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GREAT EXPECTATIONS:

AN ANALYSIS OF JOB STRESS AND PREGNANCY

By

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I dedicate this dissertation to my son who was the source of inspiration for this research.

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ABSTRACT

Research has examined the experiences of women in the workplace, yet women's experiences during pregnancy have been neglected to a large extent. Stress during pregnancy has consistently been shown to lead to detrimental consequences for women and their babies. Using the job stress theories, a conceptual model of stress during pregnancy is developed. This model includes factors from multiple levels (i.e., individual, interpersonal, sociocultural, and community) and highlights the role of job stress during pregnancy. In order to gain a deeper understanding of job stress during pregnancy, three pregnancy-specific organizational stressors are identified (i.e., perceived pregnancy discrimination, pregnancy disclosure, and identity-role conflict) and hypothesized to result in detrimental organizational, health, and family outcomes through experienced stress. The moderating roles of resources (i.e., self-regulation and resiliency) are also examined. Analyses of time-separated data from 124 pregnant employees revealed that women experience pregnancy-specific job stressors and that these stressors are associated with a variety of adverse outcomes. Furthermore, mediated moderation analyses revealed that self-regulation and resiliency function as coping resources during the stress process. Finally, a q-sort analysis of learning during pregnancy revealed nine learning themes. Contributions and future directions for research are discussed.

CHAPTER 1

INTRODUCTION

Overview / Statement of the Problem

Pregnancy can be a joyous occasion for new moms. However, along with the joy comes physical and psychological changes which can lead to stress and anxiety (Collins, Dunkel Schetter, Lobel, & Scrimshaw, 1993; Da Costa, Larouche, Dritsa, & Brender, 1999). Extensive research has been conducted in the health disciplines (e.g., psychiatry, behavioral medicine, health psychology, and social epidemiology) examining stress during pregnancy and the implications it has for the mother and her baby (Dunkel Schetter & Tanner, 2012). Stress during pregnancy has been linked to a number of dysfunctional consequences such as preterm birth, low birth weight, maternal postpartum depression, infant complications, and developmental effects lasting into adulthood (Dunkel Schetter & Glynn, 2011).

Prior to 1964, it was assumed that pregnant women would voluntarily resign or be dismissed from their jobs (Feitshans, 1994). However, this is no longer the case. Two thirds of women who have had at least one pregnancy reported employment during their first pregnancy. Furthermore, 80% of the women who reported working continued to work up until one month or less before giving birth (Salihu, Myers, & August, 2012). Despite the fact that pregnancy is a prevalent phenomenon in the workplace and it presents unique challenges not traditionally seen in a male-dominated workforce (Salihu et al., 2012), surprisingly little research has investigated the unique experiences of pregnant *employees* (Jones et al., 2013).

Women working during their pregnancy may be at risk of experiencing even greater levels of stress and anxiety as a result of their work environment. Research has shown that many employees hold the belief that pregnant employees are less productive, should not be hired or

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promoted, and should not be provided special accommodations (Bragger, Kutcher, Morgan, & Firth, 2002; Masser, Grass, & Nesic, 2007; Bakst, 2012). While every expecting mother experiences some level of stress, these negative attitudes toward pregnancy likely introduce stressors unique to the workplace. Considering that 80-90% of female employees will be pregnant at some point during their career (Fried, 2000; Johnson, 2008), it is important to better understand the challenges faced by women during this time and seek ways to help them avoid dysfunctional consequences.

Purpose and Contribution of the Research

Very little is known about the experience of pregnant employees. However, during these nine months, women may be at risk of experiencing greater levels of job stress due to the potential for pregnancy-specific job stressors. Management literature has suggested that job stress can be detrimental to employee health and well-being and negatively impacts job attitudes and behaviors (Nixon, Mazzola, Bauer, Krueger, & Spector, 2011; Perrewé et al., 2004; Podsakoff, LePine, & Lepine, 2007). Other literatures have explored the relationship between stress and pregnancy outcomes (Dunkel Schetter & Tanner, 2012). This study merges these streams of literature in order to further our understanding of stress and pregnancy, particularly within the organizational context.

The purpose of this paper is threefold: 1) to review research that has been conducted on the role of stress during pregnancy, 2) to provide a multilevel conceptual model that outlines pregnant employees' experience of job stress, and 3) to introduce and test the impact of three job stressors on organizational, health, and family outcomes.

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Organization of the Research

This dissertation is presented as follows. Chapter Two provides the theoretical foundations for the study, presents a conceptual model of the role of stress during pregnancy, and provides a thorough review of the literature. Chapter Three develops a research model and provides the theoretical foundations for the associated hypotheses related to the role of pregnancy-specific job stressors (i.e., perceived pregnancy discrimination, identity-role conflict, and pregnancy disclosure) and their impact on organizational, health, and family outcomes for the mother and her baby. Chapter Four outlines the research design and data analysis procedures used to test the research model. Finally, Chapter Five presents results and discusses future research directions and limitations of the study.

CHAPTER 2

LITERATURE REVIEW

Theoretical Foundations

Lazarus' (1966) Transactional Theory of Stress serves as the underlying theoretical foundation for this research. I also incorporate a more recent expansion of Lazurus' model, the Appraisal, Attribution, Adaptation (AAA) model of job stress (Mackey & Perrewé, 2014). The AAA model is an integrative conceptualization that combines multiple job stress theories and models (i.e., transactional model of stress, job demands-control model, job-demands resources model, and conservation of resources model). Whereas each of these theories/models tends to emphasize various key components of the stress process, they all acknowledge the importance of cognition, appraisal, and resources. The utilization of previous stress theories coupled with a discussion of the unique stressors pregnant employees may experience, allows for a more comprehensive understanding of the process through which stress impacts organizational, health, and well-being outcomes.

Organizational stressors are perceptions of job demands that elicit primary appraisals. A job demand can be any organizational, social, or physical feature of the job that requires constant physical or mental effort (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001). The pregnancy specific organizational stressors presented in this study (i.e., perceived discrimination, pregnancy disclosure, and identity role conflict) are conceptualized as socially constructed job demands. Each of these pregnancy specific stressors is a result of social features of the organization (e.g., discriminatory comments and behaviors at work, value placed on family, career expectations) and, when perceived as threatening, they will require sustained mental effort to manage. It is important to note that not all job demands are associated with costs for employees. Consistent

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with Lazurus' transactional theory of stress (1966), when employees perceive a job demand, they engage in the cognitive appraisal process (i.e., primary appraisal) to determine whether the job demand is threatening to their well-being, challenging, or should simply be dismissed as benign.

After the primary appraisal, employees will engage in a secondary appraisal to determine whether they have the necessary resources to cope with the stressor. Resources play an important role in the experience of stress, and have been highlighted in several job stress theories (e.g., transactional model of stress, job demands-control model, job-demands resources model, and conservation of resources model). A variety of resilience resources (e.g., social support, self-esteem, emotional stability, physical health) have been shown to play a role in the experience of stress during pregnancy (Dunkel Schetter, 2011). Employees' coping behaviors largely depend on the secondary appraisal. If employees perceive that they can do something to change the stressful situation, they are likely to engage in problem-solving coping. This might involve seeking information about the situation, changing their behavior, or taking action on the environment. On the other hand, if employees perceive that they lack the ability or necessary resources to change the stressful situation, they are likely to engage in emotion-focused coping. This might include avoiding or positively reappraising the stressor. The effectiveness of employees' coping behaviors will ultimately determine the impact that the perceived threat has on organizational, health, and well-being outcomes.

A final piece of the stress process is that employees will receive feedback after responding to a stressor. Based on this feedback, employees will learn from their previous encounters with stressors and apply this to subsequent encounters (Meurs & Perrewé, 2011; Ursin & Eriksen, 2004; 2010). If they were able to cope effectively with a stressor, this will be

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reflected in subsequent appraisals of similar organizational stressors. However, if their coping was ineffective this might lead to negative appraisals of job demands in the future.

Based on the Lazarus' Transactional Theory of Stress and a thorough review of the current literature, the model presented in Figure 1 was developed as a conceptual model to guide this research. It shows the process by which organizational stressors lead to detrimental organizational, health, and family outcomes. Pregnant employees who encounter organizational stressors will go through a threat appraisal process where they determine whether the stressor is a threat and whether they have the available resources to cope. The extent to which organizational stressors are appraised as threatening will depend upon the amount of non-work related stressors pregnant employees have encountered. If they are currently dealing with several stressors outside of work, they are more likely to feel overwhelmed by additional stressors at work and thus, appraise the stressor as threatening. In determining whether and how they can cope with a perceived threat, employees will reflect on their previous encounters with job stress (i.e., learning and adapting) and the amount of resilience resources (e.g., social support, self-esteem, trait optimism) available to them. Stress will be felt if the stressor is appraised as threatening. Women's cultural background will impact the level of experienced stress because holding certain cultural values may create a context that is more conducive to dealing with stress. Next, women will engage in coping behaviors to deal with the stress and the effectiveness of these coping behaviors will determine the impact that the perceived threat has on organizational, health, and family outcomes, controlling for medical risks. Finally, there is a learning and adapting process that takes place and informs the threat appraisal the next time an organizational stressor is encountered.

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Previous research has suggested that a comprehensive understanding of birth outcomes (e.g., birthweight, gestational age, APGAR scores) requires an interdisciplinary approach and consideration of multiple levels of analysis. In their review of maternal stress and low birthweight, Dunkel Schetter and Lobel (2012) present a multilevel model that incorporates individual, interpersonal, sociocultural, and community level factors to explain how stress exposure impacts infant birthweight. The conceptual model presented in Figure 1 integrates their model with job stress theory to emphasize the role job stressors play in expecting employees' experiences of stress. Consistent with Dunkel Schetter and Lobel's (2012) multilevel approach, this model incorporates individual level factors (e.g., resilience resources in the form of individual differences, medical risks, health behaviors), interpersonal factors (e.g., resilience resources in the form of social support), sociocultural factors (e.g., SES/social class, race/ethnicity), and community factors (e.g., cultural influences). The following sections will walk through previous research that has been conducted on each factor and explain the model more thoroughly.

Organizational Stressors

Relatively little research exists in the specific area of experienced job stress that working moms might encounter during their pregnancy. The majority of the research on job stress during pregnancy has focused on objective organizational stressors (e.g., physical exertion, prolonged standing, and shift work) or utilized Karasek's (1979) Job Demands – Control Model to examine psychosocial organizational stressors as a form of job demands.

Workplace Conditions

Working conditions have long been of interest to pregnancy researchers (e.g., Fox, Harris, & Brekken, 1977). As the number of women working during their pregnancy increases,

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interest in this topic has flourished. Several workplace conditions and their impact on pregnancy outcomes have been examined. Mozurkewich, Luke, Avni and Wolf (2000) conducted a meta-analysis on working conditions and adverse pregnancy outcomes. Specifically, they examined physically demanding work (i.e., "heavy and/or repetitive lifting or load carrying, manual labor, or significant physical exertion" p. 624), prolonged standing (i.e., standing for more than 3 hours per day), working long hours (i.e., working greater than 39 hours per 5-day workweek and/or longer than 8 hours per day), shift/night work, and work fatigue. Their results, based on 29 studies (n=160,988), revealed that physically demanding work, prolonged standing, shift work, and work fatigue were all significantly associated with preterm birth. Physically demanding work was also associated with hyptertension or preeclampsia.

Van Beukering, Van Melick, Mol, Fings-Dresen, and Hulsof (2014) conducted a more recent meta-analysis examining the relationships between working conditions and preterm delivery. Similar to Mozurkewich et al., (2000), they found that prolonged standing and physically demanding work were associated with increased risk of preterm delivery. Overall, the evidence seems to suggest that working conditions during pregnancy can affect birth outcomes.

Psychosocial Characteristics of Work

Psychosocial characteristics of work have not received near as much attention as workplace conditions. In a recent review, only thirteen studies examining the effects of psychosocial work characteristics on pregnancy outcomes were identified (Mutambudzi, Meyer, Warren, & Reisine, 2011). The majority of research on psychosocial organizational stressors during pregnancy (Brandt & Nielsen, 1992; Homer, James, & Siegel, 1990; Meyer, Warren, & Reisine, 2007; Zhu et al., 2004) has utilized the Job Demands – Control (JD-C) Model (Karasek, 1979). According to the JD-C Model, high job strain is defined by a combination of high job

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demands and low job control (i.e., low decision-making freedom). A high-strain job is distinguishable from relaxed jobs (i.e., low demands and high control), passive jobs (i.e., low demands and low control), and active jobs (i.e., high demands and high control).

Homer et al. (1990) investigated the relationship between psychological stress and preterm delivery. They characterized high psychological stress as jobs that had high demands and low control and measured this by job title using Schwartz, Pieper, and Karasek's (1988) Job Characteristics Scoring System. Their results indicated that women working during pregnancy in high-strain jobs were twice as likely to deliver a low birthweight, preterm baby. However, when confounding effects of job-related exertion and maternal characteristics were taken into consideration, this relationship was no longer significant. Similarly, Meyer et al. (2007) found that the association between low job control and low birthweight was attenuated by adjusting for educational and demographic variables.

For the most part the evidence of a relationship between job strain and pregnancy outcomes has been modest (Mutambudzi et al., 2011). This could be due to the fact that job titles are often used as objective measures of job strain. However, measuring job strain in this way means that we have no way of knowing whether women actually perceive their job demands to be threatening or that they have a lack of control. In order to provide a deeper understanding of the organizational stressors pregnant employees might encounter, based on the literature three pregnancy-specific psychosocial organizational stressors (i.e., perceived pregnancy discrimination, pregnancy disclosure, and identity-role conflict) are proposed. These will be discussed in greater detail in the next chapter.

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Non-Work Related Stressors

Prenatal

For years, researchers have been suggesting that women under stress are at high risk of adverse birth outcomes. Investigation of the role of stress during pregnancy is warranted given that the impact of psychosocial processes in pregnancy are comparable to the impact of established obstetric risk factors (Dunkel Schetter, Gurung, Lobel, & Wadhwa, 2000). The assessment of stress during the prenatal period varies greatly across studies and can be categorized into two broad groups; studies examining episodic events, and studies examining chronic stressors.

Episodic Stressors.

Life events. A large number of studies have examined *life events* or major episodes that happen to individuals as episodic stressors during pregnancy. Stressful life events have been shown to affect the mother's health during pregnancy. Meijer et al. (2014) found that stressful life events during pregnancy led to increased levels of anxiety and depression. Life events have also been linked to adverse birth outcomes. Khashan et al. (2008) examined the impact of severe life events, defined as "death or serious illness in a relative during pregnancy or in the six months before conception" (p. 688). They found that mothers exposed to severe life events before conception or during pregnancy were more likely to give birth to infants with significantly lower birthweight. Experiencing a high number of stressful life events (e.g., recent move, loss of home, unusual money worries) has been tied to gestational age (Parker-Dominguez, Dunkel Schetter, Mancuso, Rini, & Hobel, 2005) and preterm birth (Dole et al., 2003). Life events experienced during pregnancy have even been shown to have an impact beyond pregnancy outcomes, such as the school achievement of children born to women who experienced stressful

life events during pregnancy (Li et al., 2013). There are a handful of researchers who failed to find a connection between stressful life events and pregnancy outcomes (e.g., Kramer et al., 2009; Lobel et al., 2008). However, considered together, evidence suggests that experiencing certain types of life events (e.g., loss events, more severe events) and experiencing high numbers of stressful life events increase the risk of adverse outcomes.

Catastrophic events. Catastrophic events are a second type of episodic stressor that has been examined during pregnancy. Catastrohpic events refer to "large-scale, destructive occurrences that fall outside the normal range of life experiences" (Dunkel Schetter & Glynn, 2011, p. 326).

