research is being conducted in the thick of a widespread pandemic that is pushing medical facilities and personnel beyond their limits of capacity, resources, finances, and mental stability. COVID-19 first affected United States citizens in early 2020, with a roaring wave of amplified case numbers and patient conditions worsening more rapidly in the Summer of 2021, especially in the Southeastern region of the United States due to new variants (Fry & Rapp, 2021). As the COVID-19 pandemic has made waves worldwide, it is necessary to take a closer look at how caring in perinatal settings has been affected.

This qualitative descriptive study enables a further description of how perinatal nurses provide "caring" care to their patients and how care is affected by perceptions of stigma. The conceptual framework for this study is Kristen Swanson's middle-range theory of caring which describes a caring process by which nurses care for patients to, in the end, enable patient well-being (Swanson, 1993). Swanson's theory of caring was used to support the development of interview questions.

As equal rights efforts rise, the level of caring provided to perinatal patients must be specifically evaluated for areas of inequality and opportunities for growth. The perinatal setting reveals many unique family situations, addictions, trauma, medical conditions, and other capacities that some may perceive as stigmatizing (Goldberg, 2005; Horner et al., 2019; Neary, 2018; Tzur-Peled et al., 2019). Therefore, the goal of this study was to identify circumstances in which decreased levels of caring may be present and to improve awareness among perinatal nurses to bring mindfulness of their own biases and the importance of providing caring care to all perinatal patients. In addition to personal bias, the presence of COVID-19 has added an element of interest to assess the effect of COVID-19 on the caring process. The aim of this study was twofold: 1) to explore perceptions of caring in perinatal nurses who perceive stigma among their patients, and 2) to explore perceptions of perinatal nurses who deliver care to perinatal patients during the COVID-19 pandemic.

Problem Statement

The level of caring nurses provide to patients in most health-related settings is greatly affected by the characteristics and life experiences of the patient. Nurses may have stigmatizing attitudes as they deliver care for their patients; however, nurses have a

responsibility to provide competent and compassionate care to those in need, even to the individuals whose life choices may be different than their own (Horner et al., 2019). A correlation has been made between structural stigma and poor health, revealing the strong need for nurses to overcome perceptions of stigma to view the patient as a person and provide sufficient care (Hatzenbuehler & Link, 2014). Perceived stigmatized patients in perinatal settings have voiced complaints regarding the level of care they receive in hospital settings, resulting in poorer patient outcomes and patient feelings of judgment and ridicule for their decisions (Neary, 2018).

Therapeutic nurse-to-patient relationships, with open lines of communication, have been shown to promote more positive patient outcomes (Neary, 2018). The importance of fostering sensitivity and communication training for nurses can help them become more aware of their own practices in delivering care. As a result of communication training offerings and their reflections, nurses may deliver higher levels of intentional care for patients who are stigmatized by society (Chan et al., 2005; Goldberg, 2005; Noonan et al., 2019; Tzur-Peled et al., 2019). Work experience may also play a part in perinatal nurse confidence in dealing with unique patient circumstances that may be perceived as stigmatizing (Chan et al., 2005). In addition, more work experience may heighten a nurse's perception of stigmatizing qualities among patients, as their experience with previously unique circumstances will influence their perceptions moving forward (Chan et al., 2005).

Perinatal nurses, who offer care to women and babies before or after birth, encounter women and families from a variety of cultural and socioeconomic groups who live a wide range of lifestyles (Goldberg, 2005; Goshin et al., 2020; Tzur-Peled et al.,

2019). Regardless of the patient's background, the nurse must carefully determine whether the patient is receiving the same quality of care, whether the nurse perceives a stigmatizing characteristic in the patient or not. Therefore, it is imperative that nurses provide quality, non-discriminatory care to all patients, recognizing that their perceptions may hinder the delivery of quality patient care. Perceptions of stigma may vary from nurse to nurse, depending on life and work experience (Hatzenbuehler & Link, 2014). Allowing nurses the freedom to evaluate their perceptions of stigma for themselves and identify qualities they classify as stigmatizing is essential.

As time and illnesses continue to evolve, COVID-19 has added a unique factor as nurses attempt to provide caring care in the face of barriers such as personal protective equipment (PPE), respiratory assistive equipment, and minimizing exposure with infected patients. An evaluation of the extent to which caring nursing care is affected in COVID-positive patients is increasingly necessary. As COVID-positive patients face extended needs for compassionate care in their time of total isolation, nurses could improve the memories of post-recovery trauma in patients if they provide caring care as described in Swanson's theory of caring (Swanson, 1993). While research has begun in areas of nurse self-care and nurse experiences when caring for COVID patients, little is being evaluated on caring practices for perinatal patients during COVID (Barnett et al., 2021; Naylor et al., 2021).

Purpose of the Study

The purpose of this study was to assess the perceptions of caring that perinatal nurses have about delivering care to perceived stigmatized patients during COVID in perinatal settings. This information will guide nurse leaders to address gaps more

appropriately in nursing care to ensure that nurses provide care and emotional support in a caring manner, free of stigmatized attitudes (Swanson, 1993). Ideally, nurses' delivery of care with less stigmatization and more positive attitudes will improve patient satisfaction and health-related outcomes (Chan et al., 2005; Goldberg, 2005; Goshin et al., 2020; Horner et al., 2019; Neary, 2018). To promote equal care for all patients, it is important that perinatal nurses provide care through a more caring lens, rather than a judgmental or negative lens, as medically suitable. Further, it is of utmost importance that nurses be made aware of how their personal prejudices may affect their care for others and overcome these barriers to offer a higher level of care.

Nurses may not consciously realize how their attitudes and biases toward certain types of people affect their caring, however, studies have shown that negative attitudes and biases exist among perinatal nurses (Goshin et al., 2020; Horner et al., 2019; Neary, 2018; Noonan et al., 2019). This study was designed to focus on how nurses perceive stigma characteristics in patients and how ineffective care may be provided to perinatal patients. For example, patients who do not speak the nurses' primary language are at higher risk of not receiving quality or safe care since they may be unable to understand or adequately respond to the nurse (Al Shamsi et al., 2020). Nurses must take extra time and effort with patients where a language barrier exists, to ensure they understand all their options and plans of care.

Furthermore, some perinatal nurses may have difficulty providing care to patients who are chronic substance abusers, incarcerated, suffer from mental illness, or have or report an untraditional sexual orientation (Goshin et al., 2020; Horner et al., 2019; Neary, 2018; Noonan et al., 2019; Tzur-Peled et al., 2019). Each of these qualities or

characteristics require that the nurse care for the patient tactfully and with more thorough communication than may be necessary for a traditional patient, with the goal of being attentive to the patient's specific needs (Goshin et al., 2020; Horner et al., 2019; Neary, 2018; Noonan et al., 2019; Tzur-Peled et al., 2019). While past work experience may allow some nurses to feel more confident in providing care to stigmatized patients, high rates of nurse burnout, especially in environments with a demanding patient population, are present (Chan et al., 2005; Horner et al., 2019). The goal of this study was to describe how perinatal nurse perceptions of stigmatizing characteristics affect the caring care that nurses provide to their patients.

Since the Spring of 2020, COVID-19, a rapidly spreading airborne virus, has affected the health and well-being of individuals in the United States and worldwide populations (CDC, 2021). Airborne precautions have been initiated in medical units to prevent illness from spreading, in addition to the use of PPE to keep patients and nurses safe during hospitalization. The long-term effects of the virus are only just now being understood, including the need to explore the enduring impact COVID-19 will have on the state of health care and providers. As a result of caring for patients during the pandemic, nurses are reporting signs of anxiety, depression, and posttraumatic stress disorder (PTSD) (Naylor et al., 2021). Therefore, it is important to evaluate the effect of those mental and emotional strains on the level of caring toward perinatal patients. For perinatal patients who have experienced COVID or have the fear of getting COVID, many pregnant women have reported increases in anxiety and depression since they were isolated at home and were unsure of the level of care that they would receive from their healthcare providers during pregnancy and birth (Mortazavi & Ghardashi, 2021). To meet

the needs of perinatal patients during COVID-19, it is imperative that nurses provide thorough patient education, effective nurse-to-patient communication, emotional support, and caring care to patients during this time. The question remains, do perinatal nurses perceive the presence of COVID as an indicator for providing more caring care, and are they taking measures to meet those needs?

Conceptual Framework

Kristen Swanson's theory of caring provides nurses the ability to practice informed caring to promote the well-being of all patients. Swanson's theory has brought a great deal of clarity and proficiency to the skill of nurses to apply intentional caring measures in clinical settings. Swanson outlines the caring processes used by nurses that enable an optimal level of care and emotional support for patients (Swanson, 1993). This middle-range theory of caring offers a structure of caring, as seen in Figure 1, as it is linked to nurses' philosophical attitude (maintaining belief), informed understanding (knowing), the message conveyed (being with), therapeutic actions (doing for and enabling), and intended outcomes (patient well-being) and guides nurses on how to care for their patients (Swanson, 1993).

A nurse's philosophical attitude is established in a maintaining belief that a patient will overcome their health events and face a meaningful future. An example, a perinatal nurse's philosophical attitude is present as a nurse cares for a couple laboring with a stillborn baby (Swanson, 1993). To provide care in a meaningful manner, the nurse would instill physical and emotional support to see them through the birth experience and invest in their overall grief and healing process. Informed understanding, or knowing, is where the nurse realistically evaluates all aspects of the patient's condition

and engages with the patient to establish their therapeutic caring relationship, which will enable the progression of the caring process (Swanson, 1993). The nurse then verbally and physically conveys the message of fully being with the patient to remain emotionally invested and present with the patient. Next, the nurse will provide therapeutic actions of doing for the patient, as they would if they had the ability, and enable the patient to practice self-care (Swanson, 1993). The intended outcome of this process is positive patient well-being.

In continuing the example of the mother laboring with her stillborn baby, the nurse evaluates the situation, knowing, and shows the patient by words and actions that he or she is being with them through their labor. To confirm this claim, the nurse will do for the grieving patient to provide physical and emotional care by treating them as they would normally treat themselves if able. By enabling the patient through the acute phase of labor and delivery, the nurse will strengthen the patient to begin providing appropriate self-care and progress toward healing from their loss. The theory of caring defines nurse caring and identifies methods of caring toward perinatal patients (Swanson, 1993). Swanson provides a standard by which to compare nursing attitudes to caring for perceived stigmatized perinatal patients.

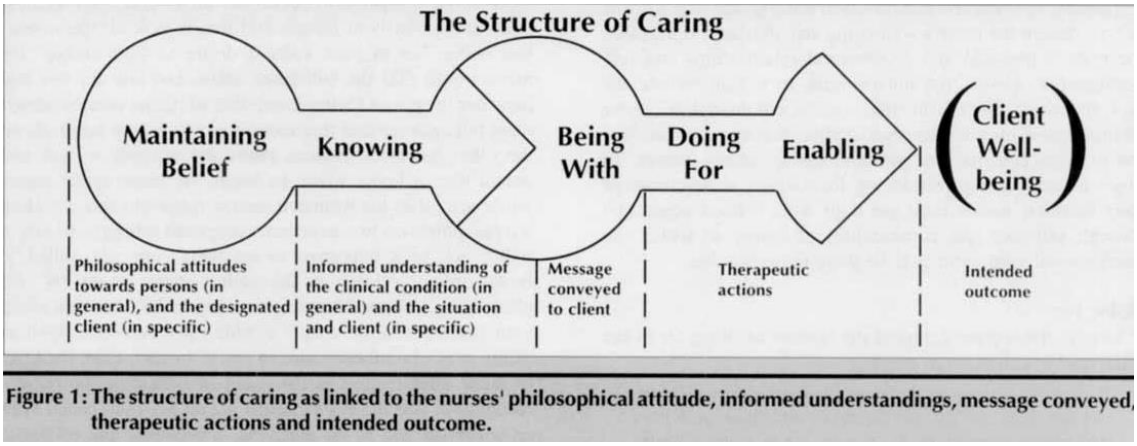

Figure 1. The Structure of Caring.

(Swanson, 1993).

Research Questions

The two central research questions for this qualitative descriptive study include:

a) What are the perceptions of caring in perinatal nurses who deliver care to perceived stigmatized patients in the perinatal patient population?

b) What are the perceptions of caring in perinatal nurses as they deliver care to perinatal patients during the COVID-19 pandemic?

Operational Definitions

For the purpose of this study, the following terms are operationally defined.

Perinatal Nurse

Perinatal nurses are specifically trained and responsible for caring for women and unborn babies who are in the period of time surrounding childbirth (Simpson et al., 2020). This period includes the prenatal or antepartum, labor and delivery, and postpartum periods.

COVID-19 Pandemic

COVID-19 is a serious virus that rapidly spreads through airborne droplets and can cause serious respiratory compromise leading to pneumonia and other complications (CDC, 2021). A pandemic is defined as a widespread occurrence that significantly affects a large portion of the worldwide population (Merriam-Webster, n.d-c). First occurring in China in late 2019, COVID-19 began to rapidly spread throughout the entire world by the middle of 2020. Due to the nature of COVID-19, not only have medical personnel had to take extra precautions to prevent transmission, but the public has gone through periods of social distancing, mask-wearing, and times of quarantine in an attempt to reduce the spread of the virus. COVID-19 has brought about many societal, physical, and mental health changes throughout the entire world.

Caring

Caring is defined as a feeling or display of concern for or showing kindness to others (Merriam-Webster, n.d-b). Caring can be exhibited in numerous ways and on a variety of different levels. Swanson's theory of caring defines caring as a nurturing personal sense of responsibility or commitment to a valued individual, for their ultimate well-being (Swanson, 1991).

Attitudes

Attitudes are defined as a mental position, feeling, or emotion with regard to a fact or state and are often formed by ideas of what is normal in the mind of an individual and what is contrary to the norm (Cherry, 2021; Merriam-Webster, n.d-a). Individuals take a mental position about their surroundings based on previous experience, bias, and even external influences.

Stigma

Stigma can be defined as a characteristic or mark of discredit or shame (Merriam-Webster, n.d-d). These characteristics are often determined by moral and cultural standards among different groups (Hatzenbuehler & Link, 2014; Pescosolido & Martin, 2015).

Assumptions

Assumptions in research consist of aspects of the study that are accepted as plausible or true (Simon, & Goes, 2013). These assumptions are listed for transparency and clarity of the study. The assumptions in this study include:

1) Perinatal nurses may perceive stigma in and make judgments about perinatal patients.
2) Perinatal nurses are likely exhibiting a differing level of caring for patients who possess marks of stigma or shame compared to patients who are perceived to be traditionally pure.
3) Nursing during the COVID-19 pandemic requires extra care as nurses sometimes function under airborne precautions in the hospital setting.
4) Perinatal COVID patients are often isolated, requiring a deeper level of emotional support than perinatal patients surrounded by family.
5) Perinatal nurses perceive some level of stigma that affects their level and ability to provide caring care to patients during the COVID-19 pandemic.
6) Nursing care has changed and faces new challenges due to PPE, adjusted visitor policies, higher acuity nursing care, and the emotional toll of

preventing transmission of disease from the patient to other high-risk individuals, like newborns.

7) People are shaped and influenced by the environment in which they exist and their previous life experiences (Swanson, 1993).

Scope

This research study took place in the Southeastern region of the United States, as perinatal nurse interviews were conducted and recorded over secured online video chat. Perinatal nurses were recruited by means of snowballing techniques, perinatal nurse Facebook groups, and local hospital administrators for distribution to perinatal nurses. Perinatal nurses were consented online, completed a demographic survey, and were contacted for an interview. Only perinatal nurses working in the Southeastern United States, in areas of prenatal care, labor and delivery, and postpartum were included in this study. Fifteen perinatal nurse virtual interviews were conducted due to saturation of responses. Interview questions were directly based on Swanson's theory of caring to optimally apply the theory to perceptions of caring for perceived stigmatized perinatal patients during the COVID-19 pandemic.

Delimitations

Delimitations are the boundaries of the study set by the researcher in order to create clarity. Delimitations also create margins for the study (Simon & Goes, 2013). The delimitations in this study include:

1) Patient perceptions of their care in perinatal settings were not evaluated.
2) Only perinatal nurses in the Southeastern United States were interviewed to localize data to only one region, for feasibility and timely research purposes.

3) Although caring can be broadly defined and applied to a plethora of settings, for simplicity and consistency, only the definition and process of caring as Swanson (1993) describes was utilized in application to the research.

Limitations

Limitations in research include constraints that are beyond the control of the researcher but may affect research outcomes (Simon & Goes, 2013). Listing the study limitations provides explanations for occurences happening outside of the study environment. The limitations in this study include:

1) To slow the spread of COVID-19, in this unique time in history where non-necessary physical contact is discouraged, this study was designed to be conducted virtually. While online avenues allow better time availability and flexibility, not being able to interview participants in person may limit the benefit of body language observation that in-person contact provides.
2) Additionally, nurse burnout has exploded during the COVID-19 pandemic, possibly resulting in a lack of interest in participating in nursing research (Galanis et al., 2021).
3) As nurse burnout may play a large role in nurses' level of caring toward perinatal patients, the nature of evaluating caring can be highly subjective. To combat this, the interview questions and research analysis were based on Swanson's theory of caring.

Significance of the Study

The significance of conducting this study was to determine the educational needs of perinatal nurses as they provide optimal care for a vastly diverse population. The

findings from this qualitative study assist in more clearly defining the phenomenon of nurse caring toward perceived stigmatized patients during the COVID-19 pandemic in perinatal settings. In addition, by completing this study, nurses had an opportunity to evaluate how their personal prejudices and attitudes may affect their patient care and identify areas that could be improved. Women who may be perceived as having a stigma, or negative stereotype, by perinatal nurses, can include substance abuse in pregnancy, mental illness, sexual orientations other than heterosexual, non-English speaking individuals, spontaneous or elective abortions, having no prenatal care, possession of sexually transmitted infections, or incarcerated women (Chan et al., 2005; Goldberg, 2005; Horner et al., 2019; Hutti et al., 2016; Lee & Lee, 2006; Link & Phelan, 2001; Noonan et al., 2019). This list is not exhaustive but are common examples noted in the literature. Understanding nurses' perceptions of stigma among their patients and during the COVID-19 pandemic is vastly important, especially since research is limited in this area (Naylor et al., 2021). As a result of nurses' perceived stigma for some patients, patients may be devalued and do not receive the same level of caring by perinatal nurses as other patients do (Goshin et al., 2020; Horner et al., 2019; Neary, 2018; Noonan et al., 2019; Tzur-Peled et al., 2019). The goal of the researcher is that socially stigmatized patients would receive intentional and increased levels of caring by perinatal nurses.