Several studies have examined the impact that exposure to the World Trade Center disaster on September 11th, 2001 had on pregnant women, but results have varied. Eskenazi, Marks, Catalano, Bruckner and Toniolo (2007) found that pregnant women who were present in New York City or upstate New York during the attack were more likely to give birth to babies weighing less than 2,000 grams in the week after September 11th than women in the comparison area. Lederman et al. (2004) found that women who were in their first trimester during the attack had shorter gestation and gave birth to babies with a smaller head circumference than women who were further along in their pregnancies. Contrary to these findings, Rich-Edwards, Kleinman, Strong, Oken, and Gillman (2005) found that women who delivered babies after the attack had *longer* gestation than those who delivered before September 11th. Furthermore, Berkowitz et al. (2003) found no significant differences in gestational age and preterm birth between groups of women who were exposed to the attack during pregnancy and who were not.

Other catastrophic events that have been studied include the Chernobyl nuclear disaster (Huizink et al., 2008; Levi, Lundberg, Hanson, & Frankenhacuser, 1989) and Hurricane Katrina

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(Xiong et al., 2008). Similar to the studies focused on the September 11th attack, results seem to be mixed. Dunkel Schetter and Glynn (2011) suggest that factors such as positive changes in behavior, increased support, and improved medical care as a result of the catastrophe may help explain the inconsistent results. Despite the fact that contradictory results have been found, it is evident that catastrophes are fairly consistent in demonstrating adverse effects on gestational age or preterm birth.

Chronic Stress. Chronic stress is different from episodic stress in that it is a recurring phenomenon. Various forms of chronic stress have been examined with relation to pregnancy. These include chronic strain, perceived racism, and community level stress.

Chronic strain. A few studies have examined the link between prenatal chronic strain, either generally or in specific forms, and pregnancy outcomes. Stein, Lu, and Gelberg (2000) examined homelessness as a specific form of chronic strain. They found that homelessness severity predicted low birthweight and preterm birth. Instead of focusing on one form of strain, Misra, O'Campo, and Strobino (2001) utilized a multidimensional chronic strain measure developed by Curry, Campbell, and Christian (1994). This measure taps into chronic strain as a result of worries associated with food, shelter, money, the pregnancy itself, abuse, and other stressors. Their results indicated chronic strain predicted preterm birth.

Chronic strain has also been shown to have effects beyond the pregnancy. Phelan, DiBenedetto, Paul, Zhu, and Kjerulff (2015) examined the impact of chronic strain on infant health outcomes during the first year after birth. Similar to Misra et al. (2001), they used a multidimensional chronic strain measure. Their results indicated that high strain during pregnancy was a significant predictor of gastrointestinal illness, respiratory illness, total number

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of illnesses, number of urgent care visits, and number of emergency department visits during the first year.

Community level stress. Community level stress is a group-level chronic stressor that may impact birth outcomes independent of individual-level stressors. Community level stress has been conceptualized in a number of ways. Ahern, Pickett, Selvin, and Abrams (2003) examined adverse neighborhood conditions (e.g., proportion of adults with less than a high school education, unemployed men, households in poverty). They found that these conditions were associated with preterm birth and that some neighborhood characteristics were different depending on individual SES. For example, having public insurance moderated the relationship between neighborhood unemployment and preterm birth such that for women without public insurance, the risk of preterm birth was highest in areas with high unemployment. Similarly, Reagan and Salsberry (2005) found that neighborhood poverty rates and housing vacancy rates increased the risk of very preterm birth for African Americans.

Bell, Zimmerman, Almgren, Mayer, and Huebner (2006) examined isolation, "the probability that an African-American resident will encounter another African-American resident in any random neighborhood encounter" (p. 3030). They found that high levels of isolation were associated with lower birthweight, premature birth, and higher rates of fetal growth restriction. They argued that isolation reflects factors related to segregation such as poor neighborhood quality. Masi, Hawkley, Piotrowski, and Pickett (2007) examined violent crime rates and group density, the extent to which individuals are racial or ethnic majority in their neighborhood. They found that violent crime rates mediated the relationship between economic disadvantage and birthweight and that group density predicted preterm birth. More recently, Phillips, Wise, Rich-Edwards, Stampfer, and Rosenberg (2013) examined the relationship between neighborhood SES

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and preterm birth. Their results suggested that low neighborhood SES was only a predictor of preterm birth for unmarried women.

Pickett, Collins, Masi, and Wilkinson (2005) took a slightly different approach. Instead of focusing on the negative aspects of a community, they examined the positive effects of a better socioeconomic context on birthweight and preterm delivery. Their results suggested that the benefits of a better SES context may be offset for minority women by the negative effects of racism or racial stigma.

Similar to some of the stressors discussed previously, community level stress has been shown to have an impact beyond the pregnancy. Willie, Powell, and Kershaw (2016) examined the impact of a social context variable, urban social stress (i.e., stressful life events, discrimination, family stress, and neighborhood problems). Their results revealed that urban social stress was associated with lower mental and physical quality of life both during pregnancy and postpartum.

Taken together, these studies strongly suggest that the environment within which pregnant women operate on a daily basis has an impact on their health and their babies' health. This highlights the need to consider multiple levels of analysis when examining the experience of stress during pregnancy.

Postnatal

The negative effect of stress on mothers and their babies does not end the moment the baby is born. In fact, stress during pregnancy has been linked to increased risk of postpartum depression (Yim, Tanner Stapleton, Guardino, Hahn-Holbrook, & Dunkel Schetter, 2015). Furthermore, the challenges associated with new motherhood, such as dealing with postpartum depression or juggling the demands associated with breastfeeding, could function as additional

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stressors. Therefore, the conceptual model presented in Figure 1 was designed to be applicable to women's postnatal, in addition to their prenatal, experiences.

Postpartum Depression. Although several of the stressors mentioned previously have been linked to postpartum depression (PPD) as an outcome (for a review see Yim et al., 2015), the experience of PPD in and of itself could function as a stressor. PPD can be defined as "a clinical condition that lasts for at least two weeks, creates significant impairment in functioning, and typically requires professional treatment" (Yim et al., 2015, p. 100). Mothers who have reached the point of PPD are exhausted, irritable, and lack the ability to function at their pre-postpartum level. They want to care for their baby but find it to be mentally and physically challenging which leads to feelings of shame and guilt, thus propelling them into a deeper depression (Hay, 2014).

Much of the research on PPD attempts to predict the risk factors (e.g., stressors) that make women more likely to experience PPD. However, I would argue that PPD could be conceptualized as a chronic stressor in the sense that women experiencing PPD may struggle to function on a daily basis; thus, using all their time and energy to meet basic needs and leaving themselves more vulnerable to other stressors that may come up. From an organizational point of view, PPD may limit women's ability to return to work and their ability to meet job demands upon returning. In a sample of working mothers, Darcy et al. (2011) found that nearly 33% of women reported postpartum depressive symptoms, which is much higher than other estimates of the prevalence of PPD (i.e., 10-15%; Yim et al., 2015). The authors suggest that the elevated rate could reflect the added strain of combining full-time work and family responsibilities and the elevated risk for depression experienced by working mothers. From a health and well-being point of view, PPD has been shown to have negative effects on the mother's physical and mental

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quality of life (Darcy et al., 2011) and the newborn's cognitive, behavioral, and emotional development (Feldman et al., 2009; Fiher, McMahon, & Taylor, 2009; Kingston, Tough, & Whitfield, 2012), with effects potentially lasting into early childhood (Kingston & Tough, 2014) and adolescence (Korhonen, Luoma, Salmelin, & Tamminen, 2012; Verbeek et al., 2012).

Breastfeeding. There are a number of benefits realized by breastfeeding. Research has suggested that breastfeeding can reduce stress (Carter & Altemus, 1997; Groer, Davis, & Hemphill, 2002) and improve mothers' mental (Dennis & McQueen, 2009) and physical health (Rea, 2004). However, breastfeeding also comes with a variety of costs for the mother suggesting that the act of breastfeeding may also function as a stressor. Hahn-Holbrock, Dunkel Schetter, and Haselton (2013) provide a thorough review of the costs and benefits associated with breastfeeding.

A specific cost of breastfeeding is the burden it places on women's time and freedom from childcare responsibilities (Hahn-Holbrock et al., 2013). On average, breastfeeding women must feed their babies or express milk eight to twelve times per day during the first six months and each feeding/expression session takes approximately fifteen to twenty minutes (U.S. Department of Health and Human Services' Office on Women's Health [OWH], 2011). This means that women providing breastmilk to their babies will spend approximately two to four hours a day breastfeeding. For mothers who are expressing milk with a breast pump, additional time is needed to clean all the parts and properly store the breastmilk after each session. Formula feeding is not quite as time consuming due to the fact that babies are able to drink a bottle much quicker than they can nurse from a breast (Hahn-Holbrock et al., 2013). Furthermore, formula feeding makes it possible for the mother to share the responsibility with others. This time commitment places a burden specifically on working mothers. Approximately 45 to 75 minutes

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per workday must be allocated to express breast milk (Mohler, 2011). In addition to the flexibility to take several breaks, working mothers also need a private place to express milk and a place to safely store the milk. Although U.S. laws require organizations to meet these needs (U.S. Department of Labor, 2013), women who request such accommodations may be perceived as less serious about their jobs and/or be stigmatized by coworkers who are uncomfortable with breastfeeding (Smith, Hawkinson, & Paull, 2011). In light of these costs associated with breastfeeding, working women have been found to be less likely than non-working women to breastfeed their infants (Grzywacz, Tucker, Clinch, & Arcury, 2010).

Breastfeeding is the perfect snapshot of work and family demands colliding. This experience of conflicting demands is also known as work-family conflict (WFC). WFC can be defined as a form of interrole conflict in which the demands of one role (i.e., work) are incompatible with the demands of the other role (i.e., family) (Greenhaus & Beutell, 1985). On the one hand, mothers feel pressured to provide the best nutrition for their babies (i.e., breastmilk). On the other hand they strive to meet their job demands and maintain a professional identity. The conflicting nature of these demands creates stress for the mothers. Thus, breastfeeding can potentially function as a postpartum stressor.

<h3 align="center">Threat Appraisal Process</h3>

The transactional theory of job stress (Lazurus, 1991) posits that when individuals encounter stressors from their environment, they will engage in two kinds of appraisals (i.e., primary and secondary threat appraisal). The primary appraisal occurs when individuals cognitively evaluate whether a stressor is a threat to their well-being. If they perceive the stressor as threatening, a secondary appraisal will occur. In this appraisal, individuals determine whether

they have the coping resources necessary to deal with the stressor. From there, they determine the best course of action to mitigate the effects of the stressor (Folkman, 1992).

As shown in Figure 1, the threat appraisal process takes place after organizational stressors have been identified. All pregnant employees could appraise organizational stressors as threatening. However, the women who are experiencing a great deal of non-work related stressors, as described above, may be more likely to appraise organizational stressors as threatening due to the fact that her coping resources are already being tapped by these external stressors. During this threat appraisal process, women will not only decide whether the organizational stressor is threatening (i.e., primary appraisal), but will also reflect on her coping resources (i.e., resilience resources) and previous experiences in dealing with stress (i.e., learning). An appraisal of an organizational stressor as threatening will lead to experienced stress, whereas the coping resources and previous encounters with stress will inform how the women attempt to cope with the stress.

Experienced Stress

The majority of studies examining strain, or experienced stress, have utilized the Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstein, 1983). This scale is a general measure of stress that reflects feelings of being overwhelmed, not in control of stressful demands, and unable to cope. In a Swedish sample of 826 women giving birth for the first time, Dejin-Karlsson et al. (2000) found no relationship between PSS scores and SGA births (i.e., births that are small for gestational age). However, they only used four items from the original scale. Pryor et al. (2003) had similar results. In a sample of women from New Zealand, they examined the difference between PSS scores for mothers of AGA infants (i.e., average for gestational age; n=870) and mothers of SGA infants (n=836). No relationship was found

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between PSS scores and gestational age (Pryor et al., 2003). Krabbendam et al. (2005) examined the association between PSS scores and pregnancy outcomes with a Dutch sample of 5,511 pregnant women. In contrast to the previous studies mentioned, their results showed that a high level of perceived stress at 14 weeks of pregnancy was associated with an increased risk of delivering an SGA infant. However, the effect was reduced after adjusting for education and smoking.

The PSS has also been used to examine the link between perceived stress and birthweight. Using a sample of 2,378 pregnant women in Missouri, Sable and Wilkinson (2000) divided the women based on whether they had given birth to an infant of normal (i.e., greater than 2,500 grams), low (between 1,500 and 2,499 grams), or very low birthweight (less than 1,500 grams). Their results indicated that high perceived stress during pregnancy, reported retrospectively, was associated with 1.5 times greater risk of giving birth to a very low birthweight infant.

More recently, Lau (2013) examined the interactive effects of PSS scores and obstetric complications and health-related quality of life. She conducted a prospective longitudinal study to examine the relationship between perceived stress and preterm birth and birthweight. Using a sample of 581 pregnant women from Macao, she found that women with high PSS scores and a history of obstetric complications were more likely to give birth to premature infants. Additionally, women with high PSS scores who reported poor health-related quality of life were more likely to give birth to low birthweight infants.

The PSS is not the only scale that has been used to measure perceived stress during pregnancy. Coussons-Read et al. (2012) examined the link between perceived stress, preterm delivery, and gestational age at birth (GAB). They recruited a sample of 173 pregnant women

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during the first trimester and followed them through delivery. Instead of utilizing the PSS, they measured pregnancy specific distress with the Revised Pregnancy Distress Questionnaire (NUPDQ; Lobel et al., 2008) and general stress with the Denver Maternal Health Assessment (DMHA). The DMHA was adapted from a validated questionnaire developed by Meikle, Orleans, Leff, Shain, and Gibbs (1995) and has been shown to be valid and reliable for assessing overall maternal stress (Coussons-Read et al., 2005, 2007). It is a combination of items assessing daily stress and hassles and life events. Their results indicated that the effects of overall stress and pregnancy specific distress on GAB were mediated by levels of circulating inflammatory markers (i.e., interleukin-6 and tumor necrosis factor-α) that support the immune system but are also linked premature labor and delivery due to their involvement in the ripening of the cervix before delivery (Coussons-Read, 2005).

Cultural Influences

Research has shown that pregnancy outcomes differ between ethnic groups. Compared with European Americans, African American mothers are more likely to give birth to infants of low birthweight and experience preterm delivery. Furthermore, African American infants are more than twice as likely to die during the first year of life as infants born to European American mothers (Giscombé & Lobel, 2005). Research has also found differences between Latinas and European Americans. Contrary to evidence that links low SES and poorer health (Adler et al., 1994), the birth outcomes of low SES Latina women is often comparable to those of more affluent European Americans (Campos et al., 2008). Although researchers have examined these disparities between ethnic groups with regards to differences in exposure to prenatal stress (e.g., susceptibility to racism and discrimination) and differences in physiological responses to stress

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(Giscombé & Lobel, 2008), they have also indicated that there is value in examining the influence of cultural background (Dunkel Schetter, 2011).

Acculturation is the "cultural modification of an individual, group, or people by adapting to or borrowing traits from another culture" (Merriam-Webster, 2016). As mentioned previously, research has shown that despite economic disadvantage, Latina women tend to experience lower levels of adverse birth outcomes. Zambrana, Scrimshaw, Collins, and Dunkel Schetter (1997) examined the relationship between acculturation of Mexican-origin women and birth outcomes. Their findings indicated that higher acculturation (i.e., higher levels of adapting the U.S. culture) were associated with risk factors during pregnancy (e.g., less positive attitudes toward pregnancy, less social support from baby's father, more drug and alcohol use).

Cultural values are "beliefs about the social world shared by a coherent group of people, of which national or ethnic groups are the most typical examples (Campos et al., 2008; p. 2). A better understanding of cultural values provides insights into the expectations and behaviors of pregnant women and their social network.

Campos et al. (2008) examined the relationship between familialism, a cultural value which emphasizes close family relationships, and stress. The Latino culture places high value on warm interpersonal relationships, especially between family members (i.e., high familialism). Campos et al. (2008) argue that high familialism would augment the benefits of social support during pregnancy. This is because familialism creates a context that facilitates the perception, obtainment, and benefit of social support from close relationships. Their results revealed that Latinas scored higher on familialism than European Americans and that familialism was positively related to social support and negatively related to stress and anxiety during pregnancy.

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Similarly, Abdou et al. (2010) examined communalism, a cultural orientation that emphasizes interdependence, and its impact on maternal prenatal emotional and physical health in a sample of African American and European American women. They found that communalism, a relational cultural factor, was a stronger predictor of prenatal negative affect and stress than ethnicity and SES.

Collectively, these studies suggest that there is value in examining the role culture plays throughout pregnancy, especially with regards to stress. Certain cultural values or orientations may create a context that is more conducive to coping with stress. Furthermore, these studies provide evidence that a model of stress during pregnancy needs to account for multiple levels (i.e., individual, interpersonal, sociocultural, and community).

Resilience Resources

Broadly, resilience refers to "good outcomes in spite of serious threats to adaptation or development" (Masten, 2001; p. 228). Resilient individuals have also been characterized as "those who continue functioning or return to functioning rapidly in the face of trauma" (Dunkel Schetter, 2011; p. 545). In this paper, the stressors previously discussed are conceptualized as the serious threat or trauma. Resiliency when faced with these stressors is likely to result from one or more personal characteristics or resources. Dunkel Schetter (2011) conceptualizes resilience resources to include 1) ego-related resources (e.g., self-efficacy, perceived control, and self-esteem), 2) social constructs (e.g., social integration, connectedness, and support), 3) personality factors (e.g., trait optimism and conscientiousness), 4) beliefs and values (e.g., world views, spirituality, and cultural values), and 5) endowed or constitutional resources (e.g., cognitive ability and physical health). Stress researchers have emphasized the importance of resources in

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the coping process (Hobfoll, 1989; Lazarus & Folkman, 1984; Demerouti et al., 2001). Pregnant women with high levels of resilience resources are less likely to experience adverse outcomes due to stress because they have the necessary resources to cope. Previous research on a few specific resilience resources is outlined below.

Social Support

Social support has been broadly conceptualized as a major factor in promoting healthy pregnancies and buffering the effects of stress (Dunkel Schetter, 2011). Social support involves the exchange of social resources between individuals and comes in three forms: emotional support (i.e., expressions of caring and esteem), informational support (i.e., advice or guidance), and instrumental support (i.e., provision of tangible goods or assistance with tasks) (Collins et al., 1993). In relation to pregnancy, Collins et al. (1993) found that women who received more support during their pregnancy experienced better progress in labor and delivered healthier babies based on APGAR scores. Furthermore, Feldman, Dunkel-Schetter, Sandman, and Wadhwa (2000) found that social support predicted infant birth weight independently and to the same extent as that of traditional risk factors (e.g., obstetric risk). More recently, Tanner Stapleton et al. (2012) examined the impact that support had on emotional distress postpartum. They found that partner support during pregnancy was associated with lower maternal distress postpartum and lower infant distress to novelty.

Much of the research conducted on the role of social support during pregnancy has focused on significant other or family support. However, given that support is more effective when it targets particular stressors (Cohen & Wills, 1985), it is logical to assume that supervisors could play an important role in mitigating the negative effects of workplace stressors on mothers'

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and babies' health. Supervisors are more salient at work and have the power to provide support in ways that family and significant others cannot.

Personal Resources

As mentioned previously, resilience resources can take a variety of forms (e.g., self-esteem, emotional stability, physical health). One approach to examining personal resources has been to combine different resilience resources to create a psychosocial index (Cliver et al., 1992). Although this approach makes it difficult to examine the effect of individual resources, some studies suggest that low levels of mastery, self-esteem, and self-efficacy are associated with low birthweight and preterm birth (Copper et al., 1996; Jesse, Seaver, & Wallace, 2003). Rini, Dunkel Schetter, Wadhwa, and Sandman (1999) examined personal resources by creating a latent factor composed of mastery, dispositional optimism, and self-esteem. Their results indicated that personal resources were directly associated with giving birth to larger babies. Furthermore, personal resources were indirectly associated with gestational age through stress reduction.

Other than social support, there are only a handful of studies that examine specific resilience resources. A personal resource that has received some attention is self-efficacy. Self-efficacy can be defined as a person's belief in their ability to accomplish a task (Bandura, 1982). Nierop, Wirtz, Bratsikas, Zimmermann, and Ehlert (2008) found that self-efficacy predicted lower psychological and physiological stress reactivity during pregnancy. Bolten, Fink, and Stadler (2012) examined the impact of mothers' self-efficacy on the relationship between prenatal stress and infant crying behavior. They found that infants of mother reporting high levels of prenatal stress cried less when their mothers had high levels of self-efficacy.

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Research has also examined dispositional optimism (Scheier & Carver, 1985) as a personal resource during pregnancy. Dispositional optimism refers to a generalized expectation that future outcomes will be positive. Optimism during pregnancy has been associated with lower emotional distress (Lobel, Yali, Zhu, DeVincent, & Meyer, 2002) and higher birthweight (Lobel, DeVincent, Kaminer, & Meyer, 2000). However, Catov, Abatemarco, Markovic, and Roberts (2010) failed to find a relationship between anxiety, optimism, and birthweight. Lobel et al. (2002) found that optimists were more likely to evaluate their high-risk pregnancy as controllable, which was associated with lower distress. Research has also suggested that optimists adopt healthier behaviors during pregnancy such as avoiding risks such as smoking (Park, Moore, Turner, & Adler, 1997) and exercising (Lobel et al., 2002).

Coping Behaviors

A key component of the transactional stress theory (Lazurus, 1966) is that once an event is appraised as stressful, a secondary appraisal takes place to determine if anything can be done to cope with the stressor. Coping is defined as a person's "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the person's resources" (Folkman, Lazarus, Dunkel Schetter, DeLongis, & Gruen, 1986; p. 993). The study of coping during pregnancy has been identified as an area full of opportunities for future researchers (Dunkel Schetter, 2011). However, a few studies have sought to build knowledge and theory about how pregnant women manage stress in pregnancy (e.g., Hamilton & Lobel, 2008; Huizink, de Medina, Mulder, Visser, & Buitelaar, 2002; Lobel et al., 2008; Yali & Lobel, 1999; 2002).

Huizink et al. (2002) examined the association between a particular coping strategy and pregnancy outcomes. Lazurus and Folkman (1984) identify three different coping strategies:

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emotion focused, problem focused, and avoidance coping. Emotion focused coping involves regulating affect surrounding a stressful situation (e.g., expressing feelings to others or positively reappraising the situation). On the other hand, problem focused coping involves taking action to alleviate the stressful situation (e.g., planning, information seeking, and finding solutions to the problem). Finally, avoidance coping involves avoiding the stressful situation all together (e.g., engaging in distracting activities or seeking social diversions). Up until this point, research on coping during pregnancy had focused on high-risk populations (e.g., homeless women, teen expectant mothers, and substance abusers). Using a sample of low-risk, nulliparous women, Huizink et al. (2002) assessed coping strategies used during early, mid-, and late pregnancy. Their findings revealed that emotion-focused coping was used most frequently in early pregnancy and that problem-focused coping was used most frequently during early and mid-pregnancy. Coping strategies were predicted by maternal characteristics such as locus of control, education, age, depression, and situation appraisal.

Yali and Lobel (1999) developed a pregnancy-specific coping measure: the Prenatal Coping Inventory (PCI). It has four coping subscales: Preparation, Avoidance, Positive Appraisal, and Prayer. Hamilton and Lobel (2008) revised the PCI so that it could be administered by interview and so that it was appropriate for use throughout pregnancy. Exploratory factor analysis revealed three factors: planning-preparation, avoidance, and spiritual-positive coping. Their results indicated that spiritual-positive coping was used most frequently across pregnancy (early, mid-, and late pregnancy) and that avoidance was used least often. Mothers characterized by high state anxiety and pregnancy-specific distress tended to used avoidance coping whereas mothers characterized by greater religiosity and optimism were more likely to use spiritual-positive coping.

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Collectively, these studies suggest that women use different strategies to manage prenatal stress. They also suggest that women's characteristics and perceptions impact their choice of coping strategies.

Maternal Health Behaviors

Research has also identified several health behaviors that women might utilize as a form of coping with prenatal stress. Research has shown that individuals experiencing high levels of stress are more likely to engage in unhealthful behaviors that have been linked to adverse health outcomes such as smoking and substance use, poor diet and nutrition, lack of physical activity, and overall unhealthy lifestyle (Ng & Jeffrey, 2003). Furthermore, prenatal stress may also impact women's attitudes toward their pregnancy which, in turn, influences their health behavior (Dunkel Schetter & Lobel, 2012). Engagement in these behaviors as a coping mechanism helps explain the link between prenatal stress and birth outcomes.

<center>**Risk Factors**</center>

An examination of stress and health outcomes requires that one take into consideration a variety of risk factors. Researchers examining stress and adverse pregnancy outcomes have focused on three groups of risk factors: medical history, prenatal care, and behavioral risk factors.

Although there are a variety of medical risk factors that must be taken into consideration when examining pregnancy, research has found that both individually and combined, these factors tend to explain a small amount of variance (Dunkel Schetter & Glynn, 2011). Medical risk factors include *medical history factors* (e.g., LBW or PTB in a previous pregnancy; multiple second trimester spontaneous abortions [i.e., miscarriages]; prior first trimester induced abortion;

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history of infertility; nulliparity [i.e., no prior births]; cervical, uterine, and placental abnormalities; and DES exposure) and *current pregnancy conditions* (e.g., gestational bleeding, intrauterine growth retardation, preeclampsia, urogenital infections, inadequate weight gain). Additionally, short stature, low pre-pregnancy weight, and low body mass index are also risk factors (IOM, 2006). Prenatal care has also been studied as a risk factor. Research has shown that late or no prenatal care increases the risk of preterm birth and low birth weight (Masi et al., 2007).

Several behavioral risk factors have been proposed by researchers (e.g., use of tobacco, cocaine, marijuana, and other illicit drugs; caffeine intake; dietary intake; sexual activity during pregnancy; and physical activity; Dunkel Schetter & Glynn, 2011). However, many of these behavioral risks have not had as strong an impact on adverse health outcomes as presumed. For example, Neggers, Goldenberg, Cliver, and Hauth (2006) examined the impact of "health practices" on pregnancy outcomes. The health practices variable was a score assigned to each woman regarding her diet, exercise, alcohol use, tobacco use, and the use of preventative medical and dental services. Their results revealed that health practices were not associated with any of the pregnancy outcomes they examined (i.e., low birthweight, prematurity, and intrauterine growth retardation).

Learning & Adapting

As mentioned previously, the process of identifying and coping with stressors does not occur in a vacuum. Instead, individuals are capable of learning from their previous stressor experiences and adapting their future behaviors accordingly (Ursin & Eriksen, 2004; 2010). As shown in Figure 1, learning and adapting will take place after women have experienced the outcomes of their stress and coping. This learning and adapting will then inform women's

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subsequent appraisals of stress. If they were able to cope effectively with a stressor, the next time they encounter this stressor it may not be appraised as threatening as it was previously since they know how to effectively cope with it. However, if their coping was ineffective this might lead to more negative appraisals of organizational stressors in the future.

CHAPTER 3

ORGANIZATIONAL STRESSORS AND PREGNANCY

Research Model

In the previous chapter, a conceptual model of stress and pregnancy was presented (Figure 1) and previous research that links the various components was discussed. In order to provide a deeper understanding of the organizational stressors pregnant employees might encounter, three psychosocial pregnancy-specific organizational stressors are proposed. To my knowledge, this is the first study to examine pregnancy-specific psychosocial organizational stressors and their relationship with three different types of outcomes: organizational, health, and family. Figure 2 presents the empirical model tested in this study. Consistent with Lazarus' transactional theory of job stress, pregnant employees are hypothesized to experience stress when organizational stressors (i.e., perceived pregnancy discrimination, pregnancy disclosure, and identity-role conflict) are appraised as threatening. This experienced stress ultimately leads to adverse organizational outcomes (i.e., decreased job satisfaction, increased turnover intentions, and turnover), mother's health outcomes (i.e., postpartum depression) baby's health outcomes (i.e., decreased APGAR scores, birthweight, gestational age, and number of doctor visits), and family outcomes (i.e., decreased family satisfaction and increased work-family conflict). The following section presents preliminary findings from a pilot study on job stress and pregnancy and develops the research model and hypotheses tested in this study.

Pilot Study

The research model (Figure 2) and hypotheses for this study were based on a pilot study in which data were collected from student recruited participants. This method of data collection has been encouraged by scholars (Hochwarter, 2014) and previous research has shown that

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student recruited samples are not significantly different from non-student recruited samples regarding demographics and effect sizes (Wheeler, Shanine, Leon, & Whitman, 2013). Students of a large introductory organizational behavior class were offered extra credit in exchange for sharing the link to a Qualtrics survey with female employees 18 years or older who had given birth within the last three years. Students who did not wish to recruit participants were offered an alternative assignment. A total of 374 surveys were started in Qualtrics, but after discarding unfinished surveys, those that were completed in less than five minutes, those that did not answer 2 out of 3 quality-check questions correctly, and those that indicated that they had given birth more than 3 years ago, the resulting sample consisted of 261 individuals, a useable survey rate of 70%.

The final sample consisted of mothers who worked for an organization either from their home (e.g., telecommuting; 9.5%) or outside of the home (90%). On average these women worked 39 hours a week (M = 38.98; SD = 8.05) and had been with their current organization for 5.5 years (M = 5.51; SD = 3.39). The majority of the women were married (80%) and college graduates (54%). On average, these women had given birth 1.5 years ago (M = 1.56; SD = .73) and had 1.5 children (1.54; SD = .73). The vast majority of respondents indicated that they took some type of maternity leave (91%). However, only 27% of these women were able to take *paid* maternity leave. The majority of respondents indicated that their husband was the primary financial provider for the family (62.4%). However, 28% indicated that they were the breadwinner of the family and 8% indicated that they equally shared the financial burden with their husband/significant other.

Table 1 presents the means, standard deviations, and correlations among the pilot study variables. Overall, these results suggest that organizational stressors have an adverse association

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with organizational, health, and family outcomes. Perceived pregnancy discrimination ($r = .42$, p<.01), pregnancy disclosure ($r = .41$, p<.01), and identity-role conflict ($r = .25$, p<.01) are all positively associated with psychological distress. Additionally, perceived pregnancy discrimination ($r = .29$, p<.01), pregnancy disclosure ($r = .31$, p<.01), and identity-role conflict ($r = .30$, p<.01) are all positively associated with job tension. This suggests that pregnancy-specific organizational stressors have a positive relationship with experienced job stress.

Furthermore, both measures of experienced job stress (i.e., psychological distress and job tension) are associated with organizational, health, and family outcomes of interest. Psychological distress is positively associated with turnover intentions ($r = .13$, p<.05), somatic complaints ($r = .55$, p<.01), postpartum depression ($r = .54$, p<.01), and work-family conflict ($r = .36$, p<.01). Psychological distress is negatively associated with job satisfaction ($r = -.15$, p<.05), APGAR scores ($r = -.43$, p<.01), and family satisfaction ($r = -.26$, p<.01). Similarly, job tension is positively associated with turnover intentions ($r = .39$, p<.01), somatic complaints ($r = .20$, p<.01), postpartum depression ($r = .34$, p<.01), and work-family conflict ($r = .53$, p<.01) and negatively associated with job satisfaction ($r = -.30$, p<.01) and family satisfaction ($r = -.23$, p<.01). Based on these results and a thorough literature review, the research model presented in Figure 2 was developed.

This study was designed to address the major limitations of the pilot study. First, the data from the pilot study are based on retrospective responses from women who had given birth within the last three years. The current study addressed this, by sampling women who were pregnant at the time of responding and in the middle of dealing with organizational stressors. Not only is the data from the pilot study retrospective, it is also cross-sectional. In the current study, the measurement of organizational stressors (i.e., independent variables), experienced stress and

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resources (i.e., mediators and moderators), and organizational, health, and family outcomes (i.e., dependent variables) were time-separated. The sample, measures, and procedures for this study are further discussed in the next chapter.

Hypothesis Development

Experienced Stress

The following sections present three organizational stressors and discuss how and why they may be related to organizational, health, and family outcomes for pregnant employees. As shown in Figure 2, these stressors are not hypothesized to directly impact outcomes, but instead the relationships are mediated by experienced stress, consistent with job stress theory and the conceptual model presented in chapter two. Employees do not experience stress unless a stressor is appraised as threatening and the felt stress is what ultimately leads to adverse outcomes.