Summary

The care of perinatal patients is a great responsibility that comes with great reward. The evaluation of perinatal perceptions of caring in perceived stigmatized patients during the COVID-19 pandemic is an area of research that could produce a higher standard and awareness of caring to promote equality and more positive patient

outcomes. By interviewing perinatal nurses to determine their perceived stigmas for delivering patient care, interventions can be developed to help perinatal nurses' understanding of stigma and its effect on patient care. The findings from this qualitative study describe how perceptions of stigma by perinatal nurses affect caring in perinatal settings. Moreover, the findings of the study add to the nursing body of knowledge on how stigma influences caring practices. Chapter II will discuss the current literature surrounding stigma among perinatal patients and caring during the COVID-19 pandemic.

CHAPTER II – REVIEW OF THE LITERATURE

Introduction

Perinatal nurses care for patients in a distinctive moment of their lives, where mothers may be experiencing many emotions, good and bad, surrounding their pregnancy. Regardless of maternal emotions and life circumstances, perinatal nurses are tasked with providing competent, safe care, in addition to exhibiting a level of appropriate caring. As the general environment has suffered a shift with the presence of COVID-19, nurses and patients alike have been impacted.

This literature review addresses such issues to provide current research on perinatal stigma applied research of Swanson's theory of caring and the results of nursing during the COVID-19 pandemic. Literature was found by a great deal of online investigation through The University of Southern Mississippi library system, including CINAHL and ProQuest, and Google Scholar to find nursing research, particularly in the area of perinatal nursing. Key words such as *stigma, nurse attitudes, patients, perinatal nursing, nursing care, caring, Swanson's theory of caring,* and *nursing during COVID-19*, were used to search for applicable articles and discover research gaps. To date, little research has been done on perinatal nurses' perceptions of stigmatizing qualities in patients, evaluation of Swanson's theory of caring in areas not related to bereavement, and assessment of caring among perinatal nursing during the COVID-19 pandemic

Perceived Stigma Among Perinatal Patients

It is supported that perinatal nurses perceive stigma among perinatal patients, and it is important to review how stigma is developed and what influences exist (Al Shamsi et al., 2020; Goldberg, 2005; Goshin et al., 2020; Horner et al., 2019; Neary, 2018; Noonan

et al., 2019; Tzur-Peled et al., 2019). As characteristics among perinatal patients are made aware to the nurse, the nurse may perceive stigma, which could alter the level of care provided to the patient (Link & Phelan, 2001). Structural stigma has been closely correlated with populations of poorer health, signifying the need to identify perceived characteristics of stigma among nurses and promote expectations of adequate caring for all patients (Hatzenbuehler & Link, 2014). Stigma may be perceived based on external characteristics, or physical markings, of the patient, which could indicate their level of socioeconomic status, disease state, or identity, allowing the nurse to label the patient into a category that may indicate an individual or interpersonal stigma as being present (Link & Phelan, 2001). Stigma is classified as being experienced within an individual, interpersonally, and based on social structures and morality beliefs (Hatzenbuehler & Link, 2014; Link & Phelan, 2001; Pescosolido & Martin, 2015). Therefore, it is important to allow individuals to assert their own perception of stigmatizing characteristics, as they often differ. The concept of stigma has been evaluated in some specific avenues to explore phenomena, revealing the need for better competency in therapeutic nurse-to-patient communication, and reduction in the stigma surrounding incarcerated women, untraditional sexual identities, mental health needs, substance abuse, and patients with language barriers (Al Shamsi et al., 2020; Goldberg, 2005; Goshin et al., 2020; Horner et al., 2019; Neary, 2018; Noonan et al., 2019; Pescosolido & Martin, 2015; Tzur-Peled et al., 2019).

Goldberg (2005) identified, after an extensive review of literature, the need for nurses to redefine caring for lesbian women in perinatal settings, as the majority of perinatal nurses do not recognize the need to adjust care based on the sexual orientation

of the patient. In comparison, Tzur-Peled et al. (2019), found similar results as they assessed nurses' perceptions of caring for a lesbian patient in perinatal settings. Tzur-Peled et al. (2019), identified a lack of factual knowledge in perinatal nurses about homosexuality, directly affecting perinatal nurses' assessment of their working relationship and communication with lesbian women under their care (Tzur-Peled et al., 2019). An identified need, based on perinatal nurses' unawareness of the impact that a patient's sexual orientation makes on care, was found indicating that further sexual orientation training is conducted to enable more equal perinatal nursing care (Tzur-Peled et al., 2019). Sexual orientation in perinatal patients is only one of many areas identified as stigmatizing among patients. Improvement in the knowledge of perinatal nurses regarding perceived stigmatizing characteristics of sexual orientation can promote more favorable perceptions of nursing relationships and communication with perinatal patients (Tzur-Peled et al., 2019).

Goshin et al. (2020), acknowledged the need to advocate for decreasing the stigma surrounding maternal care of incarcerated women. Goshin et al. (2020), found that low stigma of incarcerated patients from perinatal nurses, and higher perceived autonomy of the patients by nurses, revealed higher care intentions by nurses. This theme of decreasing stigma from perinatal nurses to improve nurse-to-patient interactions is a common thread throughout other research. For example, Horner et al. (2019), found that therapeutic nurse-to-patient relationships and openness of communication between the two was violated when the patient possessed a stigmatizing characteristic. Within their study, the stigma surrounded patients with opioid use disorder. Horner et al. (2019), determined that nurses desired to overcome this stigma to provide quality care to those

patients but lacked skills and support to do so. In support of this assumption, Neary (2018) identified therapeutic attitudes of perinatal nurses toward women with substance abuse addition in pregnancy as having a direct impact on more positive outcomes for mother and baby. Researchers support that fostering therapeutic relationships between perinatal patients possessing perceived stigmatizing qualities and perinatal nurses requires further nursing education and can result in better perinatal patient outcomes (Goshin et al., 2020; Horner et al., 2019; Neary, 2018).

Two major inhibitors of nurse-to-patient communication and therapeutic relationships include mental health disabilities and language barriers (Al Shamsi et al., 2020; Noonan et al., 2019). Noonan et al. (2019), identified a common stigma that exists in perinatal patient care, specifically surrounding mental health needs, among public health nurses. Researchers determined that public health nurses were less confident in caring for mental health needs in patients that were pregnant compared to those that were not pregnant (Noonan et al., 2019). This research is twofold as the pregnancy was identified as a stigmatizing quality among patients in addition to mental health needs (Noonan et al., 2019). As nurses, even outside of the realm of perinatal nurses, treat and care for perinatal patients, the barrier of stigmatizing perceptions exists prominently. Another challenge to nurse-to-patient communication exists in patients who do not share the same primary language as the nurse. Al Shamsi et al. (2020), determined that language barriers in health care result in miscommunication between the healthcare professional and patient. In addition, a language barrier not only reduces patient safety and quality of care but decreases satisfaction in both the health professional and the patient (Al Shamsi et al., 2020). As nurses encounter perceived stigma surrounding

language and mental health barriers, methods to reducing the communication barrier are essential to provide safe and caring care to perinatal patients in a pivotal time of their lives.

Stigmatizing qualities may be defined differently from nurse to nurse, as stigma is perceived and influenced by social norms and previous life and work experience (Link & Phelan, 2001). Stereotypes, judgments, and discriminations are attributes that contribute to perceptions of stigma (Link & Phelan, 2001). Stigma can cause barriers to social status such as social rejection, exploitation, exclusion, isolation, decreased support, and lower social status (Hatzenbuehler & Link, 2014; Lee & Lee, 2006). When applied to the perinatal setting, similar consequences of stigmatizing attitudes towards patients exist and result in negative patient outcomes and decreased patient satisfaction (Horner et al., 2019). Stigmatizing perceptions can develop into attitudes, which are mental in nature, but manifest through behaviors toward others and may be positive or negatively perceived (Link & Phelan, 2001; Merriam-Webster, n.d.-a). A portion of nurse perceptions of stigma regarding perinatal patients influences their attitude or feelings toward the patient and therefore elicits a behavior. As nurses cope with the behaviors, it is desired that they be intentionally mindful of how their attitude may affect their nursing care. Therefore, it is important that nurses become more aware of these biases and apply Swanson's theory of caring to guide their nursing practice for informed caring (Swanson, 1993).

Swanson's Theory of Caring Related to Perinatal Nursing

Swanson's theory of caring has been used over the years to bring definition, guidance, and clarity to nursing care. Originally developed for perinatal nursing, it

describes a process of caring that can be implemented when caring for a wide range of perinatal patients (Swanson, 1993). Swanson's theory is often applied to bereavement care but can be applied to all patients, whether perceived stigma exists or not. The goal of Swanson's theory is to enable patients to reach their full potential and long-term well-being (Swanson, 1993). A committed level of caring is achieved through a process beginning with the nurse's philosophical attitude, understanding the condition of the patient, being with, doing for, enabling the patient, and ending up at a point of well-being in the patient (Swanson, 1993). This process was used to evaluate the level of caring in perinatal nurses toward perceived stigmatized patients. The interview questions, further discussed in the Methods section in Chapter III, were developed on a basis of Swanson's Structure of Caring process. The implementation of Swanson's theory provides consistency of data collection, analysis, and application of research to the theory of caring.

Swanson's theory of caring has been used in research since its conception. Chan et al. (2005), assessed perinatal nurses' attitudes toward bereavement care and found that it could be strengthened by further education and support for nurses. A direct correlation was recognized between more experience with bereavement care and more positive nurse attitudes toward such care (Chan et al., 2005). The more equipped nurses are to provide caring care, no matter the circumstance, the higher patient satisfaction, safety, and health outcomes will be (Chan et al., 2005). Hutti et al., (2016) found that by equipping nurses to apply Swanson's theory of caring, obstetric nurses reported more positive feelings associated with their level of care in caring for perinatal patients experiencing fetal death than nurses who did not implement Swanson's theory.

Swanson's theory of caring is fitting for educating nurses on a structure of caring by which to base their perinatal nursing, for optimal patient outcomes and increased nurse satisfaction (Hutti et al., 2016). Although bereavement care is unique and involves emotional, physical, and mental aspects of care, Swanson's theory of caring is useful in other perinatal nursing situations too. Perceived stigmatizing qualities among perinatal nurses can provide a challenge to adequate care, especially in wake of the COVID-19 pandemic implications. Application of the theory of caring can provide a structure on which to provide optimal nursing care in perinatal settings.

Caring During the COVID-19 Pandemic

The COVID-19 pandemic has delivered unique challenges in inpatient care such as the necessity of PPE, emotional tolls of isolation and fear of contracting or spreading COVID-19, and caring for sicker, higher acuity patients (Mortazavi & Ghardashi, 2021). These elements have an impact on nurses' ability to provide caring care. Nurses have suffered more prevalence of increased anxiety, depression, and PTSD since the start of the COVID-19 pandemic, and their clinical and caring practice suffers as a result (Naylor et al., 2021). The long-term effects of nursing during COVID-19 will be a large area for further research in the future. Currently, self-care measures for nurses are being explored through resilience programs and exposure to human caring theories (Barnett et al., 2021).

A new nursing intervention, an Internet-based trauma recovery program, was applied for patients suffering from post-traumatic stress symptoms due to COVID-19. The program was based on Swanson's theory of caring to provide caring psychological care to patients in need (Kim et al., 2021). Although the researchers were unable to assess the effectiveness of the program on patient emotional improvement for timeliness

purposes, they established a foundation for virtual trauma recovery programs (Kim et al., 2021). Kim et al. (2021), will continue to conduct research for the effectiveness of the interventions. Even so, the researchers assert that post-disease intervention may not be necessary if Swanson's theory were applied during the patient's initial disease state (Kim et al., 2021). Not only are perinatal patients susceptible to contracting COVID-19, but they may also suffer PTSD, even if not being personally diagnosed. As visitor policies change, some perinatal patients find themselves facing traumatic events alone. Perinatal nurses can use this opportunity to implement caring care to reduce anxiety in patients and comfort them in fear-filled times (Mortazavi & Ghardashi, 2021).

Summary

Based on the review of the literature, further investigation of perinatal nurse perceptions of caring in perceived stigmatized patients is needed, as they deliver care during the COVID-19 pandemic. Perceived stigma is variable among nurses and is decided based on individual and interpersonal experiences, cultural background, and beliefs of morality (Hatzenbuehler & Link, 2014; Link & Phelan, 2001; Pescosolido & Martin, 2015). Self-awareness of personal bias is essential as nurses deliver care. Swanson's theory of caring, related to perinatal nursing, provides an appropriate basis for nurses to provide caring care in a variety of patient circumstances (Hutti et al., 2016). As the COVID-19 pandemic has brought new challenges to nurses, the delivery of caring care is altered in many ways. Only after ensuring self-care measures have been established, nurses can then begin to meet the needs of their patients adequately to ultimately promote patient well-being (Barnett et al., 2021). Chapter III will describe the study methodology in detail.

CHAPTER III - METHODOLOGY

Introduction

This qualitative descriptive study fosters the ability to take a clear look at perinatal nurse perceptions of caring in perceived stigmatized patients during the COVID-19 pandemic. As nurses face pandemic-related stressors like never before in their lifetime, it is important to evaluate how perinatal nurses perceive their caring during this time (Naylor et al., 2021). The qualitative descriptive design allows for straight descriptions of phenomena, to observe the who, what, and where of the event of interest (Sandelowski, 2000). Hsieh and Shannon's (2005) directed content analysis method was used for data analysis. Swanson's theory of caring served as the guiding framework for the study and was evaluated to determine its application to nursing perceptions of caring for perceived stigmatized patients during the COVID-19 pandemic. The directed content analysis takes a structured approach, using an existing theory to process and code the collected data (Hsieh & Shannon, 2005). The research design and analysis of data work together to provide insights on perinatal nurse perceptions of caring and stigma in perinatal patients during the COVID-19 pandemic.

Research Design

This research study followed a qualitative descriptive design that is commonly used when little research on a selected topic is found in the literature. Swanson's theory of caring will be applied to guide descriptions of phenomena related to perceptions of caring among perinatal nurses who cared for perceived stigmatized patients during the COVID-19 pandemic (Sandelowski, 2000). The qualitative descriptive study design allows the researcher to comprehensively summarize discussed or observed events, and present

meaning without needing an overtly interpretive description of events (Sandelowski, 2000). For the purpose of this study, a qualitative descriptive design was most appropriate, as a basic and fundamental description of nurse perceptions of caring in perceived stigmatized patients requires only recognition and summation of nurse reports. Although simple in nature, qualitative descriptive research still requires the researcher to analyze data and make surface-level interpretations of the data (Sandelowski, 2009) to benefit perinatal nursing and yield optimal patient care. The qualitative descriptive design was ideal for this topic of research, compared to a phenomenological, grounded theory, or ethnographic study as simplicity is allowed to present data instead of adapting a complex framework for evaluating and reading too far into the data to make inferential interpretations of meaning (Sandelowski, 2000, 2009). Within the qualitative descriptive design, researchers must present an accurate account of events in data analysis, which most researchers and participants alike would agree are true of the data, without diving into a deep interpretation of data not explicitly presented (Sandelowski, 2000). Therefore, the qualitative descriptive design supports the researcher's ability to gather available data and find surface-level meaning to the content, to better understand perceptions of caring in perinatal nurses caring for perceived stigmatized patients during the COVID-19 pandemic.

Role of the Researcher

The researcher in this study assumed the role of direct interaction with participants, data collection, and analysis. Researchers in qualitative descriptive studies remain close to the surface, or familiar, with words and event data (Sandelowski, 2000). The researcher compiled and presented data with low-inference interpretations that most

researchers would agree as present and true (Sandelowski, 2000). In addition, the researcher was held to a high standard of trustworthiness and conducted all roles with honesty and truthfulness. Trustworthiness was established through means of credibility, transferability, dependability, and confirmability (Shenton, 2004). Credibility was ensured by adopting established research methods, thoroughly examining other research findings, ensuring random sampling, and making attempts at promoting honest feedback from interview participants (Shenton, 2004). Transferability was found in the ability of the research conclusions to be applied to a broader scale of perinatal nursing, while dependability can be noted in the assumption that if the study were repeated with the same methods and participants, similar results would be present (Shenton, 2004). Confirmability was evidenced by the researcher's efforts to produce objectivity within all aspects of the research (Shenton, 2004). Researchers conducting qualitative research must adopt these elements of professionalism and trustworthiness to ensure valuable results.

Logistically, the researcher developed and distributed the demographic survey to find participation interest among the sample population. As feedback was received, the researcher reached out to willing participants, who met inclusion criteria, and conducted and recorded a virtual interview at the convenience of the participant. The researcher established an appropriate working relationship with the participant and ensured the anonymity of all information discussed. The researcher had the role of asking interview questions and gathering data through automatic transcriptions of participant answers through the virtual communication system. As the pre-written, open-ended questions were asked, the participants were encouraged to answer with honest feedback and personal reflection of past experiences. To ensure accurate interpretation of the

participant answers and perceptions, the researcher reflected upon participant answers throughout and provided a brief summation at the end of the interview.

Participant Sampling

The goal of participant sampling is to engage the sample population that is reasonable to achieve the purpose of this study (Sandelowski, 2000). The context for this study includes perinatal nurses local to the Southeastern United States, who work with perinatal patients who may be perceived as having stigmatizing qualities during the COVID-19 pandemic. The Southeastern region was delineated for timeliness and feasibility purposes. The purposive sample consisted of a general group of perinatal nurses, including prenatal, labor and delivery, and postpartum nurses. The sample population was recruited by distributing a brief explanation of the study, along with the demographic survey information for perinatal nurse Facebook groups, the snowballing techniques, and local hospital administrators for distribution to staff nurses. Snowball sampling occurs when an informant provides the contact information of another informant, who supplies the researcher with other contacts who may willing and able to participate in the study, producing a snowball effect (Noy, 2008). Fifteen interviews were completed due to data saturation being achieved.

Inclusion criteria for participation were listed initially on the demographic survey. The inclusion criteria included that the participant must be a current perinatal nurse in the Southeastern Region of the United States. Gray area exists in perinatal care as postpartum nurses traditionally have newborns under their care, in addition to the mother. For the purpose of this study, all nurses involved in women's and children's care who solely care

for newborns were excluded from participating. Nurses who are involved in maternal care were the priority of interest.