For the purpose of this paper, experienced stress will serve as an umbrella term when referring to the stress employees feel when stressors are perceived as threatening. This study will examine two different types of experienced stress: perceived stress and job tension. Perceived stress is a more general form of experienced stress whereas job tension is experienced stress specific to the work-domain and consists of felt tensions and pressures resulting from job requirements (House & Rizzo, 1972). Both are hypothesized to be related to the organizational stressors presented in this paper and ultimately to organizational, health, and family outcomes for pregnant employees. Greater detail regarding the relationships will be provided in the following sections.

Perceived Pregnancy Discrimination

In 1978, the Pregnancy Discrimination Act was passed as an amendment to Title VII of the Civil Rights Act of 1964 (U.S. EEOC, 2011). This act makes it unlawful for employers to

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discriminate based on pregnancy in terms of hiring, pay, job assignments, promotions, layoffs, training, fringe benefits, firing, and any other aspect of employment (U.S. EEOC, 2011). Further measures were taken against pregnancy discrimination in 1993 with the introduction of the Family Medical Leave Act. This act allows new parents, including foster or adoptive parents, up to 12 weeks of unpaid leave without the penalty of losing one's job (U.S. EEOC, 2011; Salihu et al., 2012). Despite the fact that these laws were meant to shield pregnant women from discrimination in the workplace, research suggests that pregnant employees actually experience a great deal of discrimination, both formally and informally (Salihu et al., 2012).

Although there is a general lack of research on pregnancy at work, the research that has been conducted suggests that pregnancy in the workplace is met with negative perceptions (Bragger et al., 2002; Masser et al., 2007; Salihu et al., 2012). Bragger et al. (2002) outlined a number of reasons that pregnancy discrimination may take place. First, the authors suggested that pregnant women may be subject to exaggerated gender stereotypes. For example, pregnancy may elicit expectations of stereotypically feminine behaviors (e.g., empathy and passivity) instead of the stereotypically masculine behaviors thought to be important in the workplace (e.g., assertiveness). Bragger et al. (2002) suggested that the extent to which these gender stereotype perceptions lead to discrimination may depend on the organizational role of the pregnant employee. A few other reasons discrimination might occur are the employer's worry about the impact that extended leave would have on the organization, doubt about pregnant women's ability to perform their job, and concern about the impact that pregnancy will have on the workload of other employees (Bragger et al., 2002).

Despite the fact that biases against pregnancy at work have been identified (Bragger et al., 2002), very little research has examined the impact of *perceived* discrimination on the

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pregnant employee. Perceived discrimination can be defined as "a behavioral manifestation of a negative attitude, judgment, or unfair treatment toward members of a group" (Pascoe & Smart Richman, 2009, p. 533).

Previous research has conceptualized the experience of discrimination as a social stressor (Pascoe & Smart Richman, 2009). In their meta-analysis, Schmitt, Branscombe, Postmes, and Garcia (2014) found that perceived discrimination was negatively related to psychological well-being (e.g., self-esteem, depression, anxiety, psychological distress, and life satisfaction). Pregnant women are well aware of their vulnerability in the workplace. They realize that they might be viewed as less competent and less committed to their organization and likely worry that this might lead to demotion or even termination. Not only does the possibility of negative outcomes create a threatening environment, the constant anticipation of being the target of pregnancy discrimination also depletes employees' resources.

Hypothesis 1: Perceived pregnancy discrimination is positively associated with experienced stress.

Pregnancy Disclosure

In addition to discrimination, pregnancy disclosure could also serve as a source of stress for pregnant employees. Due to the discrimination that can take place, pregnant employees are faced with complex disclosure decisions (Jones et al., 2013). Jones et al. (2013) examined the disclosure decisions pregnant women face. They conceptualized pregnancy as a unique stigmatized identity due to its increasingly obvious nature (i.e., pregnancy cannot be concealed forever). The authors suggested that pregnant women are burdened with two competing motives regarding disclosure decisions: authenticity (i.e., revealing) and self-protection (i.e., concealing). Once pregnant employees reveal their pregnancy, they are at an increased risk of discrimination

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(Jones et al., 2013). In order to avoid discrimination, employees may choose to conceal their pregnancy.

Concealing behaviors can be defined as "conscious, active attempts to hide a true identity and "pass" as a member of the majority group" (Jones et al., 2013, p. 3). This can include behaviors such as making up stories, avoiding personal questions, speaking in generalities, or taking measures to prevent others from learning information that may confirm an invisible identity (Jones et al., 2013). Although concealing behaviors may allow pregnant employees to avoid discrimination, the suppression of their true identities will create a discrepancy between their own understanding of self and the self they express to others (Jones et al., 2013). This discrepancy creates cognitive dissonance and can lead to a number of detrimental consequences. Given the demands associated with maintaining secrecy and the toll that cognitive dissonance can take over time, I hypothesize that pregnancy disclosure will be a source of stress for pregnant employees.

Hypothesis 2: Pregnancy disclosure is positively associated with experienced stress.

Identity-Role Conflict

Not only can the decision about how, when, and to whom to disclose their pregnancy be a source of stress, but once pregnant employees reveal their pregnancy to coworkers and supervisors, they are faced with the task of integrating both their role as a professional and as a mother. Role conflict, a traditional stressor, occurs when employees are faced with incompatible demands (Kahn et al., 1964). Previous research has linked it to a number of dysfunctional outcomes such as job dissatisfaction, psychological strain, and work-family conflict (Rizzo et al., 1970; Schaubroeck et al., 1989; Michel et al., 2011). Pregnant employees, in particular, are at risk for identity-role conflict to occur. On the one hand, they want to maintain the professional

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image they have worked hard to develop. This involves meeting *every* job demand that comes their way – sometimes even taking on more than usual. On the other hand, they are faced with a variety of new demands as a mother such as doctors' appointments, childbirth classes, and frequent trips to the bathroom.

Little et al. (2015) examined pregnant employees' strategies for maintaining a professional image. They defined professional image as "the aggregate of others' perceptions of an individual's competence and character in the workplace" (p. 8). They discovered that while pregnant women's perceptions of themselves had not changed with pregnancy, their perceptions of how they were viewed by others in the organization had changed. As a result, these women perceived their pregnancy to be a threat to their professional image and, at times, even their job (Little et al., 2015). Due to this threat, women engaged in a number of behaviors to maintain their professional image such as maintaining the same pace at work, not requesting special accommodations, working harder than before the pregnancy, shortening maternity leave, hiding the pregnancy, and downplaying the pregnancy (Little et al., 2015).

Integrating her role as a professional and as a mother can be one of the most significant challenges a woman faces in the workplace (Salihu et al., 2012). Greenberg, Ladge, & Clair (2009) found that many women felt the need to challenge common beliefs about pregnancy at work (i.e., lack of dedication, ambition, and competency). However, they found that many women also felt the need to scale back their career aspirations as the role of mother became increasingly valuable. Juggling these two roles obviously places conflicting demands on pregnant employees. Thus, I hypothesize that identity-role conflict will be a source of stress for pregnant employees.

Hypothesis 3: Identity-role conflict is positively associated with experienced stress.

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Organizational Outcomes

Stress has been linked to organizational outcomes. In their meta-analysis, Podsakoff, LePine, and LePine (2007) found that stressors were linked to decreased job satisfaction and increased turnover intentions and actual turnover. Bateman and Strasser (1983) demonstrated that job tension, a form of experienced stress, led to decreased job satisfaction. Further, their findings suggested that the relationship between job tension and job satisfaction was reciprocal. Netemeyer, Johnston, and Burton (1995) also examined job tension (i.e., experienced stress). They found that job tension was negatively related to employee job satisfaction and positively related to employee propensity to leave. Utilizing a different measurement of experienced stress, psychological distress, Hardy, Woods, and Wall (2003) demonstrated that employee psychological distress led to increased absenteeism from work.

Clearly, experienced stress has an impact on employees' organizational outcomes. Pregnancy-specific organizational stressors are likely to function similarly to more traditional organizational stressors (e.g., role stressors) in the way that they will be appraised as threatening and demand coping resources. If pregnant employees experience stressors such as perceived pregnancy discrimination, pregnancy disclosure, and identity-role conflict on a daily basis, their resources will quickly be depleted. This depletion of resources makes it difficult for women to cope with pregnancy-specific organizational stressors and leaves them more vulnerable to threats. Furthermore, a negative attitude in the workplace about pregnancy could eventually lead to decreased job satisfaction (Salihu et al., 2012). Pregnant employees' experiences at work during their pregnancy likely have a strong impact on their intentions to return to work post-maternity leave as well as their attitudes and experiences upon their return (Salihu, 2012). Thus, I hypothesize that organizational stressors will lead to important organizational outcomes such as

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decreased job satisfaction, increased turnover intentions, and actual turnover through experienced stress (i.e., job tension and perceived stress).

Hypothesis 4: Experienced stress will mediate the relationship between organizational stressors (i.e., perceived pregnancy discrimination, pregnancy disclosure, and identity-role conflict) and adverse work outcomes (e.g., job satisfaction, turnover intentions, and actual turnover).

Health Outcomes

The link between work stressors and physical health has been well documented (Nixon et al., 2011). In their meta-analysis of 79 studies, Nixon et al. (2011) found that work stressors (e.g., interpersonal conflict, lack of control, and role conflict) were associated with physical symptoms such as backaches, headaches, and fatigue. Furthermore, the link between stress and health outcomes for expecting mothers and their babies has been established (Witt, Litzelman, Cheng, Wakeel, & Barker, 2014). However, the impact of job stress, specifically, has received less attention.

In terms of mothers' health, researchers have found a link between job stress and postpartum depression. Psychological work demands have been associated with greater depressive symptoms postpartum (Dagher et al., 2009). Furthermore, unfavorable job characteristics such as high workloads, low job flexibility, lack of job security, and short family leave times have been associated with increased depressive symptoms postpartum (Chatterji & Markowitz, 2012; Cooklin et al., 2011; Dagher et al., 2011; Dennis et al., 2004).

With regard to babies' health, Vrijkotte, van der Wal, van Eijsden, and Bonsel (2009) examined the relationship between first trimester working conditions of pregnant employees and infant birthweight. Their findings revealed that high job strain was significantly associated with

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reduced birthweight and an increased risk of delivering a small-for-gestational-age infant. This relationship was particularly strong for mothers who worked 32 hours or more a week. Similarly, Lee et al. (2011) found that pregnant employees' job stress had an impact on both birthweight and gestational age. Thus, consistent with previous research, organizational stressors (i.e., perceived pregnancy discrimination, pregnancy disclosure, and identity-role conflict) will be positively associated with experienced stress and eventually lead to adverse health outcomes for expecting mothers and their babies.

> *Hypothesis 5:* Experienced stress will mediate the relationship between organizational stressors (i.e., perceived pregnancy discrimination, pregnancy disclosure, and identity-role conflict) and adverse health outcomes for mother (e.g., postpartum depression) and baby (e.g., low APGAR score, low birthweight, low gestational age, and number of doctor's visits).

Family Outcomes

Organizational stressors have consistently been linked to family outcomes (Byron, 2005; Carlson, Grzywacz, et al., 2011; Michel et al., 2011). Employees, and pregnant employees in particular, are striving to balance their work and family life. Spillover theory is frequently used in work-family research. This theory suggests that individuals' participation in one domain can impact their participation and attitudes in another domain (Carlson, Ferguson, Perrewé, & Whitten, 2011). Although spillover can be both positive and negative (Michel, Clark, & Jaramillo, 2011), it is often used in work-family literature to explain how the stress experienced by individuals at work can follow them home or vice versa.

As discussed in the previous sections, the presence of organizational stressors is likely to lead to a state of distress and tension (i.e., experienced stress). Greenhaus and Beutell (1985)

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identified three types of work-family conflict (WFC): time-based, strain-based, and behavior-based. They argued that workplace stressors lead to strain symptoms (e.g., tension, anxiety, fatigue, depression, apathy, and irritability), and that this job strain leads to strain-based WFC. Women experiencing stress at work cannot be expected to shut down these feelings the minute they leave the office. Instead, this experienced stress is likely to permeate their family life by limiting their ability to successfully perform their family-related responsibilities. This inability to meet their family demands is likely to negatively impact their satisfaction with family life. Thus, I hypothesize that experienced stress will mediate the relationship between organizational stressors and family outcomes (i.e., WFC and family satisfaction).

> *Hypothesis 6:* Experienced stress will mediate the relationship between organizational
> stressors (i.e., perceived pregnancy discrimination, pregnancy disclosure, and identity-
> role conflict) and family outcomes (i.e., WFC and family satisfaction).

The Moderating Role of Resources

Self-Regulation. A key resource in the AAA model (Mackey & Perrewé, 2014) is self-regulation. Self-regulation refers to individuals' capacity for altering their actions to conform to ideals, values, morals, and social expectations and to support the pursuit of long-term goals (Baumeister, Vohs, & Tice, 2007). Self-regulation, or self-control, enables individuals to restrain themselves from engaging in inappropriate behaviors. In the popular press, self-regulation has also gone by the name of willpower, which implies an inner strength or energy available to manage demands and bring about positive outcomes. High levels of self-regulation have been associated with positive outcomes such as good adjustment and positive psychological states, whereas poor self-regulation has been associated with increased vulnerability, substance-abuse, and eating disorders (Tangney, Baumeister, & Boone, 2004).

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In order to cope with stressors, individuals must continually monitor the environment for threats (Lazurus & Folkman, 1984). This constant monitoring requires self-regulation in the form of attention control. Mackey and Perrewé (2014) argued that individuals utilize self-regulatory resources in order to stop or buffer inappropriate coping behaviors. The previous discussion has established that pregnant employees are at risk of encountering pregnancy-specific stressors at work. Self-regulation may allow these employees to avoid coping behaviors that may be especially detrimental during pregnancy (e.g., negative emotional reactions, smoking and substance use, and poor nutrition), leading to more positive outcomes. Thus, I hypothesize that self-regulation will moderate the relationships between experienced stress and organizational, health, and family outcomes such that employees with higher levels of self-regulation will have more positive outcomes when experiencing stress than employees with lower levels of self-regulation.

Hypothesis 7a: Self-regulation will moderate the relationship between experienced stress and organizational outcomes such that high levels of self-regulation attenuate the relationships between experienced stress and adverse organizational outcomes.

Hypothesis 7b: Self-regulation will moderate the relationship between experienced stress and health outcomes such that high levels of self-regulation attenuate the relationships between experienced stress and adverse health outcomes.

Hypothesis 7c: Self-regulation will moderate the relationship between experienced stress and family outcomes such that high levels of self-regulation attenuate the relationships between experienced stress and adverse family outcomes.

Resiliency. As mentioned in Chapter 2, resiliency may play a role in pregnant women's experience of stress. Resiliency has been defined as the "capacity to rebound, to 'bounce back'

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from adversity, uncertainty, conflict, failure or even positive change, progress, and increased responsibility" (Luthans, 2002, p. 702). Resiliency has been linked to a number of positive outcomes such as improved mental and physical health (Tugade, Fredrickson, & Barrett, 2004), overall employee well-being (Avey, Luthans, Smith, & Palmer, 2010), job satisfaction, work happiness, and organizational commitment (Youssef & Luthans, 2007).

Resilient individuals are able to recover from negative setbacks and proactively learn and grow through conquering challenges (Youssef & Luthans, 2007). Scholars have described resilient individuals as having "zestful and energetic approaches to life" and being "curious and open to new experiences" (Tugade et al., 2004). When dealing with stress, resilient individuals are able to cultivate positive emotions to achieve effective coping outcomes. Moreover, they are able to elicit positive emotions in close others, creating a supportive social network to aid in the coping process (Tugade et al., 2004). Based on this, I hypothesize that resiliency will moderate the relationship between experienced stress and adverse organizational, health, and family outcomes such that women with high resiliency will experience more positive outcomes than women with low resiliency.

Hypothesis 8a: Resiliency will moderate the relationship between experienced stress and organizational outcomes such that high levels of resiliency attenuate the relationship between experienced stress and adverse organizational outcomes.