Ethical Protection Measures

The ethical protection of participants and anonymity of data was the top priority of the researcher. Before implementation of any element of study procedures, approval from The University of Southern Mississippi Institutional Review Board (IRB) was obtained (Protocol # 21-316). A thorough description of the research questions, methods of data collection, and intended use of the participant data was provided to the participants prior to completing the survey. Participants signified agreement to the informed consent by completing and submitting the demographic survey, followed by contact from the researcher for an interview. Before the interview started, participants were informed that their participation was voluntary and may be withdrawn at any time. Interviews were conducted via Zoom, in private, password-protected meetings that were recorded and automatically transcribed for ease of data analysis. All recordings, notes, and transcriptions were secured on the researcher's personal, password-protected computer.

Data Collection

The primary method of data collection was through demographic surveys and one-on-one interviews. Qualtrics was used to collect demographic information, in form of inclusion criteria, receive informed consent, and identify participant interest for nurses willing to participate in an interview session. Qualtrics is a web-based survey tool that promotes ease of use for researchers and participants alike. Demographic information included contact information, age, gender, race, geographical location, years of work

experience total, years of work experience in a perinatal setting, current position to confirm staff nurse role, and department of perinatal setting, etc. The demographic information is described in more detail in Appendix A. Online, video interviews were conducted with perinatal nurses, to gain a better understanding of their perceptions of caring for perceived stigmatized patients in the perinatal patient population. The virtual Zoom interviews were recorded, using two forms of recording, and transcribed for efficiency of data coding at the time most convenient for each participant. Participants were made aware of the recorded nature of the interviews and the secured and confidential storage of all data. At the end of every interview, the National Mental Health Hotline number, 866-903-3787, was provided to participants for those that might experience any type of distress as a result of participation in this study. The participants were informed that the hotline is available 24 hours a day to provide free and confidential mental health services. The interview questions were open-ended and directly developed from Swanson's (1993) theory of caring, as seen in Table 1.

Table 1

Interview Questions Related to Caring

	Interview Questions
Introductory Question	How do you show "caring" to your patients?
Introductory Question	How would you define "stigmatizing" qualities in patients that you care for in the perinatal setting?

Table 1 (continued).

Introductory Question	What type of patient is hard for you to provide "caring" care?
Introductory Question	How do you feel providing nursing care during the COVID-19 pandemic has changed your level of "caring"?
Swanson's Structure of Caring (Swanson, 1993)	
Maintaining Belief	Nurses perceive an attitude or belief of a patient upon meeting them. How would you say your initial belief of a person's abilities changes when you perceive them as possessing stigmatizing characteristics?
Knowing	How does your desire to get to know the entire clinical condition or situation of your patient change when you perceive them as possessing stigmatizing qualities?
Being With	Do you feel the same desire to be emotionally present with a patient who has perceived stigmatizing qualities compared to a patient who is more traditional?
Doing For and Enabling	Do you find yourself serving and enabling perceived stigmatized patients to the same degree that you would traditional patients?
Client Well-Being (Intended Outcome)	What are ways you think the level of nurse "caring" can be improved in situations where the patients possess perceived stigmatizing qualities, to promote optimal patient well-being?

Note. The interview questions were adapted from Swanson's theory of caring, Structure of Caring (Swanson, 1993)

The qualitative descriptive study design outlines a specific goal for data collection. Naturalistic inquiry is the target of qualitative descriptive research as eliciting the most natural and accurate discussion of events will enable the most precise data collection, as it would be acquired if observed in the natural environment (Sandelowski, 2000). Gaining an understanding of the basic nature and shape of what is currently occurring in perinatal settings, surrounding caring for perceived stigmatized patients during the COVID-19 pandemic is essential to the qualitative descriptive study design (Sandelowski, 2000).

Data Analysis

Hsieh and Shannon's (2005) directed content analysis method was used for analyzing interview data. Directed content analysis is a structural approach that uses specific interview questions. Swanson's theory of caring was used to develop interview questions, which will conceptually extend the theoretical framework. Not only does this data analysis method enable the application of a theory, but it allows the researcher to determine an initial coding scheme based on the theoretical foundation (Hsieh & Shannon, 2005). Codes were generated from the interview question responses and were modified as more data was collected and analyzed, not pre-existing as in quantitative data (Hsieh & Shannon, 2005; Sandelowski, 2000). Qualitative transcription data was saved and filed in a Microsoft Word document. Quotes from the transcripts were organized in Microsoft Word tables based on the corresponding coding category (Hsieh & Shannon, 2005). The categories for coding included: showing caring, nurse definitions of stigmatizing qualities, patients hard to provide "caring" care for, nursing care during COVID-19, maintaining belief, knowing, being with, doing for and enabling, and

improved patient outcomes. Coding progressed by reviewing all transcripts and highlighting recurring codes under each of the interview questions. If any highlighted codes fell outside of the specified categories, a new code was given and placed in its own subcategory (Hsieh & Shannon, 2005). The coding of data allowed for the seamless presentation of a descriptive summary of the event in the terms in which it took place (Sandelowski, 2000). Swanson's theory of caring was used to guide data analysis and discussion of findings (Hsieh & Shannon, 2005).

Trustworthiness was a top priority of the researcher in the data analysis phase of the study. Trustworthiness was achieved by means of ensuring clarity and transparency in each step of the research, specifically in preparation, organization, and results reporting (Elo et al., 2014). As content was analyzed, the researcher prioritized the validity and understandability of all reported information (Elo et al., 2014). Additionally, trustworthiness was established by maintaining credibility, transferability, dependability, confirmability, and authenticity (Elo et al., 2014; Shenton, 2004). Credibility was evidenced as the researcher identified and accurately described participants, utilized established research methods, examined current literature, and promoted honest interview responses from participants (Elo et al., 2014; Shenton, 2004). Transferability was accomplished through thorough descriptions of participant responses to interview questions, which allowed the study results to be applicable for other perinatal nursing groups. Dependability was found in the ability to repeat the study to find a consistency of results (Elo et al., 2014; Shenton, 2004). Confirmability was found in the researcher's effort to remain objective of all data. For example, if multiple researchers were conducting the study, confirmability would be found if all researchers consistently agreed

on the data's accuracy, significance, and meaning (Elo et al., 2014; Shenton, 2004). Authenticity was established when the researcher presented a fair range of realities that may be perceived (Elo et al., 2014). Each of these elements were applied to this study to provide the most reliable contribution to nursing research and practice.

Summary

The qualitative descriptive study design provided an appropriate structure for describing perinatal nurse perceptions of caring in perceived stigmatized patients in the perinatal setting during the COVID-19 pandemic. Demographic information and informed consent were obtained from interested participants and virtual Zoom interviews were conducted with 15 perinatal nurses until data saturation was achieved. Open-ended interview questions were based on Swanson's theory of caring. Transcriptions from the interviews were coded and evaluated based on Hsieh and Shannon's (2005) directed content analysis method. Chapter IV will discuss the findings and analysis of data.

CHAPTER IV – PRESENTATION AND ANALYSIS OF DATA

Introduction

This chapter will present the findings of this study and describe the data analysis process used to provide a descriptive summary of perinatal perceptions of caring for perceived stigmatized patients in the perinatal setting during the COVID-19 pandemic. In review, nine open-ended research questions were developed using Swanson's theory of caring, to conceptually extend the theoretical framework. All questions were aimed at answering the following central research questions for this study:

a) What are the perceptions of caring in perinatal nurses who deliver care to perceived stigmatized patients in the perinatal patient population?
b) What are the perceptions of caring in perinatal nurses as they deliver care to perinatal patients during the COVID-19 pandemic?

Process of Gathering Data

Participants were recruited by distributing a brief explanation of the study, along with the demographic survey information and consent form to perinatal nurse Facebook groups, local hospital administrators for distribution to staff nurses, and use of snowballing techniques. Upon completion of the demographic survey, willing participants submitted their email addresses by which the researcher contacted participants for a virtual Zoom interview at the participant's convenience. Fifteen perinatal nurse Zoom interviews were conducted with an average of 13 minutes per interview, with interviews ranging from 7 minutes to 21 minutes in length. Interviews were conducted until data saturation was met. Interviews were recorded on two devices and transcribed into Microsoft Word documents. Interview recordings were listened to at

least twice by the researcher as the Zoom transcriptions were cleaned and verified for accuracy. All research data was kept secure on the researcher's personal password-protected devices.

Once interviews were transcribed, Hsieh and Shannon's (2005) directed content analysis method was used for analyzing and coding quotes from each nurse's interview responses to each question. The quotes were copied into a coding Microsoft Word document under the corresponding, predetermined category. Subcategories were identified under each category and supporting quotes from all nurses were organized into tables in the Microsoft Word document. The coding document was used to keep track of data, researcher notes of significance, and organize nurse responses in the predetermined categories, that were based on Swanson's theory of caring.

Description of Sample

The sample population was recruited by distributing a brief explanation of the study, along with the demographic survey information to perinatal nurse Facebook groups and local hospital administrators for distribution to staff nurses. In addition, snowballing techniques were employed. As nurses expressed interest and willingness to participate in the study, 15 perinatal nurse Zoom interviews were conducted, until data saturation was met. Of the sample population (N=15), all were female and 11 currently work as a nurse in Mississippi, with the remaining nurses working in other Southeastern states, specifically, Louisiana, Tennessee, Virginia, and South Carolina. Three out of 15 nurses were postpartum nurses, while 12 reported to be working in Labor and Delivery. The ages of the nurses ranged from 20 to 50 years old with a wide range of work experience in the perinatal setting existing from 1 to 19.5 years. All nurse participants

were of White/Caucasian race, except one who is Hispanic. National demographics of perinatal nurses reveal that 91.9% are female, while 69.7% are White, which is a direct indicator of the sample population found for this study (Zippia The Career Expert, 2022). See Appendix A for more detailed demographic information. Nurses were encouraged to take time to think about their interview answers for as long as necessary and provide honest responses about what they think and feel about their perceptions of caring for perceived stigmatized patients in the perinatal setting during the COVID-19 pandemic.

Findings

The findings of this study are organized by the predetermined coding categories as follows: showing caring, nurse definitions of stigmatizing qualities, patients hard to provide "caring" care for, nursing care during COVID-19, maintaining belief, knowing, being with, doing for, and enabling, and improved patient outcomes. This coding method was based on Hsieh and Shannon's (2005) directed content analysis to extend and validate the theoretical framework of Swanson's theory of caring. Subcategories for each category were identified from interview quotes from the nurses and were listed in the coding document, with supporting quotes as evidence to promote the trustworthiness and transparency of the analysis. See Table 2 for the categories and subcategories. Each of these category findings and subcategories will be described in greater detail in the following section.

Table 2

Coding Categories for Findings

Category	Subcategories
Showing Caring	1) Developing Caring Relationships 2) Meeting Patient Needs 3) Promoting Informed Patient Choices and Positive Experiences
Nurse Definitions of Stigmatizing Qualities	1) Perceived Stigma by Nurses 2) Drug Abuse and Other Unhealthy Lifestyles 3) Appearance and Attitudes 4) Demographics
Patients Hard to Provide "Caring" Care for	1) Patient's Attitude 2) Drug Abuse 3) Other
Nursing Care During COVID-19	1) New Rules Causing Disconnect 2) Care and Presence of the Nurse 3) Concerns and Fears
Maintaining Belief	1) Nurse Attitude Changes Toward Patient 2) Nurse Assumption of Patients' Abilities
Knowing	1) Desire to Know 2) Lack of Desire to Know
Being With	1) Desire to be Emotionally Present 2) Lack of Desire to be Emotionally Present 3) Need to be Emotionally Present

Table 2 (continued).

Doing For and Enabling	1) Less Doing For and Enabling 2) Same Amount of Doing For and Enabling 3) More Doing For and Enabling
Improved Patient Outcomes	1) Educating Nurses and Changing Nursing Culture 2) Standards of Care and Expectations 3) Changes in Nursing Environment

The following categories and subcategories will be discussed in more detail. Questions for the first three categories were derived from the research questions. The remaining categories: maintaining belief, knowing, being with, doing for and enabling, and improved patient outcomes, were derived from Swanson's theory of caring (Swanson, 1993).

Showing Caring

In the Zoom interviews, nurses were asked to define how they showed caring to their patients, as seen in Table 1. The interviewer clarified the question for some by describing caring as things done or said to show the patient that they care, aside from completing nursing tasks. Caring is defined by Swanson's theory of caring as a nurturing personal sense of responsibility or commitment to a valued individual, for their ultimate well-being (Swanson, 1991). Although definitions of how they showed caring varied from nurse to nurse, three main subcategories emerged from the nurse responses including (a) developing caring relationships, (b) meeting patient needs, and (c) promoting informed patient choices and positive experiences. Fifteen nurses answered

this interview question and a vast majority (n=13) reported that developing a caring relationship through open communication and being present with the patient was a primary way they showed caring to perinatal patients.

Subcategory #1-Developing Caring Relationships. Developing caring relationships with perinatal patients was the primary way perinatal nurses (n=13) sought to show caring to their patients. Nurses reported a desire to develop personal relationships with each patient, build rapport, and be present with the patient. A postpartum nurse described her caring actions as "checking in on them [patients] and see how they feel and if they're ready to go home and kind of more like psychological than anything else" (nurse #3). Her level of caring surrounds the psychological needs above the physical needs of patients. Other postpartum nurses discussed similar actions such as,

> [H]elping them [patients] with whatever they need help with, trying to go above and beyond by, you know, just kind of truly being present with them, acknowledging what they're going through, any questions/concerns, and trying to like help them to the best of your ability. (nurse #14)

The other postpartum nurse shared that she shows caring "by being kind to them [patients], listening to them, and being attentive to their needs" (nurse #15).

Labor and delivery nurses shared similar ideas of developing caring relationships as they stated a desire to relate to the patient on a more personal level through nurturing personal conversations to discover "who they are and where they come from… knowing them and their background" (nurse #13). One nurse described her experience as "having just like a personal, like a not too personal conversation but, you know, letting them know that you're a human being too" (nurse #5). Another stated, "I try to establish a

rapport with them as early as I can, in our day and I try to make them feel comfortable and have ample opportunity to ask questions and feel comfortable asking questions" (nurse #9). A nurse described a similar method in saying, "be personable and ask them questions about themselves or give them like opportunities to ask, as many questions as they want and maybe like share my experiences too" (nurse #12). Asking questions of patients and encouraging reciprocal behavior was a common thread as the nurses discussed developing caring relationships.

Caring about patient feelings and listening to the patient were also significantly discussed actions to promote caring relationships. One nurse desired to create an ongoing feedback loop with her patient to ensure a proper understanding of her patient's perceptions of care. She described this as "listening to what, the reason they're there to start with, and then, whatever their, you know, wants and needs are, their plan for their care and just hearing their feedback, you know, from the care that you're giving them" (nurse #8). Another nurse described her positive listening skills by saying, "I attempt to always be a good listener, making eye contact with them, hearing them, I typically sit on my patient's bed or hold their hand, some type of body language" (nurse #13). Promoting these open and attentive conversations was perceived by nurses to be a primary method of caring in the perinatal setting.

Nurses also sought to "make them [patients] feel comfortable" and foster personal nurse-to-patient relationships by "truly being present" (nurse #9 & #14). A labor and delivery nurse shared "just be there for them and encourage them, every once in a while, a little tough love when they're freaking out" (nurse #6). Another nurse cared through

“making them [patients] feel valid, trying to understand where they're coming from” (nurse #10). One nurse summed this subcategory up by saying,

> Each person is just different, but caring is just giving the care that you would expect to receive during a hospital visit. Just being helpful, friendly, answering any questions that you know the answers to, and being honest to your patient when you don't know the answer and trying to find the answers for them. And just being sincere with them, and again being 100% honest. The biggest thing is honesty and letting them know what the expectation is, what your, what the outcome is expected to be, and if there are ever any unexpected outcomes. (nurse #11)

Subcategory #2-Meeting Patient Needs. Meeting the personalized needs of patients was discussed by nurses (n=8) in a manner to show caring to them. Some nurses discussed meeting basic needs such as, “they’re like clean and they have food and they’re showered” (nurse #3). Others identified the need to continually reassess and ask the patient about their wants and needs in order to best meet them. One nurse said, “I try to assess and meet their needs as often as possible” (nurse #9). The importance of letting the patient know that “you’re here for what they need” was identified by another nurse (nurse #5). One nurse even stated that “taking care of their [patient] needs first” is the top priority and “making sure that they’re comfortable” follows (nurse #7). Nurse #10 shared that nursing tasks “like doing your assessments and going through the chart checking on labs staying on top of all of their care” are methods of meeting needs that may go unseen by the patient. Even so, other nurses expressed the need to be “attentive to their [patient]

needs" and "go above and beyond" to help "them with whatever they need help with," as they create individualized caring care (nurse #14 & #15).

Subcategory #3-Promoting Informed Patient Choices and Positive Experiences. Creating an environment that promotes informed patient choices and positive patient experiences was identified by nurses (n=5) as a method of caring specifically to the perinatal setting. While developing caring relationships and meeting patient needs are other significant ways to show caring, they do contribute to the experience of the perinatal patient. As patients anxiously anticipate their perinatal care experience, expectations about the perinatal experience are present. One nurse stated that she tries "to make them [patients] feel like all their wishes are met and that they're well educated" so that they "feel comfortable in the choices that they're making" (nurse #2). A nurse shared that "birth plans are really important, their wishes for their birth process is really important" (nurse #4). Another nurse expressed the need to make the patient's experience the nurse's top priority (nurse #5). A nurse added, "We really want it to be the best experience that the patient can have" (nurse #1).

Patient safety amid the patients' wishes was identified by multiple nurses and one said, "I do my very best to try to incorporate their wishes into a safe plan" (nurse #4). Another nurse expressed a desire to "explain everything so that they [patients] feel informed and safe and as prepared" as possible (nurse #6). Informed patient choices and positive perinatal experiences were repeatedly expressed by nurses as an anchor for their exhibiting caring care.

Nurse Definitions of Stigmatizing Qualities

Stigma, as previously defined, is a characteristic or mark of discredit or shame (Merriam-Webster, n.d-d). Perinatal nurses (N=15) were asked to share their definition of stigmatizing qualities in patients that they care for, as seen in Table 1. Some nurses additionally shared their definition of stigma to support the stigmatizing qualities they identify among patients. The four subcategories identified under the category of nurse definitions of stigmatizing qualities include (a) perceived stigma by nurses, (b) drug abuse and other unhealthy lifestyles, (c) appearance and attitude, and (d) demographics. The subcategories will be individually discussed in the following sections.