Hypothesis 8b: Resiliency will moderate the relationship between experienced stress and health outcomes such that high levels of resiliency attenuate the relationship between experienced stress and adverse health outcomes.

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Hypothesis 8c: Resiliency will moderate the relationship between experienced stress and

family outcomes such that high levels of resiliency attenuate the relationship between

experienced stress and adverse family outcomes.

Learning

As previously mentioned, research has shown that individuals learn from their previous

encounters with stressors (Ursin & Eriksen, 2004; 2010). After coping with a stressor,

individuals receive feedback about whether or not their coping efforts were effective in

alleviating the stress. This feedback then informs subsequent threat appraisals. If individuals

were able to effectively cope, future encounters with similar organizational demands do not seem

as threatening because they know how to handle the situation. However, ineffective coping

attempts may lead to more negative threat appraisals.

This is particularly relevant to pregnancy. For many first-time mothers, the idea of

navigating the work environment while pregnant can seem daunting. They may worry about how

their supervisor and coworkers will react to their pregnancy, whether they will need to (or even

be allowed to) request special accommodations, and what the organizations' policy on maternity

leave. However, as time goes on, the experience of pregnancy at their organization becomes less

and less ambiguous. Furthermore, by the time a second pregnancy comes around, particularly in

the same organization, women will have gained feedback from their first pregnancy and have a

better understanding of the expectations regarding pregnancy at work. Thus, I hypothesize that

pregnant women will learn from their previous experiences with stress at work.

Research Question: Do women learn from their experiences with stress at work during

pregnancy?

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CHAPTER 4

METHODS

Procedure and Participants

Sample

Online surveys were distributed to pregnant women recruited through a post on an online pregnancy forum and on social media. Respondents were asked to complete three time-separated surveys. In exchange for their participation, at the end of each survey they were offered the opportunity to be entered into a raffle for a $100 Babies R Us gift card. Women completed the first survey during their third trimester (i.e., between 28 and 40 weeks of pregnancy). The second survey was completed four weeks later. Each woman completed the third survey approximately two weeks after her due date. The first survey included measures of perceived pregnancy discrimination, pregnancy disclosure, identity-role conflict, and several demographic characteristics. The second survey included measures of perceived stress, job tension, somatic complaints, self-regulation, and resiliency. The third survey included measures of job satisfaction, turnover intentions, actual turnover, postpartum depression, APGAR scores, birthweight, gestational age, number of doctor visits, family satisfaction, work-family conflict, and obstetric risks.

The software package, GPower was used to conduct an a priori power analysis. Utilizing the GPower calculator and assuming a small effect size (i.e., .10), a significance level of $p < .05$, and a desired power of .95, a sample size of 110 was recommended. A total of 307 women participated in the first survey. An email containing the link to the second survey was sent to all participants who provided their email addresses (n = 267). Of these, 229 women completed the second survey. Out of the 152 participants invited to participate in the third survey, 130 have

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completed it. After screening and preparing the data, six women were dropped from the sample due to incomplete responses. The final sample contains 124 participants. Thus, the final participation rate was 40%.

Women included in the final sample were, on average, 30 weeks pregnant when they completed the first survey (M = 30.20; SD = 5.68). The final sample consisted of women who worked for an organization either from their home (e.g., telecommuting; 4%) or outside of the home (96%). On average they worked 40 hours a week (M = 39.81; SD = 5.87), had been with their current organization for 4 years (M = 4.08; SD = 2.97), and had been in their current position for 2 years (M = 2.44; SD = 1.77). The majority of the women were white (89%), married (92%) and college graduates (79%). On average, their household incomes fell between $80,000 and $90,000. Finally, the majority were first time mothers (84%).

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Measures

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Perceived Pregnancy Discrimination

Perceived pregnancy discrimination was measured using nine items adapted from James, Lavato, and Cropanzano's (1994) Workplace Prejudice/Discrimination Inventory. Respondents were asked to indicate the extent to which they agreed with each statement (1 = Strongly Disagree; 5 = Strongly Agree). Sample items include "At work I felt socially isolated because of my pregnant status" and "At work pregnant employees receive fewer opportunities" (Pilot Study 1, α = .89; Sample, α = .88).

Pregnancy Disclosure

Pregnancy disclosure was measured using items from Little et al.'s (2015) passing and downplaying the pregnancy scales. Respondents were asked to indicate the extent to which they agreed with each statement (1 = Strongly Disagree; 5 = Strongly Agree). Sample items include "I

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tried to hide my physical signs of pregnancy" and "I downplay my pregnancy at work" (Pilot Study 1, α = .89; Sample, α = .83).

Identity-Role conflict

Identity-role conflict was measured with Little et al.'s (2015) twelve-item Social Identity Management Pregnancy (SIMp) Motives scale. Respondents were asked to indicate the extent to which they agreed or disagreed with each statement (1 = Strongly Disagree; 5 = Strongly Agree). Sample items include "I worry that coworkers might think I plan to quit" and "I want people to take me seriously as a professional" (Pilot Study 1, α = .84; Sample, α = .80).

Perceived Stress Scale

Perceived stress was measured with Cohen et al.'s (1983) fourteen-item Perceived Stress Scale. Respondents were asked to indicate how often they have felt or thought a certain way (1 = Never; 5 = Very Often). Sample items include "In the last month, how often have you been upset because of something that happened unexpectedly" and "In the last month, how often have you felt nervous or stressed" (Sample, α = .86).

Job Tension

Job tension was measured with a 7-item scale developed by House and Rizzo (1972). Respondents were asked to indicate the extent to which they agreed or disagreed with each statement (1 = Strongly Disagree; 5 = Strongly Agree). Sample items include "My job tends to directly affect my health," and "I work under a great deal of tension" (Pilot Study 1, α = .87; Sample, α = .84).

Somatic Complaints

Somatic complaints were measured using an adaptation of Lehrer and Woolfolk's (1982) Somatic Anxiety Assessment. Respondents were asked to indicate how often they experience

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each item during their most recent pregnancy (1 = Never; 5 = All of the time). The six-item scale contains items from the original scale such as "I felt dizzy." However, the scale has been modified to include somatic complaints often experienced during pregnancy. Some sample items are "I had heartburn", "I felt nauseous", and "My back ached" (Pilot Study 1, α = .74; Sample, α = .53).

Job Satisfaction

Job satisfaction was measured using Brayfield and Roth's (1951) three-item scale. Respondents were asked to indicate the extent to which they agreed or disagreed with each statement (1 = Strongly Disagree; 5 = Strongly Agree). Sample items include "In general, I like working at my job" and "I am generally satisfied with the kind of work I do in this job" (Pilot Study 1, α = .91; Sample, α = .88).

Turnover

Turnover intentions were measured using Cammann, Fichman, Jenkins, and Klesh's (1979) three-item scale. Respondents were asked to indicate the extent to which they agreed or disagreed with each statement (1 = Strongly Disagree; 5 = Strongly Agree). Sample items include "I often think about quitting my job" and "I will probably look for a new job in the next year" (Pilot Study 1, α = .82; Sample, α = .89).

Turnover was also assessed with a single item question "Have you returned to your previous job?" If respondents did not return to their jobs, they were asked to indicate their reason for not returning.

Postpartum Depression

Postpartum depression was measured using an adaptation of Cox, Holden, and Sagovsky's Edinburgh Postnatal Depression Scale (1987). Respondents were asked to indicate

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the extent to which they agreed or disagreed with each statement (1 = Strongly Disagree; 5 = Strongly Agree). Some sample items include "I feel scared or panicky for no very good reason" and "I feel sad or miserable" (Pilot Study 1, α = .90; Sample, α = .87 – Pilot Study).

APGAR Score

The APGAR score is used by physicians to provide a quick overall assessment of newborns' health. There are five subcategories (i.e., heart rate, respiration, muscle tone, reflex response, and color) rated on a scale of zero to two, with a total score of ten. A score of seven to ten is considered normal (American Pregnancy Association, 2015). APGAR score was measured with one item, "What was your baby's APGAR score?"

Birthweight

Birthweight was measured with a single item: "What was your baby's birthweight?" Respondents were asked to indicate both pounds and ounces.

Gestational Age

Gestational age was measured with a single item: "How many weeks pregnant were you when you delivered your baby?"

Number of Doctor's Visits

The number of doctor's visits was measured with a single item: "How many times have you taken your baby to the doctor?"

Family Satisfaction

Family satisfaction was measured with Zabriskie and Ward's (2013) Satisfaction with Family Life (SWFL) scale. Respondents were asked to indicate the extent to which they agreed or disagreed with each statement (1 = Strongly Disagree; 5 = Strongly Agree). Sample items

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include "In most ways my family life is ideal" and "The conditions of my family life are excellent" (Pilot Study 1, α = .88; Sample, α = .91).

Work-Family Conflict

Work-family conflict was measured with Matthews, Kath, and Barnes-Farrell's (2010) three-item scale. Respondents were asked to indicate the extent to which they agreed or disagreed with each statement (1 = Strongly Disagree; 5 = Strongly Agree). Sample items include "I have to miss family activities due to the amount of time I must spend on work responsibilities" and "I am often so emotionally drained when I get home from work that it prevents me from contributing to my family" (Pilot Study 1, α =.65; Sample, α = .66).

Self-Regulation

Self-regulation was measured using Tangney et al.'s (2004) thirteen-item Brief Self-Control Scale. Respondents were asked to indicate the extent to which each statement reflected how they typically are (1 = Not at all like me; 5 = Exactly like me). Sample items include "I am good at resisting temptation" and "People would say that I have iron self-discipline" (Sample, α = .79).

Resilience

Resilience was measured using Smith et al.'s (2008) six-item Brief Resilience Scale. Respondents were asked to indicate the extent to which they agreed or disagreed with each statement (1 = Strongly Disagree; 5 = Strongly Agree). Sample items include "I tend to bounce back quickly after hard times" and "It does not take me long to recover from a stressful event" (Sample, α = .92).

Learning

Learning was measured with two open-ended questions. The first was a general question about learning (i.e., "Reflecting back on your experience at work during pregnancy, what do you feel you have learned?"). The second was more specific to coping with work stress (i.e., "Reflecting back on your experience at work during pregnancy, what do you feel you have learned regarding coping with work stressors?").

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Control Variables

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Consistent with Becker et al.'s (2016) recommendation regarding their use and reporting protocol, demographic (i.e., age, race/ethnicity, and organizational tenure), mood/affect (i.e., positive and negative affectivity), and obstetric risks were included as control variables. As discussed in the literature review, race/ethnicity and medical risks are related to pregnancy outcomes. Furthermore, previous research has linked age and organizational tenure with organizational outcomes (Dobrow Riza, Ganzach, & Liu, 2015; Ng & Feldman, 2010).

One item measures were used to capture age (i.e., "What is your age (in years)?"), organizational tenure ("How many years and months have you worked at the same organization?"), and race/ethnicity (i.e., "What is your ethnicity?"). Mood/affect was measured using an abbreviated eight-item version (e.g., Zellars, Tepper, & Duffy, 2002) of Watson, Clark, and Tellegen's (1988) Positive and Negative Affect Schedule (PANAS) measure (Survey 1, PA $\alpha = .62$, NA $\alpha = .69$; Survey 2, PA $\alpha = .71$, NA $\alpha = .74$; Survey 3, PA $\alpha = .77$, NA $\alpha = .74$).

Obstetric risks were measured using the maternal subscale (Trammell, 2012) of Dean and Gray's (1985) Maternal Perinatal Scale (MPS). The MPS was designed to be a short maternal-report measure that illuminates clinically relevant information about the mother's perinatal period. The maternal subscale consists of eleven items that assess a variety of risk factors

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associated with pregnancy outcomes. Some sample items include "How much weight have you gained during pregnancy?" and "To what extent did you use cigarettes during pregnancy?"

Analyses

Hypotheses were tested using Hayes' (2013) PROCESS extension in the 22.0 Statistical Package for the Social Sciences (SPSS). PROCESS is a regression-based path analysis technique that applies bootstrapping and provides confidence intervals that can be used to test hypotheses. This method of analysis is recommended for investigating indirect effects and addresses many of the concerns researchers have of the Baron and Kenny (1986) method (Hayes, 2009). Specifically, Hayes' model 4 template was used for the direct effect and mediation hypotheses and the model 1 template was used for the moderation hypotheses.

CHAPTER 5

RESULTS AND DISCUSSION

Results

Table 2 presents the means, standard deviations, and zero-order correlations for all study variables. The bivariate relationships were consistent with expectations with regard to both direction and magnitude. Based on Fox's (1991) recommendations, the variance inflation factors (VIF) were examined to verify that they did not exceed the generally accepted value of 10 or less (Montgomery, Peck, & Vining, 2001). All of the VIF scores were less than 1.67, so multi-collinearity likely did not have a substantial impact on the results. All hypotheses were tested at the alpha .05 level. In the case of the mediation and moderation hypotheses, support was found when the 95% bootstrap confidence interval (i.e., Boot LLCI and Boot ULCI) did not contain zero.

Main Effects

Although not hypothesized, in order to gain a better understanding of the pregnancy-specific organizational stressors, I examined their main effects on each organizational, health, and family outcome included in the study. These results are presented in Table 3. Perceived pregnancy discrimination was significantly related to job satisfaction ($\beta = -.58$; $p < .01$), turnover intentions ($\beta = .44$; $p < .01$), planned turnover ($\beta = .27$; $p < .05$), birthweight ($\beta = -.23$; $p < .05$), and work-family conflict ($\beta = .22$; $p < .05$). Pregnancy disclosure was significantly related to turnover intentions ($\beta = .19$; $p < .05$) and gestational age ($\beta = -.24$; $p < .05$). Finally, identity role conflict was not significantly associated with any of the outcomes. This provides initial evidence that pregnancy-specific stressors play a role in important organizational, health, and family outcomes. It also suggests that perceived pregnancy discrimination may be the main driver.

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Hypotheses 1, 2, and 3: Pregnancy Specific Stressors and Experienced Stress

Results for hypotheses tests can be found in Tables 4 - 66. Hypotheses were tested by examining two measures of experienced stress: job tension and perceived stress. Results indicated that perceived pregnancy discrimination was significantly associated with job tension (B = .49, $t(121)$ = 4.06, p < .01; Table 4) and perceived stress (B = .17, $t(121)$ = 2.38, p < .01; Table 5). Thus, hypothesis 1 was supported. Similarly, pregnancy disclosure was significantly associated with job tension (B = .31, $t(121)$ = 2.78, p < .01; Table 6) and perceived stress (B = .13, $t(121)$ = 2.07, p < .05 Table 7). Thus, hypothesis 2 was supported. Identity role conflict was significantly associated with job tension (B = .55, $t(121)$ = 3.86, p < .01; Table 8) but not with perceived stress (B = .07, $t(121)$ = .83, p = .41; Table 9). Thus, hypothesis 3 was partially supported.

Hypothesis 4: Pregnancy specific stressors and work outcomes

Hypothesis 4 stated that experienced stress would mediate the relationship between pregnancy specific stressors (i.e., perceived pregnancy discrimination, pregnancy disclosure, and identity-role conflict) and adverse work outcomes (e.g., job satisfaction, turnover intentions, and actual turnover).

Job satisfaction. The results demonstrated that the indirect effects of organizational stressors on job satisfaction through job tension were not significant (perceived pregnancy discrimination: B = -.05, Boot LLCI = -.15, Boot ULCI = .01 [Table 4]; pregnancy disclosure: B = -.03, Boot LLCI = -.10, Boot ULCI = .01 [Table 6]; identity-role conflict: B = -.06, Boot LLCI = -.17, Boot ULCI = .02 [Table 8]). Similarly, the indirect effects of organizational stressors on job satisfaction through perceived stress were not significant (perceived pregnancy discrimination: B = -.03, Boot LLCI = -.12, Boot ULCI = .01 [Table 5]; pregnancy disclosure: B

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= -.02, Boot LLCI = -.09, Boot ULCI = .00 [Table 7]; identity-role conflict: *B* = -.01, Boot LLCI = -.09, Boot ULCI = .01 [Table 9]).

   Turnover intentions. The results demonstrated that the indirect effects of organizational stressors on turnover intentions through job tension were significant (perceived pregnancy discrimination: *B* = .17, Boot LLCI = .05, Boot ULCI = .34 [Table 10]; pregnancy disclosure: *B* = .11, Boot LLCI = .02, Boot ULCI = .25 [Table 12]; identity-role conflict: *B* = .19, Boot LLCI = .07, Boot ULCI = .38 [Table 14]). However, the indirect effects of organizational stressors on turnover intentions through perceived stress were not significant (perceived pregnancy discrimination: *B* = -.01, Boot LLCI = -.11, Boot ULCI = .05 [Table 11]; pregnancy disclosure: *B* = -.01, Boot LLCI = -.09, Boot ULCI = .04 [Table 13]; identity-role conflict: *B* = -.01, Boot LLCI = -.09, Boot ULCI = .02 [Table 15]).

   Planned turnover. The results demonstrated that the indirect effects of pregnancy-specific organizational stressors on planned turnover through job tension were not significant (perceived pregnancy discrimination: *B* = .04, Boot LLCI = -.01, Boot ULCI = .12 [Table 16]; pregnancy disclosure: *B* = .03, Boot LLCI = -.01, Boot ULCI = .09 [Table 18]; identity-role conflict: *B* = .05, Boot LLCI = -.01, Boot ULCI = .13 [Table 20]). Similarly, the indirect effects of organizational stressors on planned turnover through perceived stress were not significant (perceived pregnancy discrimination: *B* = .00, Boot LLCI = -.04, Boot ULCI = .04 [Table 17]; pregnancy disclosure: *B* = .00, Boot LLCI = -.03, Boot ULCI = .04 [Table 19]; identity-role conflict: *B* = .00, Boot LLCI = -.02, Boot ULCI = .03 [Table 21]). Thus, hypothesis 4 was only partially supported.

Hypothesis 5: Pregnancy specific stressors and health outcomes

Hypothesis 5 stated that experienced stress would mediate the relationship between pregnancy-specific stressors (i.e., perceived pregnancy discrimination, pregnancy disclosure, and identity-role conflict) and adverse health outcomes for mother (e.g., postpartum depression) and baby (e.g., low APGAR score, low birthweight, low gestational age, and number of doctor's visits).

Postpartum depression. The results demonstrated that the indirect effects of perceived pregnancy discrimination (*B* = .05, Boot LLCI = .01 Boot ULCI = .11 [Table 22]) and identity-role conflict (*B* = .05, Boot LLCI = .01, Boot ULCI = .12 [Table 26]) on postpartum depression through job tension were significant. However, the indirect effect of pregnancy disclosure (*B* = .03, Boot LLCI = .00, Boot ULCI = .08 [Table 24]) on postpartum depression through job tension was not significant. The indirect effects of organizational stressors on postpartum depression through perceived stress were significant for perceived pregnancy discrimination (*B* = .05, Boot LLCI = .01, Boot ULCI = .11 [Table 23]) and pregnancy disclosure (*B* = .04, Boot LLCI = .01, Boot ULCI = .10 [Table 25]), but not for identity-role conflict (*B* = .02, Boot LLCI = -.02, Boot ULCI = .08 [Table 27]).

APGAR scores. The results demonstrated that the indirect effects of organizational stressors on APGAR scores through job tension were not significant (perceived pregnancy discrimination: *B* = -.11, Boot LLCI = -.42, Boot ULCI = .05 [Table 28]; pregnancy disclosure: *B* = -.05, Boot LLCI = -.24, Boot ULCI = .02 [Table 30]; identity-role conflict: *B* = -.12, Boot LLCI = -.43, Boot ULCI = .06 [Table 32]). Similarly, the indirect effects of organizational stressors on APGAR scores through perceived stress were not significant (perceived pregnancy discrimination: *B* = -.09, Boot LLCI = -.33, Boot ULCI = .01 [Table 29]; pregnancy disclosure:

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B = -.05, Boot LLCI = -.23, Boot ULCI = .01 [Table 31]; identity-role conflict: *B* = -.04, Boot LLCI = -.25, Boot ULCI = .02 [Table 33]).

Birthweight. The results demonstrated that the indirect effects of organizational stressors on baby's birthweight through job tension were not significant (perceived pregnancy discrimination: *B* = .07, Boot LLCI = -.05, Boot ULCI = .20 [Table 34]; pregnancy disclosure: *B* = .05, Boot LLCI = -.03, Boot ULCI = .17 [Table 36]; identity-role conflict: *B* = .08, Boot LLCI = -.06, Boot ULCI = .24 [Table 38]). Contrarily, the indirect effects of perceived pregnancy discrimination (*B* = -.07, Boot LLCI = -.20, Boot ULCI = -.01 [Table 35]) and pregnancy disclosure (*B* = -.06, Boot LLCI = -.17, Boot ULCI = -.01 [Table 37]) on birthweight through perceived stress were significant. The indirect effect of identity-role conflict on birthweight through perceived stress was not significant (*B* = -.03, Boot LLCI = -.14, Boot ULCI = .01 [Table 39]).

Gestational age. The results demonstrated that the indirect effects of organizational stressors on gestational age through job tension were not significant (perceived pregnancy discrimination: *B* = .01, Boot LLCI = -.14, Boot ULCI = .20 [Table 40]; pregnancy disclosure: *B* = .00, Boot LLCI = -.09, Boot ULCI = .15 [Table 42]; identity-role conflict: *B* = .01, Boot LLCI = -.16, Boot ULCI = .23 [Table 44]). Similarly, the indirect effects of organizational stressors on gestational age through perceived stress were not significant (perceived pregnancy discrimination: *B* = -.05, Boot LLCI = -.22, Boot ULCI = .05 [Table 41]; pregnancy disclosure: *B* = -.04, Boot LLCI = -.19, Boot ULCI = .03 [Table 43]; identity-role conflict: *B* = -.02, Boot LLCI = -.16, Boot ULCI = .03 [Table 43]).

Doctor visits. The results demonstrated that the indirect effects of organizational stressors on number of visits to the doctor through job tension were not significant (perceived pregnancy

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discrimination: *B* = .05, Boot LLCI = -.11, Boot ULCI = .24 [Table 46]; pregnancy disclosure: *B* = .03, Boot LLCI = -.07, Boot ULCI = .17 [Table 48]; identity-role conflict: *B* = .06, Boot LLCI = -.12, Boot ULCI = .28 [Table 50]). Similarly, the indirect effects of organizational stressors on number of visits to the doctor through perceived stress were not significant (perceived pregnancy discrimination: *B* = .08, Boot LLCI = -.01, Boot ULCI = .27 [Table 47]; pregnancy disclosure: *B* = .09, Boot LLCI = -.01, Boot ULCI = .25 [Table 49]; identity-role conflict: *B* = .04, Boot LLCI = -.02, Boot ULCI = .19 [Table 51]).

Thus, organizational stressors indirectly impacted the mother's health (i.e., postpartum depression) through job tension and perceived stress, and impacted baby's health (i.e., birthweight) through perceived stress. Hypothesis 5 was partially supported.

Hypothesis 6: Pregnancy specific stressors and family outcomes

Hypothesis 6 stated that experienced stress would mediate the relationship between organizational stressors (i.e., perceived pregnancy discrimination, pregnancy disclosure, and identity-role conflict) and family outcomes (i.e., WFC and family satisfaction).

Work-family conflict. The results demonstrated that the indirect effects of organizational stressors on work-family conflict through job tension were significant (perceived pregnancy discrimination: *B* = .15, Boot LLCI = .06, Boot ULCI = .29 [Table 52]; pregnancy disclosure: *B* = .10, Boot LLCI = .02, Boot ULCI = .21 [Table 54]; identity-role conflict: *B* = .17, Boot LLCI = .07, Boot ULCI = .32 [Table 56]). However, the indirect effects of organizational stressors on work-family conflict through perceived stress were not significant (perceived pregnancy discrimination: *B* = .04, Boot LLCI = .00, Boot ULCI = .15 [Table 53]; pregnancy disclosure: *B* = .04, Boot LLCI = .00, Boot ULCI = .11 [Table 55]; identity-role conflict: *B* = .02, Boot LLCI = -.02, Boot ULCI = .10 [Table 57]).

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Family satisfaction. The results demonstrated that the indirect effects of organizational stressors on family satisfaction through job tension were not significant (perceived pregnancy discrimination: $B = -.04$, Boot LLCI = -.12, Boot ULCI = .02 [Table 58]; pregnancy disclosure: $B = -.03$, Boot LLCI = -.09, Boot ULCI = .01 [Table 60]; identity-role conflict: $B = -.05$, Boot LLCI = -.14, Boot ULCI = .02 [Table 62]). Similarly, the indirect effects of organizational stressors on family satisfaction through perceived stress were not significant (perceived pregnancy discrimination: $B = -.02$, Boot LLCI = -.10, Boot ULCI = .01 [Table 59]; pregnancy disclosure: $B = -.02$, Boot LLCI = -.08, Boot ULCI = .01 [Table 61]; identity-role conflict: $B = -.01$, Boot LLCI = -.07, Boot ULCI = .01 [Table 63]). Thus, hypothesis 6 was partially supported.

Hypothesis 7: Moderating role of self-regulation

Hypothesis 7 stated that self-regulation would moderate the relationship between experienced stress and organizational, health, and family outcomes such that high levels of self-regulation attenuate the relationships between experienced stress and adverse outcomes. Upon analysis of both measures of experienced stress (i.e., job tension and perceived stress) and all outcomes, only two models were significant. These results are reported in Tables 64 and 65. Results for non-significant analyses are available upon request.

Postpartum depression. Controlling for ethnicity, a number of health factors, positive affect, and negative affect, results indicated that the relationship between perceived stress and postpartum depression was moderated by self-regulation ($F(15,102) = 17.09$, $p = <.01$, $R^2 = .72$). The perceived stress X self-regulation interaction ($B = -.21$, $t(102) = -2.15$, $p < .05$) was significantly associated with postpartum depression ($\Delta R^2 = .01$, $p < .05$). Figure 3 presents a graphical representation of how self-regulation affects the relationship between perceived stress and postpartum depression. The interaction was probed by testing the conditional effects of

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perceived stress at three levels of self-regulation: one standard deviation below the mean, at the mean, and one standard deviation above the mean. As shown in Table 64, perceived stress was significantly related to postpartum depression when self-regulation was one standard deviation below the mean ($B = .41$; $p < .01$) and when at the mean ($B = .30$; $p < .01$), but not when one standard deviation above the mean ($B = .18$; $p = .06$). The Johnson-Neyman technique showed that the relationship between perceived stress and postpartum depression was significant when self-regulation was less than .49 standard deviations above the mean, but not significant at higher values of self-regulation. Finally, a simple slopes analysis revealed that neither the high ($b = .41$, $t = .83$, $p = .41$) nor the low ($b = .19$, $t = .89$, $p = .38$) self-regulation slopes were significantly different from zero. Therefore, the interaction, although statistically significant, may not be practically significant.

APGAR scores. Results suggested that the relationship between perceived stress and APGAR scores was moderated by self-regulation ($F(15,55) = 1.95$, $p = <.05$, $R^2 = .35$). The perceived stress X self-regulation interaction ($B = -.62$, $t(55) = -1.99$, $p = .05$) was marginally significant ($\Delta R^2 = .05$, $p = .05$). Figure 4 presents a graphical representation of how self-regulation affects APGAR scores. Utilizing the same probing procedures discussed above and as shown in Table 65, perceived stress was significantly related to APGAR scores when self-regulation was one standard deviation above the mean ($B = -.69$, $p < .05$), but not when at the mean ($B = -.38$, $p = .12$) or one standard deviation below the mean ($B = -.07$, $p = .79$). The Johnson-Neyman technique showed that the relationship between perceived stress and APGAR scores was significant when self-regulation was more than .21 standard deviations above the mean, but not significant at lower values of self-regulation. Finally, a simple slopes analysis revealed that neither the high ($b = -.59$, $t = -.38$, $p = .70$) nor the low self-regulation slopes were

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significant ($b = .03$, $t = .04$, $p = .97$). Much like the previous interaction, although statistically significant, the indirect effect of perceived stress on APGAR scores may not be practically significant.

Hypothesis 8: Moderating role of resiliency

Hypothesis 8 stated that resiliency would moderate the relationship between experienced stress and organizational, health, and family outcomes such that high levels of resiliency attenuate the relationships between experienced stress and adverse outcomes. Upon analysis of both measures of experienced stress (i.e., job tension and perceived stress) and all outcomes, only one model was significant. These results are reported in Table 66. Results for non-significant analyses are available upon request.

Controlling for marital status, number of children, positive affect, and negative affect, results indicated that the relationship between job tension and work-family conflict was moderated by resiliency ($F(7,115) = 6.39$, $p = <.01$, $R^2 = .28$). The job tension X resiliency interaction ($B = -.15$, $t(115) = -2.00$, $p = .05$) was marginally significantly associated with work-family conflict ($\Delta R^2 = .03$, $p = .05$). A graphical representation of how resiliency affects work-family conflict is presented in Figure 5. As shown in Table 66, job tension was significantly related to work-family conflict when resiliency was one standard deviation below the mean ($B = .46$; $p < .01$) and when at the mean ($B = .34$; $p < .01$), and when one standard deviation above the mean ($B = .21$; $p < .05$). The Johnson-Neyman technique showed that the relationship between job tension and work-family conflict was significant when resiliency was less than .89 standard deviations above the mean, but not significant at higher values of self-regulation. Finally, a simple slopes analysis revealed that the low ($b = .46$, $t = 5.14$, $p < .01$) resiliency slope was

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significantly different from zero. However, the high resiliency slope was marginally significant ($b = .21$, $t = 1.97$, $p = .05$). Table 67 presents a summary of the hypotheses tests and their results.

Post-Hoc Power Analysis

The software package, GPower, was used to conduct a post hoc power analysis on each of the moderation models mentioned above (i.e., Hypothesis 7 and 8). The analyses were conducted as fixed models, examining the ΔR^2 deviation from zero. The first model (i.e., self-regulation X perceived stress on postpartum depression), had a sample size of 118 and a $\Delta R^2 = .01$. The statistical power for this model was .08. The second model (i.e., self-regulation X perceived stress on APGAR), had a sample size of 71 and a $\Delta R^2 = .05$. The statistical power for this model was .14. Finally, the third model (i.e., resiliency X job tension on work-family conflict), had a sample size of 123 and a $\Delta R^2 = .03$. The statistical power for this model was .22. Thus, these analyses were quite underpowered and should be interpreted with caution.

Research question: Learning during pregnancy

Finally, a q-sort was used to analyze the research question, "Do women learn throughout their pregnancy about how to better deal with stress?" First, I analyzed women's responses to their general learning during pregnancy (N=116) and their stress-related learning during pregnancy (N=116). A total of 9 learning themes were identified. Next, two independent raters were given the list of statements and asked to indicate the theme with which each statement corresponded. Between the primary researcher and the two independent raters, there was an agreement rate of 24%. The primary researcher and Rater 1 agreed 57%, the primary researcher and Rater 2 agreed 65%, and Rater 1 and Rater 2 agreed 64%. Given the low initial agreement, a more in depth investigation was conducted which revealed that several of the open-ended responses fell into more than one theme. Additionally, upon discussion with the raters, it was

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decided to combine two of the initial themes, as it was difficult on a number of occasions to tease these apart. The final learning themes consisted of: 1) Planning and preparation are important, 2) Seek support, 3) Relationship with management matters, 4) Take care of yourself, 5) Navigating maternity leave and HR, 6) Put things in perspective, 7) Flexible work arrangements help, 8) Discrimination happens.