Subcategory #1-Perceived Stigma by Nurses. Some nurses (n=6) prefaced their explanation of stigmatizing qualities with a definition of the stigma that they use as a basis for identifying their perceptions of stigmatizing qualities. One nurse defined stigma as "preconceived notions that we may have, personal opinions that have been built by our life experiences" (nurse #2). Another nurse also used the term "preconceived notions" to define stigmas, and she added that they may indicate "the type of care they [patients] might need or the type of patient they might be" (nurse #15).

Three nurses mentioned "people" or "society" to reference their definition of stigma. An example of this is from a labor and delivery nurse that stated, "people look at a patient differently, maybe negatively" (nurse #5). Another nurse said her idea of stigma is "anything that makes them [patients] not be like status quo…a patient that society thinks is less than" (nurse #10). The third nurse mentioning "people" said, "certain characteristics about them [patients] that, I guess sometimes people, in general, can have a certain view about" (nurse #14). One nurse provided a thorough statement as she

expressed her definition of stigma to be "qualities that make me assume where they come from, who they are, and how it will be to take care of them based on their appearance, verbiage, and actions" (nurse #13). These definitions from perinatal nurses assisted to guide them in identifying stigmatizing qualities such as drug abuse, unhealthy lifestyles, appearances, attitudes, and demographics.

Subcategory #2-Drug Abuse and Other Unhealthy Lifestyles. Many perinatal nurses (n=8) identified drug abuse and other qualities of unhealthy lifestyles as primary stigmatizing characteristics of their patients in the perinatal setting. Multiple nurses stated that "drug-seeking behaviors," "drug abuser[s] or drug addict[s]," and "drug histories" are perceived stigmas in the perinatal setting (nurse #2, #3, & #10). Furthermore, one nurse mentioned that "a woman that comes in under the influence of drugs…that's the only really hard on because they were purposely doing that…not thinking of their child" (nurse #6). This idea of drug abuse is a means of harm to not only the mother's body, but the baby's also is a theme that emerged throughout the following categories as well and will be further discussed.

Additional unhealthy lifestyles that nurses mentioned included "patients who are unhoused" and "patients who don't seek prenatal care" (nurse #1). In addition, the patient's background, as far as "where they live and where they come from," was mentioned as a means of forming a stigma about a patient, in reference to unhealthy lifestyle behaviors (nurse #13). A nurse made mention of the presence of sexually transmitted diseases and "the number of children" a patient has in reference to unhealthy sexual behaviors that may be stigmatized (nurse #14). She clarified "the number of children" by saying "they've got a bunch of different, you know, baby daddies," further

describing her perception of what is considered a stigmatizing quality among patients (nurse #14). As many other qualities, such as being overweight or having poor hygiene, could be classified as unhealthy, the researcher identified such a significant nurse response about the stigma surrounding patient appearance and attitude that it was given its own subcategory.

Subcategory #3-Appearance and Attitude. Patient appearance and attitude was identified by perinatal nurses (n=8) to be a source of stigmatizing qualities for the patients they care for. Appearance qualities include "if they have tattoos or not if they are well kept or not," "different size patients," and "largely overweight patients" (nurse #7, #8, & #9). The "outward appearance" was described by one nurse as being the first impression of how the patient's hospital stay will go (nurse #8). Other stigmatizing appearances listed were "how they're [patients are] dressed, their cleanliness," and patients that "have shaved heads and colored hair and a lot of earrings everywhere" (nurse #13). In some cases, a patient's attitude may go hand in hand with their appearance.

Patient attitudes were described in different ways by perinatal nurses including patients who desire natural labor, patients exhibiting hypochondriac behaviors, vulgar language, and rudeness (nurse #4, #6, #10, & #13). Patients desiring natural labor were described as belligerent and refusing certain care interventions (nurse #4). These patients may also present with a birth plan that lists their stipulations of care. While multiple nurses did not seem to mind this practice, the attitude in which it was presented by the patient to the staff was perceived as stigmatizing by nurses (nurse #4 & #8). The patients with hypochondriac behaviors were described as complaining "about every little thing"

or coming “to the hospital for every little thing,” using up hospital resources, creating a stigma when they repeatedly presented for care (nurse #10). Vulgar language and the manner in which patients and family members talk to the nurse, whether in a rude, mean, or loud fashion, were suggested by multiple nurses as perceptions of stigma among their perinatal patients (nurse #5, #6, & #13). Patient attitudes were reported to cause a barrier in caring care for perinatal patients and will be further discussed in the following category.

Subcategory #4-Demographics. Various segments of the population were brought up by perinatal nurses (n=9) in their discussion of stigmatizing characteristics of their patients. Other nationalities, cultures, races, religions, language barrier, socioeconomic status, education level, incarceration status, young mothers, vaccination refusal, and non-heterosexual relationships were listed by nurses. Nationalities, cultures, races, and religions contrary to the American, White, and African American communities were referred to as stigmatized among perinatal patients (nurse #1, #8, #9, & #12). Multiple nurses mentioned the Hispanic community as being stigmatized, primarily due to the language barrier that exists (nurse #1, #7, #11, #12, & #15). Lower socioeconomic status patients and those with little education were pointed out by nurses as stigmatizing qualities (nurse #11 & #12). Incarcerated patients were listed as stigmatized, along with populations of young, teenage mothers (nurse #3 & #11). In the wake of the COVID-19 pandemic, one nurse mentioned the vaccination status of adults and children as a point of controversy and perceived stigma among nurses (nurse #14). In addition, the untraditional sexual orientation of perinatal patients, particularly “same-sex couples” were listed by two nurses as an “awkward situation” due to the nature of biological

principles of reproduction (nurse #1 & #15). These demographic qualities listed by nurses were based on previous experiences with a variety of patients in the perinatal setting.

Patients Hard to Provide "Caring" Care For

Perinatal nurses (N=15) were asked to describe the type of patient that they find hard to provide "caring" care for, as seen in Table 1. During the interviews, it was interesting to observe that of all the stigmatizing characteristics mentioned in the previous category, only two were identified as major barriers to providing caring care. The subcategories most nurses discussed included (a) patient's attitude, (b) drug abuse, and (c) other. The "other" subcategory was included to categorize the two nurse comments that did not fall within either of the other two subcategories.

Subcategory #1-Patient's Attitude. Patient attitudes were listed as some of the most challenging barriers to perinatal nurses (n=13) providing caring care for their patients. Themes of uninterested, unsatisfied, and ungrateful patients were listed by nurses, along with patients who were opposed to the help of nurses (nurse #1, #2, #3, #9, #11, #13, & #14). In addition, attitudes of perinatal patients who exhibited a lack of care for their unborn or newborn baby were identified by nurses as difficult to care for (nurse #4, #5, & #7). One nurse defined patients who are difficult to care for as those who are "just not interested" and "want somebody else to make their decisions for them and they don't take ownership of the situation" (nurse #1). Another nurse had similar sentiments as she acknowledged the difficulty in providing caring care for "patients that just never seem satisfied" (nurse #2). A labor and delivery nurse stated that those difficult for her to provide caring care for are

> Ungrateful patients that are outwardly ungrateful and those that have no emotion, a very flat affect. Because I don't know how to read them or they don't respond to anything, good or bad or neutral, and so I just become really neutral myself and just do baseline care. (nurse #13)

Patients with "an entitled attitude or somebody who thinks their situation is worse than somebody else's" was listed as a challenge to providing caring care (nurse #10). One nurse expounded on this idea of patient attitude as describing patients as "people that you're trying so hard to honor their wishes and what they want and they're just unappreciative or unable to listen…to the reasons for why you're doing what you're doing" (nurse #8). The lack of desire or appreciation for the nurse's help or involvement in the patient's care was a common thread throughout other nurse responses to this interview question.

Multiple nurses stated that the patients who did not desire their help or overtly opposed their help provided a major barrier to offering caring care. One nurse plainly stated, "it's hard for me to try to give care to people that don't want my help" (nurse #3). She went on to say that patients who "aren't willing to either learn or kind of accept the help that we're trying to give" prove difficult to educate and provide caring care for (nurse #3). Similarly, a nurse described her experience as patients who have "come for my help and as I'm offering it they're like speaking over me and contradicting me" (nurse #6). This behavior would understandably cause a divide in the nurse-to-patient relationship. Another nurse pointed out that "the one who does not seem to be open to bonding," or is "very closed off and like kind of refuse to engage with me whatsoever, regardless of how much kindness I pour on to them, it eventually becomes difficult to

continue to try to engage to the same degree" (nurse #9). Her honest report of her experience is a lens into how the nurse-to-patient relationship of caring can be directly closed off by the attitude of the patient. A Hispanic nurse working in Mississippi shared a scenario of how her caring has received opposition. She said,

> It's the patients that are un-wanting of your services or un-wanting of your help that feel that you know, because of either Facebook or previous encounters or previous experiences they've had either with you or other physicians they kind of just are standoffish. And they feel that they're, they've done adequate research and it's not that they haven't, it's just that they're already kind of set in their ways and how they want things to go, and when you tell them, 'hey, I understand this is the plan you had, but this is the plan that we have now because of so and so that's happening,' and they become either hostile towards you or you become incompetent in their eyes because you're not following the plan they had. (nurse #11)

Her experience with these kinds of patient attitudes in the clinical setting have contributed directly to her answer of who the hardest patients are to provide caring care for. Another nurse made similar remarks as she said,

> [T]hose [patients] that just aren't receptive to the care that you're trying to provide…they're constantly on their phone or, you know, just distracted. It's hard to really zone in and really give them the kind of care that they need at times. (nurse #14)

These nurses have listed reasonable patient attitudes that would prove difficult in providing caring care, as they are in direct opposition to the nurse. An additional attitude

nurse mentioned was difficulty in caring for mothers who did not desire or respect their pregnancy.

An example of a lack of respect and care for the pregnancy by a mother was described in detail by a nurse that shared she struggled with 12 years of infertility before becoming pregnant. She said,

> I can remember one [patient] where I did have to leave her room because I knew that I could not take care of her. She had been using drugs through her pregnancy and was miscarrying at like 19 weeks or so and had no regard whatsoever for the baby that she was losing. And was like cursing towards the baby and like, you know, 'get this F*** thing out of me.' [She] was just being horrible and I was like 'you know what, you have no idea, there are people that would do anything to have a baby, and here you are treating it like garbage.' (nurse #4)

This nurse, along with two others who found a lack of care for the baby as difficult to care for, mentioned drug abuse as the manifestation of the lack of care. One nurse said, "patients who don't want their children or like are on drugs and do things that harm and not really care for the pregnancy" are hard to provide caring care for (nurse #5). Another nurse said, "someone who is addicted to drugs and just does not care about themselves or their baby" (nurse #7). She then paused for a moment and said, "it's really hard to be compassionate with someone who absolutely does not care for the well-being of their baby" (nurse #7). A lack of "respect for pregnancy or even for their own baby" is evidenced to be a barrier in perinatal nurses providing caring care to patients (nurse #4).

Subcategory #2-Drug Abuse. The attitude of the patient in relation to the presence of drug abuse in pregnancy were prominent themes among nurse responses (n=5). In

some cases, they went hand in hand, as previously discussed by one nurse as she presented a personal experience with a drug-abusing mother who was miscarrying, and she shared her inability to continue caring for this patient (nurse #4). Not only do nurses disagree with this behavior, one nurse shared that it is "harder to relate to those people and connect on a more personal level" when patients "come in positive for different drugs or, you know, I know they're not taking care of themselves or their baby" (nurse #12). As mentioned in the last section "patients who don't want their children or like are on drugs and do things that harm and not really care for their pregnancy" were reported to be difficult to provide caring care for (nurse #5). Nurses #6 and #7 shared the same perception of drug addiction being a means of not caring for "themselves or for their baby." Although addiction is much more complex of an issue than simply an uncaring attitude for the unborn, the perceptions of perinatal nurses were consistent in describing their difficulty to overcome this stigma to provide caring care.

Subcategory #3-Other. Two nurses (n=2) provided barriers to providing caring care, that fell outside of the subcategories of patient attitudes and drug abuse, which were related to patient families and language barriers. One nurse stated that patients' "family that is overbearing or that try to overstep my care or tell me how to do my job" are difficult to provide caring care for (nurse #2). In addition, Hispanic patients were reported to be difficult to provide caring care for due to not having "open communication" and requiring a form of translation (nurse #15). She reported it being hard "when you have a whole other load of patients" and it requires "extra time in the room" when a language barrier exists (nurse #15). The time constraints and inability to effectively communicate when there is a language barrier was reported to be more of a

difficulty in providing caring care, rather than an issue with the patient themselves, as is similar when patient families are more outspoken than the patient.

Nursing Care During COVID-19

Nurses (N=15) were asked to describe how providing nursing care during the COVID-19 pandemic has changed their level of caring, as seen in Table 1. A worldwide pandemic brings with its inevitable challenges and changes to nursing care. As nurses described the major changes to caring that they experience, three subcategories were identified, including (a) new rules causing disconnect, (b) care and presence of the nurse, and (c) concerns and fears.

Subcategory #1-New Rules Causing Disconnect. Although new rules are considered necessary in the medical community, nurses (n=7) propose that these rules have inadvertently caused a disconnect in the nurse-to-patient relationship. A physical disconnect was reported to exist as a result of "having the barrier of the masks" and other PPE (nurse #1, #12, & #15). Fewer visitors were present as a result of new rules, and rule-breaking was also an issue that caused a rift in nurse caring. Many nurses (n=5) shared that the presence of masks and other PPE made it difficult to "really connect with someone when this [motions to eyes] is all they can really see" (nurse #2). Another nurse said, "there's a lot of facial expressions you can't [see]" when "they can't see your face" (nurse #4). This same nurse also mentioned that in her facility "the significant others are supposed to wear a mask. And that just stinks for like their first family photo, the dads' wearing a mask" (nurse #4). Another nurse referenced COVID-positive patients specifically to share her experience in "not being able to connect as much" with them (nurse #12). She said,

> [H]aving to gown up and be in all of that stuff like makes me a little less comfortable talking to them more, trying to keep distance or get out of their room because I'm sweating… not being able to like get as close to them or spend as much time with them as I'm comfortable with... we've had fewer visitors with COVID also so that kind of takes away from like getting to know the patient's family, you know, their dynamics more. (nurse #12)

Another nurse shared a similar regret for the lack of visitors as she attempts to sympathize with her patients since "this is a big and great emotional time and fantastic time in their life" and other family members do not get to be a part of it (nurse #11).

While these rules create physical barriers to caring care, they may also cause tension between the nurse, patient, and patient families. One nurse reported that "people have been trying to break the [visitor] rules" (nurse #6). She reports being a rule follower and when people are "refusing to wear a mask in the room…it makes them not bond with you well when you're like 'I'm sorry, you know, that's the rules, you got to put on your mask'" (nurse #6). "You feel like the bad guy and they almost are like aloof with you after that" (nurse #6). She attributes this to "more family members than usually the patient themselves" (nurse #6). COVID-19 has brought with it much more than rapidly spreading infectious disease, it has brought new challenges to provide caring care.

Subcategory #2-Care and Presence of the Nurse. Among perinatal nurse (n=7) reports, conflicting opinions about the level of nurse caring and the presence of nurses with patients being affected by the COVID-19 pandemic were stated. Some nurses reported that more time was spent with COVID-positive patients, while others suggested that less time was spent with COVID-positive patients due to fears of contracting or

spreading COVID-19, the discomfort of wearing full PPE, and the need to re-wear PPE for a time (nurse #4, #7, #12, & #15). Other nurses suggested that patient care was unchanged as a result of COVID-19 while some made suggestions that more attentive care was offered during the pandemic (nurse #4, #10, & #14). Noted by other nurses, it was mentioned that less care and resources were given to certain patients due to the pandemic (nurse #5 & #15).

For example, one nurse stated, “I don’t know that it’s [COVID-19] necessarily affected my care…If anything, the nurses are probably in there [COVID patient rooms] for longer periods of time instead of the in and out that we normally would do” (nurse #4). In support of this statement, another nurse added,

> I think I am more personal with patients because patients have less family there... I was always personal, but I had a room full of the family so that what they needed me to interact with them on a ‘hey today's your day’ type basis was more limited. And in my nursing care now it's me and one other family member so like I'm their hype squad too and so I think it makes me, has made me far more, I want to fill in the gaps for who all is not there… With COVID-positive patients just like really attentive, as in like they're in an unknown time and unknown pandemic, an unknown illness so just really giving them utmost care because it's unknown for all of us and they know that. (nurse #13)

These two nurses are under the impression that more time and attentive care is given to COVID-positive patients, while others shared differing opinions. For instance, another nurse said,

> I feel like [having] COVID, in general, is a big stigma on patients. I don't feel like sometimes they get the full care that other patients get just because of having COVID. For example, patients who may need lactation services. They [lactation staff] may not want to go and see that patient or provide full care to them in regards to thinking they're going to spread it [COVID] to someone else but like that patient is missing out on that opportunity, just because of having COVID. (nurse #5)

Other nurses mentioned "the potential to lower the quality of care or caring care because you [nurses] want to group everything you can whenever you [nurses] go into that room or just buzz in the room and be like 'hey, are you okay?'" (nurse #15). This nurse also mentioned wanting "to keep your [her] distance" from patients to decrease the risk of getting COVID-19 from them, which "could really hinder the care that you [nurses] provide" (nurse #15). In a similar response, a labor and delivery nurse said she felt unable to,

> [C]onnect as much as with patients who are [COVID] positive. Having to gown up and be in all of that stuff like makes me a little less comfortable talking to them more, trying to keep my distance, or getting out of their room because I'm sweating… (nurse #12)

She also shared that she did not like "not being able to like get as close to them [patients] or spend as much time with them [patients]" (nurse #12). Another nurse shared her thoughts in saying,

> I hope that it hasn't affected my care towards patients. I'm probably not as careful around patients as I should be at this point… Do I really need to wear a gown and

> gloves and eye protection, just to hand off a cup of ice water? Which I guess could affect patient care as far as if, you know, I'm caring for a COVID patient and a non-COVID patient, I guess, maybe I don't respect the, you know, how serious it is as much… (nurse #10)

This lack of care for procedures could be detrimental to the spread of COVID-19, but the reality was spoken by this nurse, as she indicated burnout in following the strenuous new pandemic-related protocols. Another nurse shared a story about a decrease in the presence of nurses with patients as a result of the COVID-19 pandemic. She stated,

> [W]e ran into nurses probably not even wanting to go in the room as often because of having to reuse PPE… After we were able to be vaccinated my level of comfort working with patients changed, but also about that time, we had more adequate access to PPE and weren't having to reuse the same mask for three months. (nurse #7)

Her response indicated a betterment of the caring situation after more resources for protection became available.

Subcategory #3-Concerns and Fears. Many nurses (n=7) reported concerns and fears surrounding all things COVID-19. They shared fears of not having enough PPE, the difficulty of consistently wearing protective equipment, fears of the unknown, and the evolution of the unknown becoming "not as daunting" (nurse #7, #8, #9, #14 & #15). One nurse mentioned COVID-19 as being politized, causing it to be "a touchy subject to talk about" and making conversations with patients and families awkward (nurse #3). Another nurse shared how "everything was scary and unknown," making her not "even wanting to go into work" (nurse #7). She went on to share her "biggest fear" was for

herself and her well-being, not knowing how sick she could get or possibly bringing COVID-19 home to her family (nurse #7). She reported that not having adequate PPE and "having to reuse PPE…dampened patient care for sure" and added to feelings of uncertainty (nurse #7). Another nurse shared similar remarks,

> When COVID first hit, and we were having to be, you know, no downtime for nurses, we don't get the quarantine, you know, we didn't stay put at home. I think when it was first very scary…when we didn't have masks…but it was like am I going to pick up COVID from this patient? So, it was almost like you wanted to keep your distance. And that, you know, that could really hinder the care that you provide. (nurse #15)

The theme of nurse weariness continued as one nurse shared,

> [I]t's just been a very difficult stretch of time for everyone, patients and nursing staff alike… I have a different empathy and try to put myself in the shoes of the patient who is hospitalized during or while having COVID…I can only imagine that they feel a bit ostracized and we're coming in, in these, this hazmat dress… It is, it is tiring over the long haul to have to go to these extreme measures when caring for [COVID] patients… so I probably have had less patience and less desire to jump in, and you know volunteer to take the COVID patients. (nurse #9)

Although nurses experienced the weight of fear and concerns for themselves and their own families, other nurses expressed new concerns for the patients under their care. As previously mentioned in the last subcategory, a nurse reported the need to be "really attentive" to COVID-positive patients because they are in "an unknown time and unknown pandemic, an unknown illness" (nurse #13). Another nurse mentioned the

added difficulty of not only providing nursing care but in the perinatal setting, also "monitoring their [patients], you know, decline if they're [patients are] actually sick with COVID" and "in the pregnant patient…you also have to worry about how COVID's affecting their baby too" (nurse #8). The added pressure of monitoring for unknown events in an unknown disease state was reported by perinatal nurses to take a toll. However, another nurse shared her experience from the beginning of the pandemic to now. She said,

> In the beginning, I feel like it was a little bit more challenging, especially for people that may be had COVID-19 because you have to gown up, do all the things in order to go into their room and like, whereas now I feel like it's not quite as, now that we know more, it's not as scary, I guess, as like a healthcare provider. Like you're not as nervous and hesitant to like go into their rooms and do what you've got to do. Whereas before they're like 'Oh, you need to distance, you need to be careful, you need to…' And so now you can, you know, go in there and kind of get done what you need to get done, even though you still have to, you know, obviously take all the precautions and stuff… the unknown is not as daunting because there's more known. (nurse #14)

It is the hope that as time continues to pass and "more [becomes] known," that nurses may feel more comfortable providing care during the COVID-19 pandemic (nurse #14).

Maintaining Belief

This and the following interview questions were based on Swanson's theory of caring, as it provides an outline for nurse caring and can easily be applied to the perinatal setting. Maintaining belief is the philosophical attitude of the nurse that describes their

belief of whether the patient will overcome their health events to have a meaningful future (Swanson, 1993). This interview question to perinatal nurses (N=15) was formed based on the idea that nurses perceive an attitude or belief of a patient upon meeting them. Nurses were asked to describe how their initial belief of a person's abilities changes when they perceive patients as possessing stigmatizing characteristics, as seen in Table 1. Two subcategories emerged from nurse responses including (a) nurse attitude changes toward patients and (b) nurse assumptions of patients' abilities.

Subcategory #1-Nurse Attitude Changes Toward Patients. Upon the first perception of stigma among perinatal patients, nurses (n=12) shared that in some way, their attitude toward the patient changed. This attitude may manifest in a way that treats a substance-abusing patient as if "they don't care about their health or prenatal care" (nurse #1). Another nurse said, "I almost feel like it's futile to educate patients that have been stigmatized…they're still not going to understand so what's the point?" (nurse #2). This nurse is also making an assumption about the patient's abilities, which will be discussed in the next section, but she is changing her attitude about not wanting to educate the patient as a result of their perceived stigma. Another nurse similarly adds that she changes her initial belief of a patient on a "case by case basis" (nurse #7). She said,

> [F]or example, if I find out that someone is a drug user and has been a drug user their entire pregnancy. Of course, that changes, it can change the way you talk to them, the way you approach them, the way you ask them questions. You may not, or I may not believe everything they say. Especially if I know they are a drug user, it's documented in their chart, and they deny it. (nurse #7)

Her attitude toward a drug-abusing patient is skeptical and changes the way she interacts with the patient. Another nurse adds that she hopes her attitude changes "in a way that's beneficial towards the patient," but she also said she "probably would be less patient with them [stigmatized patients]" (nurse #10).

Other nurses shared the need to spend more time with the patient, indicating a more curious attitude that better assesses patients' backgrounds and "why they are the way they are" so that "you're [the nurse is] able to provide better care and then hopefully not stigmatize certain patients in the future like you might would have" before (nurse #8). In following with this hope of not stigmatizing future patients, one nurse admitted that she has "been proven wrong a lot" as "the story has developed" (nurse #13). She shared that as she learns more about a patient, she can see "the reason she's [the patient is] being this way is because these things in her life are painful" (nurse #13). She admitted that "it is hard to change my [her] initial thought," but that her initial attitude toward the patient often does change (nurse #13). Another nurse shared that spending time with a perceived stigmatized patient is necessary,

> [T]o get to know them a little bit more because they're more than just that stigma or that label, that people like kind of put on. And, also, I just feel like there are deeper things underneath as to why like certain things are happening. So, talking with them and really getting to know them and not just their, like a certain stigma that's associated with them… some of the things that kind of being stigmatized like there are deeper issues as to why some of those things are coming out. So, talking to them and trying to see like, okay, 'what can we do for you, how can we best help you in your situation?' (nurse #14)

This nurses' attitude toward perceived stigmatized patients suggests that "they're more than just that stigma" (nurse #14). Meanwhile, other nurses shared that they often form their first perception of a patient on the report they get from the previous nurse. One nurse said,

> [Y]ou already have a… profile built on a patient before you meet them just by seeing how they walk in the door, how they are, their attitude… or the report that's given from one person to another gives off a lot of, you know, they're going to give their own opinion in that report, and although you don't want to take in that opinion just because it's given in their report you already kind of have that stigma of that patient. (nurse #11)

Another nurse said, in reference to getting a report from opinionated nurses, "I tend to not listen to that kind of stuff, honestly, and go in and just meet the patient myself and try to build a rapport myself," in an attempt to form her own maintaining belief and attitude toward the patient (nurse #4). Bias in nurse reporting and nurse culture was also discussed as an issue and means of change to promote improved patient outcomes, which will be discussed in that corresponding category.

Two other nurses reported their attitudes and feelings to be as if they have "their guard up" or "feel uncomfortable to take care of" patients who possess a perceived stigma (nurse #3 & #5). These nurses were transparent in their responses and all nurses indicated a need to adjust their care in some way for perceived stigmatized patients. Although nurses may change their attitude toward a patient, some may even assume what the stigmatized patient's abilities are and treat them accordingly. Nurse assumptions of patients' abilities will be discussed in the next subcategory.

Subcategory #2-Nurse Assumptions of Patients' Abilities. Perinatal nurses (n=6) reported assumptions about patients' abilities upon meeting them. They based these assumptions on appearance, patient history, and demographics. In some cases, nurses report it feeling "futile to educate patients that have been stigmatized" if "they're still not going to understand" (nurse #2). Another nurse shared that she "might talk to…lower socioeconomic status people or lower education levels…a little different and then later kind of find out that they understand a little bit better that I [she] initially thought" (nurse #6). Caring for patients where a language barrier exists or very young patients may also bring an assumption of a lack of understanding of the things the nurse is attempting to communicate, and the nurse may feel that "the message is still not gotten across," despite all efforts (nurse #15). Sometimes assuming the level of understanding of a patient could be detrimental in situations like newborn care.

Another nurse even mentioned her assumption that patients who are "homeless or have a long history of drug abuse, that may be their level of education and knowledge isn't the same as a more status quo patient" (nurse #10). She went on to say that she "might pay more attention to like making sure they're up to date on getting vaccines if I [she] know[s] they haven't had access to health care or prenatal care lately" (nurse #10). The assumption of the nurse can, in a case as nurse #10 described, prompt even more thorough care than what may be given to a "status quo patient" (nurse #10). Similarly, another nurse discussed her "unfair assumption" that a "grossly obese patient maybe is not as compliant with her care, maybe she doesn't like take care of her health in the way we [nurses] would recommend," causing an assumption to possibly guide the care and interaction between the nurse and patient in a different direction due to perceptions of

stigma (nurse #9). In addition, a nurse shared that she "may not believe everything they [a drug-abusing patient] may say," again, causing a rift in the nurse-to-patient relationship of trust and open communication (nurse #7). These maintaining beliefs of patients take place as the initiating moment between the nurse and the patient, moving forth into a desire to get to know the patient on a level deeper than the surface.

Knowing

Knowing, or the desire to get to know the patient on a clinical and personal level is the second part of the caring process. Swanson also calls this knowing stage, informed understanding, where the nurse evaluates all aspects of a patient's condition and engages with the patient to establish their therapeutic caring relationship, which will enable the progression of the caring process (Swanson, 1993). In the interviews, perinatal nurses (N=15) were asked to share how their desire to get to know the clinical condition or situation of their patient changes when they perceive their patient as possessing a stigmatizing quality, as seen in Table 1. Of nurse responses, two main subcategories were identified by the researcher, including (a) desire to know and (b) lack of desire to know. The majority of nurses (n=12) revealed a desire to know the clinical condition and situation of the patient, while few (n=4) reported a lack of desire to know perceived stigmatized patients as well.

Subcategory #1-Desire to Know. As perinatal nurses (N=15) answered this interview question, many (n=12) reported a present desire to get to know the clinical and personal situation of perceived stigmatized patients. A general desire to explore how perceived stigmatized patients gained their stigma and what happened to make them who they are today was noted by many nurses (nurse #1, #5, #7, #8, #10, #11, & #14). One

nurse even said that sometimes “after you have taken care of them [stigmatized patients] and get to know them better, then you know, sometimes that stigma might go away after you see the reasons for who they are, [and] why they do what they do” (nurse #8). Another nurse shared that she feels a “need to know the full clinical picture [of a patient], so that you [nurses] can give them [patients] the care that they need” (nurse #1). She also mentioned wanting “to learn as much as I [the nurse] can, and sometimes the clinical picture does help, along with the, you know, the social background and that part of the picture” (nurse #1). Similarly, another nurse expanded this idea of desiring to know the patient more for the purpose of giving the patients individualized care. She said,

> I really try and focus on how they're going to take care of themselves with a certain condition… Like whether they were drug dependent and have Hep-C now, are they taking care of that or are we just going to like let that go? And [I] kind of judge it based on what they want to do about their certain condition. Again, I want to help as much as possible, but I definitely don't want to push anyone to make them feel uncomfortable if they're not ready yet. (nurse #3)

Not only does she desire to know the patient, but she also wants to assess their readiness for self-improvement and treatment.

Other nurses shared a desire to know the patient’s background in order to evaluate how they got to where they are. One nurse said she wants to “know the clinical situation [of stigmatized patients] even more to try to understand,” to “look into their background and say like what’s changed or, you know, if this has just been something that has always been with that patient” (nurse #5). Another nurse shared similar desires but reported that she does not “want to look nosey or anything like that,” as she tries to “see where they’re

coming from" (nurse #10). Even a story of connecting with perceived stigmatized patients was shared by a nurse as she said,

> I've actually bonded with people who did have drug addictions, and who did have issues because if you look a little bit farther into their story they usually have a sad story and they usually don't even love themselves. So, they need that love from us. It changes your perception of, you know, looking at the clinical picture. (nurse #7)

Another nurse also shared, "I feel like I try to get to know everyone. Like, that's something that's very important to me is to try to make everyone feel safe and loved" (nurse #8). A similar desire to try "to help them [stigmatized patients] get to where they want to be" was expressed by another nurse (nurse #14). This same nurse reported wanting "to delve a little bit deeper" "to figure out" "why things are happening in order to provide kind of better care to them. Because, maybe they just, you know, lack education or lack support" (nurse #14). These nurses are exhibiting pride in their profession and desire to gain an informed understanding of their patients to provide optimal caring care.

One nurse found it necessary to specifically investigate the cultural background of "patients from another country" (nurse #15). She listed her desires to know what experiences from the other country the patient may not be reporting, and she stated: "how brave they [foreign patients] are to deliver their babies in a country that doesn't speak their language" (nurse #15). Other nurses sought to find the explanations for patient behaviors in the source of mental illness. One nurse said, "mental health issues do play a big issue in how you can help and treat a patient" (nurse #11). Another nurse stated, "I

would say they [homeless people and drug abusers] almost always either have a mental illness or have been abused or both, so I try to think about that" (nurse #10).

In relation to a desire to know more about the clinical condition and situation of a patient with a perceived stigma, one nurse shared that she does not feel the presence of stigma changes her desire to know the patient, unlike other nurses who were driven to discover more of the stigmatized patient (nurse #4). She said, "I still want to know everything about their clinical picture so that I can give them the best care because that's ultimately what I'm responsible for" (nurse #4). Another nurse shared, "I probably, honestly, have days where I don't feel driven to get to the bottom of the full-back history and story and other days when maybe I do" (nurse #9). Her response was wavering in her desire to know her perceived stigmatized patients more, but she attributed this to personal motivation on a day-to-day basis more than her bias of stigma compared to traditional patients (nurse #9). Her response was coded in both subcategories as she reports both a desire to know and a lack of desire to know the patient at various times.

Subcategory #2-Lack of Desire to Know. Perinatal nurses (n=4) reported a lack of desire to know their perceived stigmatized patients on a clinical and personal basis, which causes a break in the caring process to occur. A lack of desire to establish a therapeutic caring relationship between the nurse and patient hinders the ability of the nurse to be with, do for, enable, and promote improved patient outcomes as a part of Swanson's theory of caring (Swanson, 1993). One labor and delivery nurse shared that a lack of time to explore the patient background and condition is the most pressing reason for not gaining a more informed understanding of the patient (nurse #6). She shared,

> [T]hat patient [drug abusing stigmatized patients] requires, so many extra hands-on works and you honestly don't even have the time to like go through their chart to find out what all is going on with them. And they almost always come in, like about to deliver… I don't know that I've ever had one that wasn't kind of wild and crazy and, you know, just you can barely find out what her name is. So, there's not much time to look back, but I would definitely say I'm definitely not looking into that stuff as I might some other people. (nurse #6)

It was discussed in the previous subcategory that depending on the personal state of the nurse, the desire to "dig deep" into knowing the patient may waver (nurse #9). One nurse said, "maybe there are sometimes when I maybe feel less inclined to dig deep and get the whole story" (nurse #9). Another nurse shared that,

> [I]f they [patients] have limited prenatal care, I probably will just assume there's not much to dig into or if…for the past several years they've used drugs…I just assume that I kind of already know what their medical history is going to contain, whether that's right or not. (nurse #12)

This nurse referenced her assumption about the patient's lack of recorded history as a reason for not pursuing more knowledge of the patient. Another nurse had a different perception as she stated, "when their [patients are] punks, I can be lazier in like, 'I'm trying to help you but you're not letting me help you" (nurse #13). She went on to describe her thoughts by saying "I don't know that it ever changes the care I provide them. I do not desire to get to know them. It does not change my level of nursing care but my caring attitude towards them changes" (nurse #13). This nurse plainly summarized

her thoughts, while incorporating a very insightful divide between nursing care and caring care, as it relates to Swanson's theory of caring.

Being With

Being with, or message conveyed, to the patient is when the nurse verbally and physically conveys the message of fully being with the patient (Swanson, 1993). Being with enables nurses to remain emotionally invested and present with the patient. Perinatal nurses (N=15) were asked to share if they have the same desire to be emotionally present with a perceived stigmatized patient as they do with more traditional patients, as seen in Table 1. Among the nurse responses, three subcategories were identified, including (a) desire to be emotionally present, (b) lack of desire to be emotionally present, and (c) need to be emotionally present. A difference was noted in nurse responses when some reported that they want or do not want to be emotionally present compared to a need to be emotionally connected to certain perceived stigmatized patients.

Subcategory #1-Desire to be Emotionally Present. A desire to be emotionally present with perceived stigmatized patients was indicated by perinatal nurses (n=6) for varying reasons. Some nurses reported a stronger desire to connect with perceived stigmatized patients (nurse #1, #11, & #15). One nurse said,

> I definitely want to make a connection with them [the patient], even if we don't have anything in common…I would like for them to leave the hospital saying that they had the best possible experience that they [could have] had and if I can help with that in any way, I really want to be that person. (nurse #1)

Another nurse said she had similar desires as she said it saddens her,

> [B]ecause a lot of times they're [stigmatized patients are] alone and being in the field that we are, this should be like the most happiest, fun time for them. And they just have so many mixed emotions because they're alone and it's very heartbreaking… (nurse #11)

She went on to share that she feels a need to fill in the gaps and be there for the patient in the absence of her partner and offer "positive reinforcements" to the perceived stigmatized patients under her care (nurse #11). She added that "as far as being there for them, stigmatized or not stigmatized, is always the same" (nurse #11). Her response was also coded in the third subcategory as it reveals the patient need for emotional presence with the nurse.