Post Hoc Analyses

In order to gain a deeper understanding of the impact of job stress during pregnancy, I conducted a few post-hoc analyses. First, using Hayes' (2013) PROCESS extension template 14, I tested for moderated mediation in the three significant moderation models previously presented (Hypothesis 6 and 7). As discussed in Hayes (2015), moderated mediation is supported when the 95% bootstrap confidence interval of the index of moderated mediation does not contain zero. The indirect effect of perceived discrimination on postpartum depression through perceived stress, conditional upon self-regulation was significant (Index = -.04, Boot LLCI = -.10, Boot ULCI = -.004). The indirect effect of pregnancy disclosure on postpartum depression through perceived stress, conditional upon self-regulation was significant (Index = -.03, Boot LLCI = -.08, Boot ULCI = -.002). However, the indirect effect of identity role conflict on postpartum depression through perceived stress, conditional upon self-regulation was not significant (Index = -.02, Boot LLCI = -.07, Boot ULCI = .01). Thus, the moderated mediation models for perceived pregnancy discrimination and pregnancy disclosure were supported. These results are reported in Tables 68-70.

The conditional indirect effects of perceived discrimination (Index = -.17, Boot LLCI = -.47, Boot ULCI = .02), pregnancy disclosure (Index = -.09, Boot LLCI = -.34, Boot ULCI = .02)

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and identity role conflict (Index = -.08, Boot LLCI = -.37, Boot ULCI = .02) on APGAR scores were not significant. These results are presented in Tables 71-73.

The indirect effect of perceived discrimination on work-family conflict through job tension, conditional upon resiliency was significant (Index = -.09, Boot LLCI = -.19, Boot ULCI = -.01). The indirect effect of pregnancy disclosure on work-family conflict through job tension, conditional upon resiliency was significant (Index = -.06, Boot LLCI = -.14, Boot ULCI = -.01). Similarly, the indirect effect of identity role conflict on work-family conflict through job tension, conditional upon resiliency was significant (Index = -.10, Boot LLCI = -.22, Boot ULCI = -.01). Thus, moderated mediation was supported for all organizational stressors. These results are presented in Tables 74-76.

Based on the results, perceived discrimination seemed to be a main driver of experienced stress during pregnancy. Due to this, I conducted additional analyses to gain a better idea of how perceived discrimination at work impacted women's and babies' health and under what conditions discrimination was more likely to occur. Using the MPlus software (Muthén & Muthén, 2012), I conducted structural equation modeling to examine the relationship between perceived discrimination and two health outcomes, postpartum depression and APGAR scores, through job tension.

In order to create evenly distributed constructs, reduce item-specific error, and reduce the demands placed on the data, a partial disaggregation technique (parceling) was utilized. Specifically, following the factorial algorithm technique (Little, Cunningham, Shahar, & Widaman, 2002; Rogers & Schmitt, 2004), I created three parcels for each latent construct. This was done by conducting a separate CFA for each latent construct, ordering the items from

strongest to weakest based on their loadings, and then assigning them to one of three parcels in a serpentine fashion. This guarantees that one parcel is not made up of the strongest loading items.

To test the measurement model, a CFA using maximum likelihood estimation was conducted. Figure 6 presents the model along with the standardized results. To determine overall model fit, I examined the values for chi-square (χ^2), root mean square error of approximation (RMSEA), Comparative Fit Index (CFI), Tucker-Lewis Index (TLI), and standardized root mean residual (SRMR). According to the cutoff points suggested by Schreiber, Nora, Stage, Barlow, and King (2006), the model has good fit (χ^2 [80] = 148.24, p<.01; RMSEA = .08; CFI = .93; TLI = .90; SRMR = .06). The structural model, was estimated using SEM with the latent variables measured in the CFA described above. The fit indices indicated that there was reasonable fit between the structural model and the data (χ^2 [215] = 355, p<.01; RMSEA = .07; CFI = .87; TLI = .85; SRMR = .09). Figure 7 presents the structural model along with standardized results.

Results indicated that perceived pregnancy discrimination was positively associated with job tension (γ = .47, p < .01). This suggests that as perceived pregnancy discrimination increases, women experience greater job tension. The path from job tension to postpartum depression was significant (γ = .22, p < .01), controlling for ethnicity, positive affect, and negative affect. However, the path from job tension to APGAR scores was not significant (γ = -.10, p = .45), controlling for ethnicity, number of previous pregnancies, weight gain, labor experience, prior risk pregnancies, cigarette use, alcohol use, and blood pressure. Results also indicated that perceived discrimination had significant indirect effects on postpartum depression (γ = .11, p < .01) through job tension.

Given that my hypotheses tests suggested that perceived pregnancy discrimination could impact both mothers' and babies' health, I analyzed the relationship between perceived

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discrimination and a number of variables to determine when discrimination may be more likely to take place. I selected a number of variables that could play a role in whether discrimination takes place. The bivariate relationships between these variables and perceived pregnancy discrimination are reported in Table 75. There was a positive relationship between the number of physical job demands (e.g., working long hours, standing for long periods, heavy lifting) and perceived discrimination ($r = .51$, p < .01). Interestingly, the visibility of a woman's pregnancy ($r = .02$, *n.s.*), the number of weeks pregnant she was when she revealed her pregnancy ($r = -.09$, *n.s.*), and her organizational level ($r = -.04$, *n.s.*) did not have a relationship with her perceived discrimination. Furthermore, it did not seem to matter whether her supervisor was female ($r = -.05$, *n.s.*) or a parent ($r = -.04$, *n.s.*). These results suggest that women can experience discrimination under a variety of circumstances. However, women employed in more physically demanding jobs tend to perceive higher levels of pregnancy discrimination.

Discussion

This study is one of the first to examine pregnant women's experiences at work. Research has established a link between stress and pregnancy outcomes (Dunkel Schetter & Tanner, 2012). Yet, very little is known about the impact of psychological job stressors during pregnancy. This investigation reviewed the research that has been conducted on the role of stress during pregnancy and developed a multilevel conceptual model that outlines pregnant employees' experience of job stress. Furthermore, this study introduced three pregnancy-specific organizational stressors and tested their impact on adverse organizational, health, and family outcomes.

It was hypothesized that pregnancy-specific organizational stressors (i.e., perceived discrimination, pregnancy disclosure, and identity role conflict) would lead to increased levels of

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experienced stress. The results revealed that these stressors were indeed positively associated with experienced stress. Perceived discrimination and pregnancy disclosure were positively associated with both measures of experienced stress (i.e., job tension and perceived stress). Identity role conflict was positively associated with job tension. However, the relationship between identity role conflict and perceived stress, a more general measure of stress, was not significant.

Consistent with job stress theories (Lazarus, 1966; Mackey & Perrewé, 2014), it was hypothesized that the pregnancy-specific organizational stressors would not lead directly to adverse outcomes, but that the relationship between the stressors and outcomes would be mediated by experienced stress. Overall, this hypothesis was supported. In terms of organizational outcomes, job tension mediated the relationship between all three pregnancy-specific organizational stressors and turnover intentions. In other words, when women perceived discrimination, worried about disclosing their pregnancy, or felt that their professional and maternal identities conflicted, they experienced greater levels of job tension which lead to increased turnover intentions. This suggests that the experience women have at work during their pregnancy impacts their desire to return to work postpartum. However, perceived stress did not function as a mediator between stressors and organizational outcomes. This could be due to the fact that organizational outcomes are more dependent on job-specific stress (i.e., job tension) instead of stress in general (i.e., perceived stress). Neither job tension nor perceived stress mediated the relationships between the pregnancy-specific organizational stressors and job satisfaction or planned turnover. Interestingly, perceived pregnancy discrimination was directly associated with decreased job satisfaction and increased turnover intentions and planned

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turnover. This suggests that women's perceptions of discrimination during pregnancy not only increases their levels experienced stress, but also directly impacts their work attitudes.

With regard to health outcomes, results support the hypothesis that pregnancy-specific stressors indirectly impact the mother's health. Both job tension and perceived stress mediated the relationships between the pregnancy-specific organizational stressors and postpartum depression. This suggests that women's experience at work during her pregnancy is linked to her mental health postpartum. Perceived stress also mediated the relationships between perceived discrimination and birthweight, and between pregnancy disclosure and birthweight. Neither job tension nor perceived stress mediated the relationships between the pregnancy-specific organizational stressors and other indicators of baby's health (i.e., APGAR, gestational age, number of doctors' visits). Despite the fact that mediation did not occur in all models, some direct effects occurred between the pregnancy-specific organizational stressors and baby's health outcomes. At the .10 alpha level, perceived pregnancy discrimination was directly associated with lower birthweight. Similarly, pregnancy disclosure was directly associated with lower gestational age at the .10 alpha level. These tests were very conservative and controlled for a number of maternal health factors that tend to impact infant health. Thus, the possibility that women's work experiences during pregnancy can impact infant health merits future research.

Support was also found for the hypothesis that pregnancy-specific organizational stressors indirectly impact family outcomes. Results indicated that job tension mediated the relationships between stressors and work-family conflict. However, perceived stress did not function as a mediator between stressors and work-family conflict. Neither job tension nor perceived stress mediated the relationships between the pregnancy-specific organizational stressors and family satisfaction.

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As discussed previously, a number of resilience resources can aid women in dealing with stress during pregnancy. This study specifically examined the buffering effect of self-regulation and trait resilience. Self-regulation was found to moderate the relationships between perceived stress and postpartum depression, and between perceived stress and APGAR scores. However, it is important to note that simple slopes analyses revealed that neither the high nor the low level slopes of self-regulation were significantly different from zero. Thus, this buffering effect should be interpreted cautiously.

When perceived stress was high, women with high self-regulation experienced lower levels of postpartum depression. This is consistent with the buffering hypothesis. It could be that women with high self-regulation have more positive psychological states (Tangney et al., 2004) than women with low self-regulation, making them less susceptible to postpartum depression. Another explanation could be that women who are able to self-regulate experience lower levels of postpartum depression because they are able to stay on task at work and at home, regardless of how they truly feel, allowing them to reduce their overall stress level. When not already overwhelmed by stress, these women may be less vulnerable to postpartum depression.

Despite the previous discussion that would classify self-regulation as a resource during pregnancy, my findings indicate that there could be a downside to self-regulation. Under high perceived stress, women with high self-regulation reported lower APGAR scores. Although not intuitive, it could be that women with high self-regulation are regulating themselves to the point of exhaustion, which in turn impacts the baby's health. Pregnancy takes a toll on the body. Women tend to be more emotional due to hormonal changes and need more rest during pregnancy. High self-regulators may be ignoring their bodies cues to take a break, cry, or eat a snack. Whereas low self-regulators may be giving in to these cues more often, despite the

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expectations and norms at work. While self-regulation may allow women to push through and complete responsibilities, it may come at the cost of exhaustion and ultimately impact the baby's health, as indicated by lower APGAR scores. Future research should address the benefits and risks of engaging in self-regulation. It seems that self-regulation could be a double-edged sword that functions as a resource in some instances (i.e., postpartum depression) but as a hindrance in others (i.e., APGAR scores).

Resiliency was found to moderate the relationship between job tension and work-family conflict. When job tension was high, women with high resiliency reported lower levels of work-family conflict. This suggests that trait resiliency functions as a buffering resource. Previous research has shown that resiliency allows individuals to deal with stress by cultivating positive emotions and achieve effective coping outcomes (Tugade et al., 2004). This seems to be true for women experiencing stress during pregnancy.

The final piece of this study addressed the research question "Do women learn from their experiences with stress at work during pregnancy?" Results suggest that women do learn during their pregnancy and analyses revealed eight broad learning themes: 1) Planning and preparation are important, 2) Seek support, 3) Relationship with management matters, 4) Take care of yourself, 5) Navigating maternity leave and HR, 6) Put things in perspective, 7) Flexible work arrangements help, 8) Discrimination happens.

With regard to the first theme, several women noted the importance of planning ahead and preparing for the baby. Some women emphasized financial planning due to unpaid maternity leave, some wished they would have planned for a longer maternity leave, and others mentioned the importance of being proactive in getting their job responsibilities covered during their leave.

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A number of responses emphasized the importance of the second theme, seeking support from others. Women mentioned the importance of asking for help when they needed it and accepting help when it was offered. Responses about support included seeking support at work from coworkers and at home from family and friends.

Responses that fell into the third theme, relationship with management matters, stressed the importance of communicating with management. One woman mentioned that her supervisors were happy to work with her, but that she had to make her needs known. Also, women noted that a supportive and flexible supervisor was very helpful in managing their stress levels.

The fourth theme, take care of yourself, consisted of the most responses. Several women mentioned that they learned to recognize their limitations at work. These limitations included their ability to complete physical tasks as well as just realizing that they were growing a baby, and could not expect themselves to function at the same level as they did before pregnancy. Many women noted that they learned to engage in coping techniques such as relaxing, exercising and taking breaks.

Responses that fell under the fifth theme dealt with learning how to navigate maternity leave and HR policies. Responses seemed to emphasize the difficulty that accompanies understanding organizations' maternity leave policies. A few women mentioned the importance of understanding their supervisor's expectations during leave (i.e., expected to answer emails, phone calls, etc.). One woman's response highlighted the limitations of the FMLA when she mentioned learning not to take a new job when 24 weeks pregnant because she wasn't qualified for any time off.

Several women mentioned that their experiences with stress during pregnancy helped them put things in perspective. Some women mentioned a perspective shift with regard to their

job such as realizing how much they disliked their current job or how much they would have preferred to have a less physical job during pregnancy. A few women mentioned that they realized how fortunate they were compared to friends in terms of the support and benefits they received during their pregnancy. The majority of the responses that fell under this theme indicated gaining an understanding that work was no longer a top priority with a baby on the way. As one woman put it, "six months from now, nobody will care about whatever it is."

With regard to the seventh theme, several women noted the value of flexible work arrangements during pregnancy. Women mentioned that the ability to work from home, particularly in late pregnancy, was very helpful in managing their stress. Additionally, working with a flexible supervisor and having the scheduling flexibility were cited as helpful.

Finally, several women noted that the one thing they learned from their experiences during pregnancy was that discrimination happens. Women mentioned that they learned that they would be treated differently due to their pregnancy. A few women noted feeling judged by upper management. The discrimination was not limited to employees either. One woman, a salon owner, indicated that she lost several male clients once she became pregnant.

Interestingly, several women utilized maternal language when explaining what they had learned during pregnancy. Some women mentioned learning patience in dealing with their coworkers and that they hoped it would be good practice for dealing with a newborn. One woman actually referred to people at work as "toddlers demanding attention." Another mentioned feeling more nurturing and understanding toward coworkers. In my opinion, this indicates a level of learning that applies not only to the workplace, but also to her new role as a mother. In other words, there may be a spillover of learning where women apply skills they learned at work during pregnancy to their family life. For example, practicing patience at work

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may help with patience at home. Overall, it is evident that learning takes place and it is possible that learning during pregnancy could greatly influence women's stress levels during pregnancy. Future research should examine this phenomenon further.

One of the main contributions of this study is that it examined the effects of psychological job stressors on mothers' and babies' health. Perceived pregnancy discrimination seemed to be a driving force behind women's stress during pregnancy. In order to gain a deeper understanding of the effects of perceived pregnancy discrimination on health outcomes, I conducted a few post-hoc analyses. These analyses revealed that perceived pregnancy discrimination leads to increased job tension which, in turn, leads to increased postpartum depression. Furthermore, the indirect relationships from perceived pregnancy discrimination to postpartum depression through job tension were significant, controlling for a variety of maternal health factors.

Women seem to be at risk of discrimination under a wide variety of circumstances. Women working in jobs that require more physical labor were more likely to perceive pregnancy discrimination taking place. It could be that some of this discrimination is the result of coworkers and/or supervisors trying to take care of the employee by not letting her engage in activities that might hurt her or the baby. For example, a well-meaning supervisor could treat a pregnant employee differently by not allowing her to lift heavy objects, stand on her feet for long periods, or work night shift hours. Although the supervisor may not mean to be discriminatory, if the employee does not want or need the extra attention, she may feel discriminated against due to her pregnant status. One might think that women would be less likely to experience pregnancy discrimination if they worked for supervisors who were parents themselves. Similarly, one might expect a female supervisor to be more understanding of pregnancy, resulting in less

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discrimination. However, results indicated that neither the parental status nor the gender of supervisors played a role in whether women experienced pregnancy discrimination. Interestingly, characteristics of the woman did not play a role in her perceived pregnancy discrimination either. The visibility of her pregnancy, the number of weeks pregnant she was when she revealed her pregnancy, and her organizational level did not have a relationship with her perceived discrimination. These results suggest that all women are at risk of perceived pregnancy discrimination. Future research should examine other factors that might indicate whether pregnancy discrimination is likely to take place, especially given its relationship with important organizational, health, and family outcomes.