A postpartum nurse reported bonding "better with 'stigmatized patients' than I [the nurse] do [does] with traditional patients" (nurse #3). She reported that "those [stigmatized patients] are probably the patients that I worry about the most going [discharging] home" (nurse #3). She added,

> [T]hose are probably the ones I like to bond with the most and you try to spend the most time with them in the rooms… because you just want them to know they're supported because more times than not, they have no one else. (nurse #3)

Another nurse reported bonding well with perceived stigmatized patients as she shared an example of communicating with a Hispanic woman in the presence of a language barrier. She said,

> To me, there's something about communicating with a person more with your facial expressions or your eyes or with your gestures or the way that you may touch them or handle them when you can't communicate everything on the spot

> that you're doing. Sometimes I think you almost get to know the person's spirit, a little bit more when you're just communicating nonverbally, I guess, or with what little bit of their language that you know, and then you can smile and laugh about it. I usually end up really enjoying taking care of those patients. (nurse #15)

A nurse reported being open to "come close to any patient" "as long as they are allowing me [the nurse] to" as a means of providing optimal care (nurse #8). In reference to responding to patient openness to bond and become emotionally involved in their care, a Caucasian, Mississippi, labor and delivery nurse of 16 years shared her experience with patients who may place a stigma on her upon meeting her. She said,

> [M]aybe there have been times when I walk into a patient's room, meet them, to take care of them for the day, and this would be more of like a racial situation, and I feel, conversely, even if I'm not thinking anything about them. I sense although I could be wrong, but I sense that perhaps they have a set expectation of me racially… maybe there's a stigma that they attached to me, on the other side of that coin. And so I sense an unspoken expectation, maybe, what they expect of me or how they expect me to take care of them that day or how they expect me to engage with them. And I'll say that I think they expect less than what I would give them, or they expect a negative something, or they don't expect me to love on them the way I might someone else. So, I think that's been one of my favorite things is seeing their wall come down as I love on them the same way that I would somebody else and by the end of the day, I can feel that they trust me, and we have bonded to a level that they did not expect. (nurse #9)

This nurse's story is a beautiful example of Swanson's theory of caring at work, as this nurse pours out caring care on her racially dissimilar patient, she breaks down the walls of stigma to connect and bond with them on a new level.

Subcategory #2-Lack of Desire to be Emotionally Present. A lack of desire to be emotionally present with perceived stigmatized patients was reported by some perinatal nurses (n=7). The nurses shared that their lack of desire to be emotionally present is for multiple reasons including the patient is not emotionally invested in themselves or as a means of protection (nurses #4, #5, #7, & #12). Other nurses just responded with a quick "no" (nurse #2 & #13). One nurse said,

> [I]t's just more of a natural reaction. Like, you know, maybe I don't want to be completely emotionally invested in someone that truly doesn't care or that isn't invested in herself… let me get my care done, let me give you the best care I can, but I'm probably not going to be as emotionally invested… (nurse #4).

Another nurse admitted feeling "more comfortable with a traditional patient" (nurse #5). She said "that doesn't necessarily mean that I don't want to take care of, you know [stigmatized patients]. I just feel like sometimes it's hard to like put your emotions aside depending on, like, the stigma situation" (nurse #5).

Emotional barricades for nurse protection were mentioned by another nurse as she said, "it's harder to be emotionally present for patients that I don't feel like care about their child or care about their pregnancy or care about themselves" (nurse #7). She went on to share,

> I put up an emotional barricade where I don't allow myself to be as emotionally involved, because it can be, you know, hard to accept that this person may be

> taking a baby home that they're not going to take care of or that they're not going to take care of themselves, no matter what I do. Because a lot of times those stigmatized qualities, like someone who is a drug user, or has a history of it, we're not going to fix that problem while they're in the hospital and I like to fix problems like that and it's so, you kind of, I personally, have to emotionally distance myself from things like that. (nurse #7)

Additionally, a nurse shared that she does not desire to be emotionally present because she thinks she "won't impact them [stigmatized patients] as much if they've already, you know, made their life pretty set in the way that it is" (nurse #12). Another nurse added that "being emotionally present is a struggle" of hers anyway, but she thinks it is even more challenging to be emotionally present with stigmatized patients rather than traditional ones (nurse #10).

Subcategory #3-Need to be Emotionally Present. Few perinatal nurses (n=3) reported the patient need as the reason for being emotionally present, aside from their desire for emotional presence with perceived stigmatized patients. One nurse even shared her "first hesitation is to like build up those walls and not be" emotionally present, but she went on to say,

> I feel like you [nurses], almost need to be more emotionally present because they [stigmatized patients] don't have that kind of traditional, maybe, support system… so you need to be like that person for them to try to help them through whatever it is. (nurse #14)

She added "in order to be caring to them… put those [walls] aside and be there and be emotionally present for them" (nurse #14).

Another nurse made note of the "pushing process" (nurse #6). She said, "you have to be very connected with almost all of the people, but specifically them [stigmatized patients under the influence of substances] because they are coherently not really able to focus well" (nurse #6). She shared, "we really have to rally together to give her extra support than a regular, traditional patient at that [pushing] time" (nurse #6). This necessary nurse-to-patient connection was noted by another nurse as she shared the need to fill in the gaps for stigmatized patients that are alone, regardless of the nurse's personal desire to emotionally engage (nurse #11).

Doing For and Enabling

Perinatal nurses (N=15) were asked to evaluate whether they serve and enable perceived stigmatized patients to the same degree that they do traditional patients, as seen in Table 1. Doing for and enabling are considered by Swanson to be therapeutic actions provided by the nurse to the patient (Swanson, 1993). These therapeutic actions of doing for the patient are serving them as they would if they had the ability to do it themselves and enabling the patient to practice self-care (Swanson, 1993). As nurses were asked to compare their therapeutic actions for perceived stigmatized patients to traditional patients, three subcategories of responses were found, including (a) less doing for and enabling, (b) the same amount of doing for and enabling, and (c) more doing for and enabling.

Subcategory #1-Less Doing for and Enabling. Some perinatal nurses (n=5) reported less serving and enabling of perceived stigmatized patients than for traditional patients. The reasons for this were reported to be a lack of desire to engage with the stigmatized patient, a lack of resources for stigmatized patients, and a language and

cultural barrier that may hinder therapeutic actions (nurse #2, #6, #12, #13, #15). One nurse reported that when she has a perceived stigmatized patient, such as a patient who is being difficult or a "punk," she tends to "check out" and not "enable or "pet as much" (nurse #13). Another nurse had a similar response by saying that she serves and enables the stigmatized patient when she is "at the bedside," but "outside of the room," she is disconnected and does not serve the patient's needs as well (nurse #2).

A lack of resources was reported to be a reason for less serving and enabling. One nurse shared an example in saying,

> I am also a certified lactation counselor so a woman who is, has a positive UDS [urine drug screen] is not allowed to receive help from me for breastfeeding. So, I might go a little over the top, for someone who really, really wants to try to breastfeed, tell them all these resources, things like that and that person [with a positive UDS], I wouldn't do anything like that, because the one I'm legally not allowed to, but, you know, I wouldn't like try to find a local [breastfeeding] support group for moms, you know, with positive UDS or something like that. (nurse #6)

Similar to a lack of resources, a lack of efficient language interpreting technology may cause a decrease in the nurse's ability to provide therapeutic actions to the perceived stigmatized patient. One nurse shared that "with the non-English speaking community, just having to use the translator…takes more time and there's confusion," and she reported a "need to be more motivated to do" more serving and enabling despite the language barrier (nurse #12). Another nurse shared that if she knows "there are some things that that culture values or prefers" she tries to do that but there are still many

therapeutic actions that are left undone due to a lack of understanding of the needs and preferences of certain perceived stigmatized patients (nurse #15).

Subcategory #2-Same Amount of Doing For and Enabling. Many perinatal nurses (n=8) reported providing the same amount of therapeutic actions of serving and enabling to perceived stigmatized patients as they do traditional patients. Most of these nurses pride themselves on providing the same level of service to all of their patients, regardless of the presence of perceived stigma (nurse #1, #3, #4, #8, #9, & #11). One nurse, as mentioned in the last subcategory, reported providing the same level of care to the patient "in the room, at the bedside with the patient" but not being as engaged in service when "outside of the room" (nurse #2). A labor and delivery nurse said that her "hospital has such a high population of stigmatized patients that they really are our [their] traditional patients" (nurse #1). Another nurse reported trying "to treat everyone kind of the same," to provide equal levels of caring to all types of patients (nurse #3). Another nurse shared similar thoughts but stated, "it's a little harder" to provide equal care if "the stigma, like, starts to become like an issue with how they treat me [the nurse]" (nurse #5).

Other nurses reported pride in their "calling and opportunity to serve" and desire to "give the same type of care to all" patients (nurse #9). The nurse's routine was noted as a means of consistent care to all patients. As one nurse said, "I treat all my patients the same, I encourage them. I help them in every way I could. I do, my routine, it never changes" (nurse #11). She explained further to say, "the way I approach them after [learning] their personality…approaching them is different" but the care "never changes" (nurse #11).

Subcategory #3-More Doing For and Enabling. Few perinatal nurses (n=3) reported more serving and enabling of perceived stigmatized patients than traditional patients. The reason for this, among all three nurses reporting this behavior, was due to the higher demands of needs for the perceived stigmatized patients (nurse #7, #10, & #14). One nurse reported,

> [P]atients that we stigmatize can be more demanding than patients that we don't stigmatize. And I think that is because they recognize that if they aren't as demanding as they are, they may not get the same quality of care. A lot of times, you know, you're in their room more… because they are requesting more or have behaviors that require you to be at the bedside. (nurse #7)

Similarly, another nurse said,

> I baby a stigmatized patient more because I feel like maybe they're lacking that. And I hadn't really thought about it until now, it may be because I think that they can't do it at a level that I would like it to be done at… I like to think I would treat them equally or maybe even a little bit more serving towards a stigmatized patient. (nurse #10)

The other nurse reported the need to spend "even more time in" the perceived stigmatized patients' rooms "as opposed to the traditional ones'" (nurse #14). She provided the example of "a single mother versus one that's married" (nurse #14). "At least like the traditional one has a little bit more support," not requiring so much therapeutic action from the nurse (nurse #14). All of these methods of therapeutic communication enable optimal patient outcomes.

Improved Patient Outcomes

Improved patient outcomes, or positive patient well-being, are the final step to the caring process and intended goal of all nurse caring behaviors (Swanson, 1993). Perinatal nurses (N=15) were asked, as the final research question is seen in Table 1, to describe some ways they think the level of nurse caring can be improved in situations where the patients possess perceived stigmatizing qualities, in order to promote optimal patient well-being. Nurses presented ideas of environmental changes that could be made, organizational changes, and entire shifts that must occur in nurse culture in order to improve patient well-being in situations where perceived stigma exists. Three subcategories were identified among nurse responses including (a) educating nurses and changing nursing culture, (b) standards of care and expectations, and (c) changes in a nursing environment.

Subcategory #1-Educating Nurses and Changing Nursing Culture. Educating nurses in various avenues and stages of nursing, along with making strides toward shifts in nursing culture were reported by perinatal nurses (n=6) to be methods of improved patient outcomes when perceived stigma is present among patients. One nurse proposed that "educating the nurse" to "treat all patients with the same respect that they deserve within their own situation" would improve caring among perceived stigmatized patients (nurse #1). She was not specific about how this education would look in real-life circumstances, but another nurse added that changing nurse caring when perceived stigma exists "starts at the foundation of nursing education and really pushing the fact that we [nurses] really need to use empathy" (nurse #2). She went on to say, "we [nurses] really need to possess that as an individual and grow on that," which challenges the idea

that personal growth and perceptions of stigma greatly affect nurse caring as well (nurse #2).

A mention of sensitivity training to "make you [nurses] realize like what stigma, like which ones do you have and like, how can you better" "get over those in order to provide better care for your patient" was made by a nurse (nurse #14). She also brought up the need to "self-reflect" on qualities of the stigma that the nurse perceives and ask, "how do I get over that and…look at the individual patient, not the certain qualities that are associated with them?" (nurse #14). She added that it may be helpful to have and offer "different resources" like "educational pamphlets, or things like that" that attempt to "meet their [stigmatized patients'] needs" (nurse #14). Another nurse made note of the importance of providing "culturally competent care" for patients who are foreign to the nurses' geographical location and culture (nurse #15). She proposed that lessons on culturally competent care would be helpful as "patients or people from, you know, whatever different type of people group" would "give feedback or [describe] things that they would expect" from nurse caring in relation to their cultural preferences (nurse #15).

A labor and delivery nurse made a reference to caring for patients who have different qualities than the nurse and the need to educate nurses to care in the face of diversity. She said,

> [I]t starts with just good [nursing] education and therapeutic communication and understanding that there are people from all walks of life that you're going to have to serve and take care of and they're going to be people completely different from you and people who don't agree with you, and you just have to understand that that's part of it and you still have to take care of them the same way. (nurse #10)

This idea of therapeutic communication and informed understanding of the patient are themes that can also be recognized in Swanson's theory of caring. Another opportunity for change noted by the nurses was a shift in nurse culture to change or eliminate the discussions surrounding stigma. One nurse said,

> I think we probably have a bad habit of sitting around the nurse's station and talking about all the things… but it would probably be helpful if we would, you know, maybe tame our own tongues and not contribute to even probably talking about things. We don't even realize, we are contributing to that stigma about certain patient populations… or just, you know, making sure I'm responsible for what I say, and what I don't say and not adding to, you know, not adding fuel to the fire… don't encourage a conversation or don't participate in the conversation that might be doing that very thing, or maybe speak up sometimes when it needs to be nipped in the bud. (nurse #9)

These methods of nursing education and a shift in the nursing culture could enable more effective caring care toward perceived stigmatized patients and possibly decrease the level of perceived stigma to optimize patient well-being and improve patient outcomes.

Subcategory #2-Standards of Care and Expectations. Some perinatal nurses (n=5) recommended that changes in standards of care, supported by healthcare organizations, and higher expectations of caring care for nurses may improve patient outcomes where perceived stigma exists. One nurse noted that "the organization and management also has to support" the idea that "diversity, equity, and inclusion help to enhance patient care" (nurse #1). Another nurse mentioned the importance of standards of care and being "held to a higher standard of care with everybody that" is under nurses' care (nurse #7). She

shared that there are "standards of care that we kind of already have set in place, help to ensure that we give the same level of care to those different [stigmatized] people" (nurse #7). "A routine point of care" was mentioned by another nurse as she explained,

> [E]verything should continue to be the same. How you approach the patient, obviously, is going to vary from patient to patient. And I think just the way report is given should be changed to only give what's pertinent to the patient and what's pertinent to care…I think if all that fluff is just left out, you go into the room and make your own assumption and make your own care and make your own…perception of how the patient is and what to expect from them. (nurse #11)

A shift in the expectation of nurse reporting from patient to patient could be a beneficial change for reducing perceived stigma surrounding patients in nursing routines.

Other nurses reported changing personal expectations for their own nursing care as a means of more optimal care for perceived stigmatized patients (nurse #8 & #13). One nurse said she would recommend "taking a step back and remembering that we [nurses] have a job to do. The patient is there to be cared for, no matter, you know, who they are, what they believe" (nurse #8). She added that "just listening to what they need and just following that throughout your, you know, entire time that you're caring for them" is another method of offering positive caring care to patients (nurse #8). The other nurse who reported similar changes in personal expectations stated that "just treating every single patient as your family member, as your doctor's most prized patient" is a mindset shift that could be applied (nurse #13). She added,

> [O]ften, in our line of work, we treat the patient based on how much their doctor adores them and loves them and how VIP they are to their specific doctor. And if

> every patient was VIP in that way, that could definitely improve… there's always a choice. I don't think there's any practical way about it other than every patient is my, as important as my best friend, sister, daughter, and I'll treat her as such. (nurse #13)

Although many changes in standards of care and personal expectations can occur, physical and environmental barriers still exist when caring for perceived stigmatized patients.

Subcategory #3-Changes in Nursing Environment. Perinatal nurses (n=7) recommended changes that must be made in the nursing environment in order to promote more positive patient outcomes in situations where perceived stigma exists among the patient. A nurse mentioned the strain that COVID-19 has put on nurses, causing them to not "want to do hourly rounds because they didn't want to gown up and do all that stuff" (nurse #3). She added that "right now in nursing, it's so weird because no one wants to be there… people need to like love their profession again" (nurse #3). When asked about changes she thought maybe helpful she said, "I don't think there's a quick fix to help nurses… safer staffing or, you know, extra bonuses, or I don't even know if that would help… I think it's just [going to take] time" (nurse #3). Other nurses suggested more concrete changes to the environment that may assist in more optimal patient outcomes.

A few nurses were specific to changes among the individual patients and nurses as one said, "sometimes I think it's okay to change the patient assignment… making sure there's a good fit between the patient and the nurse" (nurse #4). Another nurse also mentioned "if something about the patient is going to be a little more time consuming and to provide them good care, you [the nurse] need[s] a little extra time," "looking at

staffing ratios" may be necessary (nurse #15). The other nurse added that "a one-on-one talk with the patient" may assist in getting the patient's attention and exploring the reasons for "having a stigma toward the patient" (nurse #5). Other nurses added practical changes in the nursing environment like a more effective relationship between social workers and nurses and more efficient translation devices for times when a language barrier exists (nurse #6, #7, #12, & #15).

A nurse mentioned the involvement of social workers to offer "better resources prenatally would be the only true thing that we [nurses] could [do to] help" to prevent, for example, patients from "coming in [to deliver] intoxicated" (nurse #6). Additionally, a closer involvement of social workers with the nurses was suggested as a means of improvement (nurse #12). This nurse said,

> I would benefit or enjoy working more with a social worker for some people, just because there's so much that I don't really understand… maybe if we can work more with the social workers to like figure out a plan or like how we could help them when they leave or care for their kids, I think that would help a lot… or even to like to have a meeting with them about the patient, you know. We kind of come in passing with them [social workers] in the hallway but we don't really like share anything with them [about the patient]. (nurse #12)

Furthermore, a tangible method of change was suggested to be "if each room had translator abilities," "something that's on the spot, that you don't have to search down," "that's a little more easily accessible" (nurse #15). The current translator situation at this facility was described as one translator iPad that is shared among both perinatal, labor and delivery, and postpartum units (nurse #7 & #15). The presence of the device was

reported to help “because it’s made it a little bit quicker for us [nurses] to assess them [patients with a language barrier] and to translate what we need to do,” but there is room for improvement “as far as being able to meet their care [needs] in a timely manner” (nurse #7). Promoting informed and safe caring care is noted in these nurses’ suggestions for not only more efficient translator capabilities, but also for suggestions of better staffing ratios and closer work with social workers.

Trustworthiness

Trustworthiness of data collecting, analysis, and reporting is of utmost importance to the researcher as contributions to nursing research must achieve a standard of accuracy and honesty. No research was conducted until the study was reviewed and approved by The University of Southern Mississippi’s Institutional Review Board (IRB), protocol number 21-316. Trustworthiness was held in high esteem throughout the research process as transparency of data recording, coding, and analysis is clearly presented and exhibited among the study findings. As content was analyzed, the researcher prioritized the validity and understandability of all reported information (Elo et al., 2014). Trustworthiness was also established by providing credibility, transferability, dependability, confirmability, and authenticity (Elo et al., 2014; Shenton, 2004). Credibility is found where the study participants were described in the description of the sample section, established research methods were used and discussed, the current was literature examined in Chapter II, and honest interview responses were encouraged from nurses (Elo et al., 2014; Shenton, 2004). These interview responses were directly transcribed, and direct quotes were used to code, identify, and support subcategories for each predetermined category. The researcher’s field notes were also utilized in the data analysis process. Transferability was

evidenced by the ability of the study results to be applied to a broader area of perinatal nursing. Dependability was demonstrated by the ability of the study to be repeated, using the detailed data collection and analysis process to likely find similar results (Elo et al., 2014; Shenton, 2004). Confirmability was found in the objectiveness of the researcher to accurately analyze and report data in a manner where other researchers would agree upon the accuracy, significance, and meaning of data (Elo et al., 2014; Shenton, 2004). Authenticity was achieved through the presentation of possible realities that were supported through interview quotes and context (Elo et al., 2014). All of these elements were carefully considered and incorporated by the researcher to promote the most reliable and valuable contribution to nursing research.

Summary

This qualitative descriptive study was conducted by interviewing 15 Southeastern perinatal nurses using Zoom to assess their perceptions of caring in perceived stigmatized patients in the perinatal setting during the COVID-19 pandemic. Nurses were asked to describe how they show caring care to patients, define their perceptions of stigma among patients they care for, discuss changes that the COVID-19 pandemic has ushered in, and reflect on how Swanson's theory of caring is applied to their care of perceived stigmatized patients. Many nurses discussed similar events and perceptions within the perinatal setting, with few outlier reports. These nurse interview quotes were coded in a Microsoft Word document chart with predetermined categories and further organized into subcategories based on nurse responses. Trustworthiness and accuracy of data coding and reporting were held as a top priority of the researcher. The perinatal nurses' perceptions of caring for perceived stigmatized patients will assist in extending Swanson's theory of

caring to applications of how caring is affected when perceived stigma exists among patients. Chapter V will provide further discussion of the findings, conclusions, and recommendations for further research and actions.

CHAPTER V – DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

Overview

Perceptions of nurses caring for perceived stigmatized patients during the COVID-19 pandemic in perinatal settings were explored by interviewing 15 Southeastern perinatal nurses using Zoom. The interviews consisted of questions based on Swanson's theory of caring, used as the guiding conceptual framework for this qualitative descriptive study. Hsieh and Shannon's (2005) directed content analysis method was used for data analysis, to enable systematic coding of interview data and further extend Swanson's theory of caring. Predetermined categories, based on the interview questions and Swanson's theory of caring, were used and subcategories were made to organize nurse responses within the categories. The research questions used to anchor the study include:

1. What are the perceptions of caring in perinatal nurses who deliver care to perceived stigmatized patients in the perinatal patient population?
2. What are the perceptions of caring in perinatal nurses as they deliver care to perinatal patients during the COVID-19 pandemic?

After conducting 15 nurse interviews, the researcher coded all data and described nurse responses in detail, as seen in Chapter IV. Descriptions of how nurses perceive they provide caring care, what they perceive as a stigma among their patients, and patients who are difficult for them to provide caring care for were discussed. Additionally, nurse perceptions of how they provide caring care to perceived stigmatized patients, based on Swanson's Structure of Caring were described (Swanson, 1993). Changes in caring care

as a result of the COVID-19 pandemic were also explored. This chapter will further interpret and discuss the study findings.

Interpretation of Findings

The researcher perceived the reports of overall compassionate caring care, as described by Southeastern perinatal nurses, to serve perceived stigmatized patients as a refreshing attitude, despite the presence of challenges that arise for nurses as a result. Within the interviews, nurses were provided a moment to stop and evaluate their care toward perceived stigmatized patients, compared to more traditional patients they may serve. Multiple nurses indicated they "hadn't really thought about it [caring for perceived stigmatized patients] until now" at the interview. These interview questions provided an opportunity for a nurse to define how they provide caring care to patients; define their perception of stigmatizing qualities among patients; describe patients who they perceive as difficult to provide caring care for and discuss the changes to care that have occurred due to COVID-19. The nurses were then asked a series of five questions that follow Swanson's Structure of Caring to provoke them to consider how their desire or presence of a maintaining belief, knowing, being with, and doing for and enabling changes or adapts when they are caring for perceived stigmatized patients compared to traditional patients (Swanson, 1993). Nurses were also asked to share some ideas for improved patient outcomes when perceived stigma exists among perinatal patients. Swanson's (1991) definition of caring was the description of a caring, nurturing relationship with another individual who is valued by the nurse, that nurses were encouraged to consider as they answered the interview questions. Study findings will be discussed under the research questions in this chapter.

RQ1: What are the perceptions of caring in perinatal nurses who deliver care to perceived stigmatized patients in the perinatal patient population? A discussion of the first research question will be provided under categories of showing caring, nurse definitions of stigmatizing qualities, patients hard to provide "caring" care for, maintaining belief, knowing, being with, doing for and enabling, and improved patient outcomes. The theory of caring section will provide a summary of how the theory was supported by the findings.

Showing Caring

Perceptions of nurse caring, in general, were discussed with nurses, prior to the introduction of caring for patients with perceived stigmatizing qualities. Of the 15 perinatal nurse interviews, a vast majority of nurses shared that building caring and personal relationships with patients, being present with patients, and fostering open communication were primary ways they show caring care to their patients. In addition, the nurse responses directly supported elements of Swanson's theory of caring such as knowing, being with, and doing for, and enabling (Swanson, 1993). Some nurses also expressed a desire to promote informed patient choices and positive experiences, which revealed the goal of their care was to align with Swanson's goal of caring, promoting optimal patient outcomes (Swanson, 1993). These qualities of caring set the stage for nurses to consider how their level of caring may shift as they provide care to perceived stigmatized patients in the perinatal setting. Overall, nurse responses supported the presence of the application of Swanson's theory of caring in perinatal nursing environments in the Southeastern United States.

Nurse Definitions of Stigmatizing Qualities

Nurses then began to define their personal definitions of what they consider to be stigmatizing characteristics in patients they care for in the perinatal setting. The predominant responses: drug abuse and unhealthy lifestyles, appearance and attitudes of patients, and patient demographics. The nurse perceptions of stigma are supported by the findings of Link and Phelan (2001) as they assert that stigma is identified by humans as they label other individuals due to human differences, differences that matter socially, and associate those attributes as negative qualities. Stigma is described by Link and Phelan (2001) to be perceived on a basis of external characteristics and physical markings that may indicate the patient's level of socioeconomic status, identity, or level of self-care. Of all nurse reports of stigma, only socially significant attributes that are different to that of the nurse were viewed as a stigma, not attributes that made the patient similar to the nurse or more socially upstanding.

Drug abuse and addiction was mentioned by some nurses to be a "really hard" stigmatizing characteristic because of the known harm the mother is bringing not only to herself, but also to the unborn, or recently born, child. Drug abuse is noted in the literature as a significant stigma identified by nurses among perinatal patients, and the presence or lack of therapeutic nurse-to-patient relationships directly impacts patient outcomes (Horner et al., 2019; Neary, 2018). Horner et al., (2019) suggested that nurses desire to overcome this perceived stigma so they can provide optimal care to drug-abusing patients, but a lack of skill and support was identified as a barrier to quality care. This finding was supported by Horner and colleagues (2019), who found that nurses lack role adequacy and legitimacy when it comes to the presence of stigma among patients,

such as drug abuse. Horner and colleagues (2019) went on to explain that role adequacy and legitimacy are established when the nurse feels knowledgeable about their work and when they feel they have the right to ask questions and act when certain issues arise. This finding, and the many nurses identifying drug abuse as a stigma, proposes the need to fill this void of knowledge and nurse preparedness to address patients with perceived stigma and heighten the quality of caring care provided to them (Horner et al., 2019).

Unhealthy lifestyles were described as "patients who are unhoused," "patients who don't seek prenatal care," patients with sexually risky behavior with multiple sexual partners, and the presence of STDs. Other perceived stigmas by nurses included: patient appearance such as the presence of tattoos, unnatural hair color and style, poor hygiene, "largely overweight patients," and patient attitudes like those who desire natural labor only and refuse care interventions, have hypochondriac behaviors, and patients with vulgar and rude language. In addition, patient demographics that were also reported by nurses to be sources of stigma, including: (a) certain nationalities, (b) cultures, (c) races, (d) religions, (e) language barrier, (f) lower socioeconomic status, (g) lower education level, (h) incarceration status, (i) young mothers, (j) vaccination refusal, and (k) non-heterosexual relationships. The perinatal nurse responses of their perceptions of stigma were consistent with literature as the stigma has been explored surrounding incarcerated women, untraditional sexual identities, substance abuse, and patients with language barriers (Al Shamsi et al., 2020; Goldberg, 2005; Goshin et al., 2020; Horner et al., 2019; Neary, 2018; Pescosolido & Martin, 2015; Tzur-Peled et al., 2019). However, one stigmatizing characteristic that was not mentioned by perinatal nurses but is described by

other perinatal nursing literature includes perinatal patients with mental illness (Noonan et al., 2019).

Patients Hard to Provide "Caring" Care For

After descriptions of perceived stigmatizing characteristics were discussed with nurses, they were asked to describe what kind of patients are difficult to provide caring care for. Nurses shared that overbearing patient families and the presence of a language barrier are difficult to provide caring care for. This finding is consistent with Al Shamsi and colleagues (2020) as they suggest that a language barrier between the nurse and patient results in miscommunication, reducing patient safety and the level of nurse caring provided. Interestingly, decreased satisfaction of the caring process is present on both ends of the nurse-to-patient relationship (Al Shamsi et al., 2020).

Furthermore, the overwhelming majority shared that the patient's attitude was the most challenging barrier to providing caring care. Patient attitudes of disinterest, dissatisfaction, and ungratefulness, accompanied with opposition to receiving the help of nurses were listed to be difficult attitudes to overcome in order to offer caring care to the patient. Nurses also described the difficulty in caring for patients who lacked care and respect for their own pregnancies. Nurses reported the difficulty in caring for patients with drug-abusing behaviors because of the harm it causes to the mother and baby. Research completed by Selleck and Redding (1998) supports this occurrence of perinatal nurses having more negative attitudes toward substance abuse in the perinatal period compared to nurse perceptions of substance abuse outside of pregnancy, due to the direct effects of the mother's action on the unborn baby.

Drug abuse was listed by some nurses to be another barrier in providing caring care to patients. This finding is consistent with Horner and colleagues' (2019) study that found the nurse-to-patient relationship to be directly violated by the presence of stigma surrounding drug abuse. Although, Horner and colleagues (2019) suggest that nurses still desired to overcome the stigma to provide better care. In contrast, one nurse shared, "it's really hard to be compassionate with someone who absolutely does not care for the well-being of their baby." Nurses reported to assume that "someone who is addicted to drugs" "just does not care about themselves or their baby." This opinion was shared by other nurses who opposed a desire to overcome this stigma and provide better-caring care, as Horner et al., (2019) suggested. This finding is significant as previous research shows that therapeutic attitudes of perinatal nurses with patients who are drug abusers in pregnancy have direct impacts on more positive outcomes for the mother and baby (Neary, 2018).

Maintaining Belief

Once nurses began exploring their perceptions of caring and stigma, they were asked direct questions about their level of caring for perceived stigmatized patients, as seen in Table 1. As mentioned earlier, Swanson's Structure of Caring was used as a format for the research questions to follow in order to more accurately describe differences in aspects of informed caring from nurses toward perceived stigmatized patients, compared to traditional patients (Swanson, 1993). Maintaining belief, or the philosophical attitude of the nurse toward the patient's ability to overcome their health events and face a meaningful future, was the first category to be assessed among nurses (Swanson, 1993).

In general, most nurses reported a change in their attitude toward the patient upon first meeting them, if they were first perceived to have a stigmatizing characteristic. Some nurses reported a more negative attitude toward patients, as they have "their guard up," or "feel uncomfortable to take care of" patients with perceived stigmatizing characteristics. A general skepticism of perceived stigmatized patients and decreased patience was also noted, especially in cases where drug abuse or noncompliance was evident. Few nurses reported positive attitudes toward perceived stigmatized patients, suggesting more time spent with the patient helps the nurse to see where the patient comes from so they can better understand the patient's background and current needs. This attitude is a direct reflection of Swanson's theory of caring as nurses attempt to assess the patient to "define what matters and where to address care" (Swanson, 1993, p. 354).

Moreover, some nurses shared that they made assumptions about the patient's abilities upon meeting them due to their appearance, history, and demographics. These primary assumptions of patients' abilities included a lower level of ability to understand education from the nurse if they have a lower socioeconomic status, lower education levels, or a language barrier. Additionally, homeless, drug-abusing, and "grossly obese" patients were reported by nurses to be perceived as uncompliant or uncaring about their personal health. While these nurses are assessing what they see based on patient qualities, their perceptions of the patients' abilities to learn and overcome their circumstances are merely assumptions made as a result of perceived stigma, opposite to that which is desired when Swanson's theory is applied to nurse caring (Swanson, 1993). This finding is consistent with the findings of Link and Phelan (2001) as they emphasize the rapidly

declining perception of another's status when stigma is perceived. The declining perceptions of another's status could fall within social, economic, intellectual, or emotional competence characteristics, when perceived stigma may be present (Link & Phelan, 2001).

Knowing

Nurses were given the opportunity to discuss their desire to get to know their perceived stigmatized patients on a clinical and personal level. This stage of Swanson's "Structure of Caring" is the anchor of offering caring care as the nurse establishes an understanding of "events as they have meaning in the life of the" patient (Swanson, 1993, p. 355). Knowing a patient "involves avoiding assumptions, centering on the one(s) cared for, thoroughly assessing all aspects of the client's condition and reality, and ultimately engaging the self or personhood of the nurse and client in a caring transaction" (Swanson, 1993, p. 355). Despite many nurses having negative, initial maintaining beliefs toward perceived stigmatized patients, perinatal nurses still shared a desire to get to "know" their patients. Many nurses described a desire to investigate how patients gained their stigma and what past experiences contributed to who they are, in order to "give them [patients] the care that they need." These nurse reports of desires to learn more about the source of the patient's stigma is consistent with other findings in literature, such as Horner and colleagues' (2019) report that nurses desired to understand what brought patients to their drug abusing state. Additionally, Tzur-Peled et al., (2019) suggests that the more knowledge a nurse has of a stigma, such as nontraditional sexual identities, the more likely the nurse is to make an effort to get to "know" the patient possessing that stigma.

Some nurses reported a lack of desire to know perceived stigmatized patients on a more in-depth basis, causing an abrupt break in the structure of care. One nurse said she assumes she already knows "what their medical history is going to contain," while another nurse attributed her lack of desire to the extra work that is often required for perceived stigmatized patients. An introspective comment was made by one nurse as she said "it [perceived stigma] does not change my level of nursing care but my caring attitude towards them [perceived stigmatized patients] changes." Swanson (1993) proposes that "a nurse's knowledge of self, sets the stage for how willing a nurse is to truly know another's reality" (p. 355). While it is possible that an unstable personal identity, as reported by Swanson (1993), is the reason for nurses lacking a desire to "know" their perceived stigmatized patients, Tzur-Peled et al., (2019) suggests a lack of knowledge about the stigmatizing characteristic as the main contributing factor to a lack of desire to get to know perceived stigmatized patients more.

Being With

Being with, emotionally present, and invested in the patient, is the third part of the structure of caring. Being with is the step where the nurse conveys to the patient "that they and their experiences matter to the nurse" (Swanson, 1993, p. 355). Nurses were asked to share their desire to be emotionally present with a patient with perceived stigmatizing quality. Some nurses shared that despite the desire to be emotionally present with the patient, perceived stigmatized patients require the emotional presence of the nurse due to their, often, lack of support in the perinatal setting. These nurses felt that emotional barriers needed to be set aside for the sake of the positive well-being of the perceived stigmatized patients under their care. Neary (2018) would claim that this

attitude of perinatal nurses toward stigmatized patients will result in more positive outcomes for both mother and baby.

Other nurses reported a true desire to be emotionally present with perceived stigmatized patients. Some of these nurses shared that they desired to be emotionally present with patients because they know the perceived stigmatized patients need an encouraging presence, while others share a personal responsibility and commitment to offer "positive reinforcements" and spend time educating the patient, so they are ready to eventually become self-sufficient. One nurse even shared a story about how her persistent desire to be totally present with and serve a patient usually pays off, even if faced with some resistance by the patient at first. This example of caring makes a direct correlation with Swanson's theory of caring, as the patient's initial stigma of the nurse is eventually changed by the continual offer of emotional presence and service by the nurse.

Perinatal nurses reported a lack of desire to be emotionally present for perceived stigmatized patients in the perinatal setting. Some nurses reported this lack of desire to be because of perceived stigmatized patients not wanting to be emotionally invested in themselves or as a means of self-protection for the nurse. One nurse even said, "I put up an emotional barricade where I don't allow myself to be as emotionally involved." A lack of willingness to be emotionally present with patients that have certain perceived stigmas could be detrimental to patient outcomes and causes the message that is conveyed to the patient to be one of disconnect and distrust. Horner et al. (2019), even support that the therapeutic nurse-to-patient relationship was violated when patients possessed a stigmatizing characteristic, specifically drug-abusing behaviors. Swanson (1993) and Horner et al., (2019) propose that a solution may be that organization administrators

"promote caring among nurses" in order to provide better support and skills to overcome perceptions of stigma to improve care for patients (p. 356). This change must take place by making sure nurses' "work-related needs [are] met through self-care and communities of caring in which the interpersonal work ethic is to be there for each other" (Swanson, 1993, p. 356).

Doing For and Enabling

Doing for and enabling are therapeutic actions that offer service to the patient, as the patient would do if they had the ability to do it themselves. Doing for, as defined by Swanson (1993), "includes comforting the other, anticipating their needs, performing competently and skillfully, protecting the other from undue harm and ultimately preserving the dignity of the one done for" (p. 356). Enabling is defined by anything, like coaching, teaching, helping, and supporting, that assures "the other's long-term well-being" (Swanson, 1993, p. 356). Among nurse interview responses three levels of doing for and enabling were identified: less, equal, and more. Some nurses listed reasons for offering less therapeutic actions to be a lack of desire to engage with the stigmatized patient, a lack of resources and technology for stigmatized patients, and a language and cultural barrier that may hinder therapeutic actions. This finding is consistent with the literature, as evidence of nurses exhibiting less therapeutic actions for perceived stigmatized patients, such as patients with a language barrier, have been described (Al Shamsi et al., 2020). Suggestions for improvements for the lack of resources and technology will be further discussed in the following section.

Many nurses shared that they offer the same number of therapeutic actions to perceived stigmatized patients as they do traditional patients, taking pride in their

equality of serving and enabling all patients, regardless of stigma presence. Few nurses reported more therapeutic actions for perceived stigmatized patients, due to the higher need demands of the patients. They each shared that in some way the perceived stigmatized patients are either more demanding of the nurses' time and service or need further physical and psychosocial support because they are alone. The nurse responses were noteworthy as they reported a willingness to do more for and enable their patients to best meet their needs and promote optimal patient well-being. Overcoming the barriers of stigma to provide more optimal patient care is reported in the literature to be an overall desire of nurses (Horner et al., 2019).

Improved Patient Outcomes

Perinatal nurses were asked to provide suggestions for change that may assist in promoting more positive patient outcomes and optimal patient well-being in situations where patients may possess perceived stigmatizing qualities. Positive patient outcomes and patient well-being are the intended goals of the structure of caring (Swanson, 1993). One suggestion made by some nurses was to educate nurses and ignite shifts in nursing culture to offer more caring care to perceived stigmatized patients in the perinatal setting, including providing nursing education on the importance of showing respect and empathy for all patients. Self-reflection of personal stigma and sensitivity training was also recommended. Lessons on culturally competent care and therapeutic communication skills were listed to assist in equipping nurses to "serve and take care of" "people from all walks of life." Other research related to stigma among patients also supports that further educating nurses assists in promoting higher levels of caring when stigma is present (Chan et al., 2015; Goldberg, 2005; Hutti et al., 2016; Tzur-Peled et al., 2019).

Standards of care and higher personal expectations of caring care were reported by some nurses to be used for promoting "diversity, equity, and inclusion" of nurse caring and "to enhance patient care." However, the support of healthcare administration is necessary to begin altering standards of care and fostering expectations of caring care for all patients (Swanson, 1993). Nurses suggested making nurse caring more of "a routine point of care" and promoting shifts in the minds of nurses to remember "the patient is there to be cared for, no matter, you know, who they are and what they believe." Suggestions for changes in the nursing environment were also made by nurses. Some of these included safer staffing ratios, nurse bonuses, adjusting patient assignments when needed, closer relationships between social workers and nurses, and more efficient translation devices for when a language barrier exists. These suggestions are confirmed by Al Shamsi et al. (2020) Horner et al. (2019), and Cheung et al. (2008) and are recommended for nurse educators and nursing leaders alike, as optimal patient outcomes are the top priority of all nursing care.

Theory of Caring

It is evident that nurse caring is affected by the presence of stigma, as one nurse said, stigmatizing characteristics do "not change my [the nurse's] level of nursing care but my [the nurse's] caring attitude towards them [perceived stigmatized patients] changes." Swanson's theory of caring provided a seamless assessment of how nurse caring is affected as a result of the presence of perceived stigma among patients. In the interviews, it was apparent that nurses agreed with the flow of the theory as they walked through the different facets of how they provide care to patients. This theory allowed the

evaluation of aspects deeper than simple nursing tasks, in order to explore more precisely the areas of nursing care that are truly affected when perceived stigma exists.

For instance, although many nurses indicated a negative attitude or maintained belief toward perceived stigmatized patients, the vast majority of nurses still desired to get to know them. Additionally, most nurses reported the same amount or more doing for and enabling patients, but a major decline of nurse caring was noted when asked about being emotionally present with perceived stigmatized patients. Nurses lacked a desire to be emotionally present with a patient "who isn't invested in herself," while others "put up an emotional barricade" to "emotionally distance" themselves from perceived stigmatized patients. Nurses with equal or increased levels of doing for and enabling perceived stigmatized patients, attributed this to their routine care, or the increased demand of service required by these patients. This finding is supported by Horner and colleagues' (2019) study that reports nurses' routine, and sometimes heightened level of care for perceived stigmatized patients exists. While it is apparent that nurses provide a standard level of nursing care to all patients, there is a need to continue investigating areas for improvement of emotionally present and invested caring care by nurses.

RQ2: What are the perceptions of caring in perinatal nurses as they deliver care to perinatal patients during the COVID-19 pandemic?

Nursing Care during COVID-19

The COVID-19 pandemic has caused a ripple of change across the entire world as the virus rapidly spreads, mutates, and leaves lasting impacts on individuals. New rules were created in many United States hospitals in order to protect patients, visitors, and medical staff from contracting or spreading the virus. These new rules have placed nurses

as enforcers in many facilities, which have inadvertently ignited a disconnect in the nurse-to-patient relationship. COVID-19 has caused major shifts in the role of nurses, which have added stress to nurses and newfound areas for conflict (Yousaf et al., 2021). In this study, some nurses reported not only the physical "barrier of the masks" and other PPE, but also the shift to limiting visitors, which has caused changes in dynamics when rules are broken by patients and family members. The level of care and the presence of the nurse in caring for patients during COVID-19 revealed conflicting opinions among nurses regarding whether more attentive and present care was provided to patients, compared to other nurses who suggested less time and careless care is given to patients, was a result of COVID-19. The fears of contracting or spreading COVID-19, along with the discomfort of wearing PPE was reported to be a source for less presence and decreased levels of nurse caring. This finding is consistent with Yousaf and colleagues (2021) as they found the presence of added stressors on nurses to directly affect care for patients.

It was evident from nurses that caring during COVD-19 has brought with it many concerns of not having adequate PPE supply, burnout from consistently wearing PPE, fears of the unknown, and the path to learning more about the virus and navigating its management, a finding also reported by other researchers (Naylor et al., 2021; Yousaf et al., 2021). In addition, a nurse made mention that "everything was scary and unknown," making her not "even wanting to go into work." Naylor et al. (2021) supports the developing presence of fear and concerns surrounding COVID-19 and suggests a higher prevalence of anxiety, depression, and PTSD among nurses since the start of the COVID-19 pandemic, causing direct impacts on nurse caring.

As more distance from the initial shock and emotional toll of the COVID-19 pandemic begins to bring healing to many in health care, the trauma of nursing during COVID is only yet to be discovered. As researchers began to dive into nursing impacts as a result of the pandemic, emotional turmoil among nurses was identified (Naylor et al., 2021). It stands to reason that as nurses continue working tirelessly under the weight of the pandemic, their caring care is likely to suffer as a result. The long-term implications of nurse caring in perinatal settings during the COVID-19 pandemic is an area for further research. In addition, the need to further develop and test widespread healing resources, resilience programs, and self-care measures for nurse populations exists (Barnett et al., 2021; Kim et al., 2021).

Implications for Social Change

The presence of alterations in nurse caring, as a result of perceived stigma among perinatal patients during the COVID-19 pandemic, has provided room for improvement and implications for social change, in addition to changes in nursing education and culture. Stigma is defined as labeling, discrimination, or stereotyping on a foundation of personal bias and perceptions of what society considers normal (Link & Phelan, 2001). Society is a major contributor to how individuals perceive stigma and consequences of perceived stigma exist in areas such as "earnings, housing, criminal involvement, health, and life itself" (Link & Phelan, 2001, p. 363). Furthermore, consequences of perceived stigma exist in nursing care as the presence of stigma causes nurses to lack a desire to be emotionally present with their patients and have a negative philosophical attitude toward their patients. These barriers to forming caring nurse-to-patient relationships have direct, negative impacts on patient outcomes (Neary, 2018). Changes in nursing education and

the nursing culture are areas where improvements can be made as nurses gain awareness of personally perceived stigma and learn ways to combat altered levels of caring as a result. Broader social changes include diminishing consequences of perceived stigma by way of providing equal opportunities to stigmatized populations and reducing the power of actions that allow dominant societal groups to punish stigmatized groups (Link & Phelan, 2001).

Recommendations for Actions

The study results indicate two main opportunities for changes in nursing, including additional nursing education and the prompting of nurses to maintain moments of self-reflection regarding perceived stigma among patients and how their level of caring may be unintentionally affected. Within the nurse interviews, multiple mentions of additions to nursing education were provided including added sensitivity training, therapeutic communication, cultural competence, respect and empathy for perceived stigmatization patients, and personal evaluation of internalized perceived stigma and prejudices among nurses. In addition, the realization that the interview questions prompted nurses to introspectively consider how their caring may be altered when patients have perceived stigmatizing qualities indicates an effective resource for improvement. One nurse even said what a few other nurses indicated during the interview questions, she said she "hadn't really thought about it [caring for perceived stigmatized patients] until now."

Another area to consider, based on the significance of the research results, is the reason for decreased willingness of nurses to be emotionally present with perceived stigmatized patients. While many nurses may have indicated an initial negative attitude

toward perceived stigmatized patients, the majority shared a desire to get to know the patient fully. Serving perceived stigmatized patients with therapeutic actions was reported by nurses to be done equally or more so among them compared to traditional patients. The contrast to these results is the decreased willingness of nurses to be emotionally present with perceived stigmatized patients. Swanson (1993) suggests that a reason for this is due to the nurses' needs not being met within their organization or personal lives. Other nurses reported they felt perceived stigmatized patients required their emotional presence, causing nurses to be emotionally present out of obligation rather than desire. As a result of Swanson's (1993) suggestions that nurses' "work-related needs [be] met through self-care and communities of caring," organizations and the entire nursing culture must make shifts to foster this type of environment so nurses do not feel the need to build "an emotional barricade" when caring for perceived stigmatized patients (p. 356).

Exploring the full effect of the COVID-19 pandemic on perinatal nurse caring will be a lengthy and arduous process for many researchers in the years to come. The snapshot gained in this study of how COVID-19 has changed perinatal nurse caring is a valuable contribution to nursing research. Nurses reported physical barriers of PPE in addition to barriers created between them and patients as a result of nurses becoming the enforcers of new rules. Other avenues for enforcing changing visitor policies and PPE protocols in healthcare facilities need to be explored to alleviate the burden on nurses so they may remain focused on the goal of providing caring care to patients (Yousaf et al., 2021). Conflicting reports were recognized as nurses shared that more attentive care and presence was given by nurses to patients during the pandemic compared to nurses that

shared less time and careless care was provided to patients. In addition to the alterations in caring care, many nurses expressed concerns and fears prompted by the pandemic. These nurse reports suggest a need for further investigation of how concerns and fears from the pandemic may be affecting the care and presence of nurses with patients.

Following a successful dissertation defense, the study results will be emailed to the 15 perinatal nurse participants for their review, with a message of appreciation for their contribution to nursing research. Additionally, this dissertation will be published on the USM Aquila website for viewing. Nursing educators and nurses alike are the intended recipients of this research, as the goal is that nursing education would be altered based on the findings and self-reflection practices of current nurses in the workforce.

Recommendations for Further Studies

The replication of this study with a wider sample population of perinatal nurses would promote further consistency of study results and more explanation of nurse perceptions of caring for perceived stigmatized patients during the COVID-19 pandemic. Improvement opportunities, if a similar study were conducted, would be to share the interview questions with the nurses prior to the interview and incorporate a designated time to explain stigma, caring, and Swanson's theory of caring to the participants. A brief PowerPoint presentation or video of the researcher explaining the terms and theory used in the study would allow nurses to gain a better understanding of expressions such as caring, stigma, maintaining belief, knowing, being with, and doing for and enabling for more clarity for nurse responses. Although it would require more time and nurse participation, the implementation of a focus group of perinatal nurses would allow nurses to discuss their perceptions of caring for perceived stigmatized patients among one

another to provide more fluid and consistent results. Additionally, interviewing recent perinatal patients to assess their experiences of receiving care by perinatal nurses may be a beneficial area for future study too.

It was noted that many nurses reported the most difficult patients for them to provide caring care for were patients with attitudes of disinterest, dissatisfaction, and ungratefulness, accompanied with opposition to the help of nurses. Among five nurses, patient attitudes were reported to be a stigmatizing quality. Repeating this study with specific emphasis on patient attitudes as the source of stigma may be beneficial to evaluating nurse perceptions of caring when patient attitudes show they are uninterested, unsatisfied, and ungrateful concerning their care. Additionally, patients whose attitudes show disdain for their pregnancy or newborn could be a topic worth incorporating, as a nurse caring for patients with certain attitudes are researched. As some nurses answered the interview questions for the study, they held on to a certain personally defined stigma to consider how they care for those patients, but the stigma was different for many nurses, creating some inconsistency in their reports. Some nurses referred to drug-abusing patients throughout the interviews while others referenced patients with a language barrier or patients who act like "punks." As a result, it may be beneficial to further study how a specific perceived stigma, such as patient attitude, affects nurse caring in the perinatal setting.

Reflections from the Researcher

The researcher found great enjoyment in interviewing perinatal nurses from across the Southeastern region to hear their perceptions and experiences of caring for perceived stigmatized patients during the COVID-19 pandemic. The researcher has spent

the last two and a half years as a labor and delivery nurse in South Mississippi, serving many of the perceived stigmatized patients mentioned in nurse interviews. As the researcher continues to offer caring care in the perinatal setting, further consciousness of perceived stigma and altered levels of caring has emerged, in addition to more awareness of personal bias and the presence of stigma within the nursing culture. Changes due to the COVID-19 pandemic have also been personally experienced by the researcher and it was refreshing to hear other nurses are also fighting for a renewed sense of normalcy.

The researcher began nurse interviews with a pessimistic idea of nurses' response in caring for stigmatized patients. The initial perception of the researcher was that the majority of nurses would confess overall decreased levels of caring for perceived stigmatized patients. Instead, the researcher was surprised by the compassionate and dutiful levels of caring offered by nurses, regardless of stigma. The researcher sought to remain close to the script of the interview questions and not offer personal bias or perceptions of stigma, as to generate the most honest responses from nurses. The researcher was pleased to have the opportunity to conduct the nurse interviews and analyze it for significance in nursing research.

Conclusions

This qualitative descriptive study was conducted to allow the nursing community a glimpse of what caring care looks like in the perinatal setting when stigma among patients is perceived. Based on the findings, nurse perceptions of caring are affected when perceived stigma is present among patients. Nursing during the COVID-19 pandemic has also weighed on nurses to the point where caring care has been reported as compromised by many nurses. Aspects of caring care, such as the philosophical attitude

of the nurse and being emotionally invested in the patient are altered as a result of having perceived stigma against patients. Although the nurse has a desire to connect with the patient, more therapeutic actions are needed when stigma is perceived in the patient. Opportunities for growth in nursing education and the entire nursing culture and environment were provided by nurses who desire improvement in caring care when perceived stigma exists.

APPENDIX A – Demographic Record

Demographic Record

Nurse #	Age	Race	Current Position	State of Work	Perinatal Department	Years of Work in the Perinatal Setting	Years of Work as a Nurse Total
#1	41-50	White/ Caucasian	Staff Nurse	Louisiana	Labor and Delivery	6	12
#2	20-30	White/ Caucasian	Staff Nurse	Mississippi	Labor and Delivery	5	5.5
#3	20-30	White/ Caucasian	Staff Nurse	Tennessee	Postpartum	1.5	1.5
#4	41-50	White/ Caucasian	Staff Nurse	Virginia	Labor and Delivery	19.5	19.5
#5	20-30	White/ Caucasian	Staff Nurse	Mississippi	Labor and Delivery	2.5	2.5
#6	31-40	White/ Caucasian	Staff Nurse	South Carolina	Labor and Delivery	6	10
#7	31-40	White/ Caucasian	Staff Nurse	Mississippi	Labor and Delivery	15	16
#8	20-30	White/ Caucasian	Staff Nurse	Mississippi	Labor and Delivery	2	5
#9	31-40	White/ Caucasian	Staff Nurse	Mississippi	Labor and Delivery	16	17
#10	31-40	White/ Caucasian	Staff Nurse	Mississippi	Labor and Delivery	1	12
#11	31-40	Hispanic	Staff Nurse	Mississippi	Labor and Delivery	1	5

#12	31-40	White/ Caucasian	Staff Nurse	Mississippi	Labor and Delivery	3.5	9
#13	20-30	White/ Caucasian	Staff Nurse	Mississippi	Labor and Delivery	5	5
#14	20-30	White/ Caucasian	Staff Nurse	Mississippi	Postpartum	3.5	3.5
#15	31-40	White/ Caucasian	Staff Nurse	Mississippi	Postpartum	5	7.5

APPENDIX B – IRB Approval Letter

Office *of*
Research Integrity

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NOTICE OF INSTITUTIONAL REVIEW BOARD ACTION

The project below has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services regulations (45 CFR Part 46), and University Policy to ensure:

- The risks to subjects are minimized and reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered involving risks to subjects must be reported immediately. Problems should be reported to ORI via the Incident submission on InfoEd IRB.
- The period of approval is twelve months. An application for renewal must be submitted for projects exceeding twelve months.

PROTOCOL NUMBER:	21-316
PROJECT TITLE:	Perceptions of Perinatal Nurses Caring for Perceived Stigmatized Patients During the COVID-19 Pandemic in Perinatal Settings
SCHOOL/PROGRAM	Systems Leadership & Health Outcome
RESEARCHERS:	PI: Deborah Tucker Investigators: Tucker, Deborah~Copeland, Debra~
IRB COMMITTEE ACTION:	Approved
CATEGORY:	Expedited Category
PERIOD OF APPROVAL:	15-Dec-2021 to 14-Dec-2022

Donald Sacco, Ph.D.
Institutional Review Board Chairperson

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