The relationships between perceived pregnancy discrimination and important organizational, health, and family outcomes begs the question, "What is perceived pregnancy discrimination?" An examination of some open-ended responses suggests that much of the discrimination taking place is informal. In particular, many women mentioned dealing with inappropriate comments about pregnancy from their coworkers and supervisors.

Many women cited the discriminatory nature of inappropriate, personal questions such as asking whether the pregnancy was planned and if the baby belonged to her husband. Some women even had coworkers who commented on her active sex life.

Other women noted that coworkers and supervisors would comment on their pregnant bodies. One woman's experience with her supervisor is described below:

"Look! She's eating again!"; "Did they widen the doors for you yet?"; "Do we need to get you a stronger chair?"; "You must be having twins right?"; "How many times are you going to eat today?"; "What do you do? Bring food with you everywhere you go?"; Not a day goes by without comments like these!"

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A few other women had to deal with inappropriate comments from their coworkers:

"Someone told me he was going to watch me and let me know when I start to waddle."

"A single male coworker commented about how large my breasts were becoming, and that my husband must be thrilled."

"I think you're having a girl because a girl takes the beauty from her mother's face."

In terms of work, many women mentioned being restricted from certain activities or being given easier and fewer tasks regardless of whether they asked for it (or wanted it). For example, being scolded for lifting objects even if those objects were not above the weight restriction or not being invited on work travel trips the rest of the team goes on. A few women felt that they had been passed up for a promotion due to their pregnancy. One woman noted:

"My boss has suggested that I will not be returning to work. My coworker has indicated that I will not be able to advance until I am finished having children. My coworker has indicated disapproval that they are to cover my shifts while I am on maternity leave."

Although these responses only provide a small window into pregnant employees' experiences at work, I believe they highlight the need to continue research in this area. It is obvious that pregnancy brings challenges for employees. Future research should strive for a deeper understanding of pregnancy discrimination. Only then can we move toward solutions for more inclusive work climates.

Theoretical and Practical Implications

This paper makes a number of contributions to research. It extends our understanding of expecting employees' experience at work and the impact it might have on multiple aspects of women's lives. This study reviewed the research that has been conducted on stress during pregnancy, provided a multilevel conceptual model that outlines pregnant employees' experience

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of job stress, and is one of the first studies to conceptualize pregnancy-specific organizational stressors (i.e., perceived pregnancy discrimination, pregnancy disclosure, and identity role conflict) and to test their relationships with important organizational, health, and family outcomes. This study answers a call for more research on the psychosocial variables that might play a role in adverse birth outcomes (Feldman et al., 2000). Furthermore, this study fills a gap in the management literature by examining a ubiquitous yet largely ignored phenomenon in the workplace, pregnancy.

On a more practical level, the results of this study suggest that pregnancy-specific stressors exist and that pregnant women are at risk of stress above and beyond the normal, everyday job stress. This comes at a time when stress is especially detrimental. Furthermore, this study showed that women's experiences at work during pregnancy can impact multiple areas of their life: work, health, and family. Management needs to be made aware of the existence of these pregnancy-specific stressors so that they can do their best to support their pregnant employees. They could provide support by remaining flexible throughout their employee's pregnancy and educating their staff on discriminatory behaviors and maternity leave policies and benefits. The most important and effective way to support a pregnant employee may be to just talk to her and find out what she needs. Everyone and every pregnancy is different.

Perhaps most importantly, the results of this study provided evidence that workplace experiences have a societal impact beyond that of the employees. Previous research has demonstrated spillover and crossover effects where stress at work can follow employees home and impact their family members (Carlson et al., 2011). However, this is one of the first studies to show the impact of psychological job stressors on female employees' unborn babies. This

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highlights the need for organizations to pay closer attention to the workplace climate, particularly with regard to perceived pregnancy discrimination.

Limitations

As with most research, this study is not without its limitations. In this study, the sample was comprised of pregnant employees who worked 35 or more hours a week. As this was a convenience sample that recruited women via online blogs and social media, the findings may not generalize to all pregnant employees. It is possible that differences exist between women using online pregnancy forums and social media and those who do not. Further, this sample was relatively homogeneous in terms of ethnicity and socio-economic status. This could also limit the generalizability of the findings. Therefore, I strongly encourage future researchers to use representative population samples. Specifically, authors could work with pregnancy centers or doctors' offices to connect to a wider variety of women. Another limitation of this study was the small sample size. Although the sample size was large enough to conduct regression-based analyses, it prevented analyzing a full-blown SEM model.

Another limitation is the sheer number of analyses that were conducted. Over 140 models were run. Given this large number of analyses, there is always the possibility that some of the findings presented in this study are due to chance. Thus, interpretation of these analyses should be done with caution.

From an empirical standpoint, the primary limitation of this study was the self-report nature of the data, which may increase the likelihood of common method bias (Podsakoff et al., 2003; Podsakoff et al., 2012). Common method bias can result in inflated or deflated relationships between study variables, yet research has suggested that its effects are often exaggerated (Chan, 2000). Furthermore, research has shown that rather than create artificial

interaction effects, it is likely to attenuate true interaction effects (Evans, 1985; Siemsen, Roth, & Oliveira, 2010). Thus, some of the concern is alleviated by the fact that one of the purposes of this study was to examine interaction effects. Additionally, I utilized a few procedural remedies recommended by Podsakoff et al. (2003) meant to limit the effects of common method bias (i.e., protecting respondent anonymity and temporally separating the measurement of predictor and criterion variables) and incorporated objective data into the analyses (i.e., APGAR scores, birthweight, gestational age) to help alleviate concerns associated with common method bias. Further, VIF scores suggested that multicollinearity was not a major concern with this data.

Finally, it is important to note one of the strengths of this study, the responsiveness of the participants. It was obvious that respondents were interested in this research. The carefully written and lengthy responses to the open-ended questions suggested that respondents took their time filling out the surveys, therefore the analyses presented in this study were based on quality data. Furthermore, the interest and excitement these women showed in sharing their experiences during pregnancy suggest that this is an area of research that needs to be done and that is full of potential.

<div align="center">**Directions for Future Research**</div>

Seeing as only a handful of studies have examined pregnant employees' experiences at work, there are several promising avenues for future research. The first, and perhaps most pressing issue, is to further explore the link between perceived pregnancy discrimination and health. Based on this study, perceived pregnancy discrimination seems to be a main driver of stress and negative outcomes for the mother and her baby. Future researchers might consider creating a scale that measures perceived discrimination that pertains particularly to pregnancy instead of relying upon modified discrimination scales. This would help to hone in on the true

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problems presented by pregnancy discrimination and allow researchers to offer better recommendations to practitioners in terms of policies and employee training.

Another area for future research would be to compare the pregnancy-specific stressors presented in this study to the typical job stressors (e.g., role stressors and abusive supervision). By examining both pregnancy-specific stressors and traditional job stressors, we could reach a better understanding of pregnant women's risk of increased stress levels during pregnancy. Furthermore, a comparative study between pregnant employees and non-pregnant employees would also help address this question.

Researchers may also want to consider a longitudinal study that follows women not only throughout their pregnancy, but also throughout the postpartum period. Results in this study suggested that women who experience stress at work have higher turnover intentions. Following up with these women would provide a fuller picture of the lasting effects of pregnancy-specific stress. Furthermore, postpartum depression was consistently linked to experienced stress at work. Postpartum depression is a scary phenomenon and can have detrimental effects on the women and their husbands, children, family, and friends. Researchers should strive to better understand the links between experienced stress during pregnancy and postpartum depression, as it could lead to early interventions and potentially decrease women's risk of falling victim to postpartum depression.

Finally, researchers should investigate the resources that might aid pregnant employees in alleviating their experienced stress at work. This study examined two traits, self-regulation and resiliency, but there are a number of resources that organizations could provide that might help. For example, women often referred to the importance of supervisor support, flexibility, and maternity leave benefits in their statements of learning during pregnancy. Furthermore, the

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results of this study suggest that self-regulation may not always be a helpful resource. This is contrary to a body of research focused on the positive impact of self-regulation (Baumeister & Alquist, 2009). Future researchers should investigate the "dark side" of self-regulation further.

Conclusion

This study has examined women's experiences at work during pregnancy. It reviewed the existing literature on stress during pregnancy and developed a conceptual multilevel model outlining the process by which stress, and job stress in particular, negatively impacts organizational, health, and family outcomes for the mother and her baby. Furthermore, three pregnancy-specific job stressors (i.e., perceived pregnancy discrimination, pregnancy disclosure, and identity role conflict) were introduced and their relationships with important organizational, health, and family outcomes were examined. Although not all hypotheses were supported, this study arrives at the conclusion that job stress matters during pregnancy and is not something to be ignored. Overall, this paper arrives at the conclusion that Bakst stated so well: "Women should not be forced to choose between a healthy pregnancy and her job" (2012). It is my hope that this research will inspire researchers to further explore the experiences of pregnant women at work.

TABLE 1

Means, SDs, and Correlations among Pilot Study Variables

Variable	M	SD	N	1	2	3	4	5	6	7	8	9
1. Perceived Pregnancy Discrimination	2.07	.72	261	.89								
2. Pregnancy Disclosure	2.35	.87	259	.40**	.89							
3. ID-Role Conflict	3.36	.61	259	.37**	.44**	.84						
4. Psychological Distress	2.55	.86	260	.42**	.41**	.25**	.90					
5. Job Tension	2.72	.86	261	.29**	.31**	.30**	.26**	.87				
6. Job Satisfaction	3.96	.81	261	-.26**	-.21**	-.07	-.15*	-.30**	.91			
7. Turnover Intentions	2.38	1.15	261	.28**	.28**	.23**	.13*	.39**	-.68**	.82		
8. Somatic Complaints	3.10	.74	260	.24**	.20**	.22**	.55**	.20**	-.04	.03	.74	
9. Postpartum Depression	2.27	.75	261	.38**	.32**	.21**	.54**	.34**	-.30**	.24**	.36**	.90
10. APGAR	8.10	1.91	65	-.26*	-.01	-.27*	-.43**	-.07	.02	.02	-.36**	-.29*
11. Birthweight	7.74	1.12	249	-.09	.02	.00	-.07	.01	.03	-.04	-.12	.03
12. Gestational Age	38.42	4.14	259	.08	-.02	.01	-.06	.05	-.05	.03	-.10	.05
13. Family Satisfaction	3.90	.77	261	-.21**	-.14*	-.13*	-.26**	-.23**	.35**	-.19**	-.18**	-.44**
14. Work-Family Conflict	2.58	.84	261	.33**	.33**	.29**	.36**	.53**	-.33**	.46**	.12*	.43**

*Notes: *p<.05; **p<.01; Cronbach's alpha reported along the diagonal*

TABLE 1 (continued)

Variable	10	11	12	13	14
10. APGAR	-				
11. Birthweight	.24	-			
12. Gestational Age	.01	.20**	-		
13. Family Satisfaction	.11	-.03	.05	.88	
14. Work-Family Conflict	.02	-.01	-.03	-.30**	.65

*Notes: *p<.05; **p<.01; Cronbach's alpha reported along the diagonal*

TABLE 2

Means, SDs, and Correlations among Study Variables

Variable	*M*	*SD*	*N*	1	2	3	4	5	6	7	8
1. Perceived Discrimination	1.89	.67	124	*.88*							
2. Pregnancy Disclosure	2.50	.73	124	.35**	*.83*						
3. ID Role Conflict	3.61	.56	124	.55**	.44**	*.80*					
4. Job Tension	2.91	.92	124	.38**	.27**	.36**	*.84*				
5. Perceived Stress	2.74	.52	124	.23**	.20*	.10	.33**	*.86*			
6. Job Satisfaction	3.95	.88	124	-.48**	-.13	-.32**	-.30**	-.23**	*.88*		
7. Turnover Intentions	2.63	1.31	124	.50**	.34**	.32**	.40**	.17	-.60**	*.89*	
8. Planned Turnover	1.27	.63	113	.10	-.12	-.11	.08	.02	-.34**	.23*	-
9. Postpartum Depression	2.06	.62	124	.19*	.17	.05	.21*	.55**	-.20*	.31**	.05
10. APGAR	8.69	.85	75	.06	-.03	.05	-.15	-.24*	.06	.00	.01
11. Birthweight	7.57	1.00	124	-.19*	-.12	-.04	.02	-.19*	.12	-.23*	.03
12. Gestational Age	39.14	1.46	124	-.14	-.21*	.01	-.06	-.20*	.10	-.21*	-.04
13. Doctor Visits	2.61	1.31	124	-.05	.06	-.03	.04	.18*	-.04	.07	.03
14. Work-Family Conflict	2.37	.81	124	.32**	.29**	.26**	.46**	.29**	-.36**	.41**	.02
15. Family Satisfaction	4.21	.66	124	.00	.03	.05	-.09	-.24**	.14	-.08	-.02
16. Self-Regulation	3.51	.52	124	-.07	-.05	.03	-.06	-.31**	.17	-.14	-.18
17. Resiliency	3.50	.82	124	-.10	-.25**	-.07	-.21*	-.53**	.13	-.27**	.00
18. Age	28.67	3.54	123	-.09	.08	.10	.09	-.01	.06	-.12	-.14
19. Organizational Tenure	4.08	2.97	123	-.02	.07	.06	.14	.01	-.07	-.05	-.05
20. Marital Status	2.02	.57	123	-.13	.07	-.16	-.05	-.05	-.11	-.07	.08
21. Number of Children	1.20	.50	123	.12	.06	.20*	.10	.13	-.04	-.01	-.12
22. Ethnicity	.92	.27	119	.08	-.04	.03	.09	.07	-.07	.05	.01
23. MPS-Previous Pregnancies	.38	.74	123	.13	-.04	.12	.10	.18*	-.17	.04	-.09
24. MPS-Vaginal Bleeding	.45	.79	123	.04	.12	.12	.09	.17	-.13	.06	-.05

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TABLE 2 (continued)

Variable	*M*	*SD*	*N*	1	2	3	4	5	6	7	8
25. MPS-Weight Gain	3.97	1.23	123	-.01	-.02	-.01	.13	.06	-.10	.00	.14
26. MPS-Age	3.47	.60	123	-.18	-.09	-.01	.04	-.07	.12	-.18*	-.10
27. MPS-Labor	2.03	1.16	123	-.11	-.09	-.08	-.19*	-.23*	.15	-.12	-.15
28. MPS-Prior Risk Pregnancies	.34	1.11	123	-.07	-.06	.05	.05	.04	-.11	-.02	.02
29. MPS-Cigarette Use	.05	.38	123	-.06	-.16	-.13	-.03	-.13	.01	-.06	.15
30. MPS-Alcohol Use	.52	1.35	123	-.07	-.03	.04	.05	.07	.01	.03	.09
31. MPS-Blood Pressure	1.33	.86	123	.01	.01	-.02	.05	.25**	.07	.09	-.03
32. PA	2.98	.89	124	.03	-.13	.01	.00	-.32**	.06	-.17	.08
33. NA	1.99	.67	124	.00	.00	.07	.04	.29**	-.11	.12	.07

*Notes: *p<.05; **p<.01; Cronbach's alpha reported along the diagonal*

TABLE 2 (continued)

Variable	9	10	11	12	13	14	15	16	17	18
9. Postpartum Depression	.87									
10. APGAR	-.14	-								
11. Birthweight	-.03	.03	-							
12. Gestational Age	-.17	.09	.58**	-						
13. Doctor Visits	.04	.01	-.14	-.40**	-					
14. Work-Family Conflict	.33**	-.11	-.02	-.16	.07	.66				
15. Family Satisfaction	-.34**	.26*	.00	.18*	-.13	-.22*	.91			
16. Self-Regulation	-.22*	-.16	.17	.20*	-.21*	-.06	.04	.79		
17. Resiliency	-.44**	.19	.14	.06	-.17	-.23**	.07	.21*	.92	
18. Age	-.09	.04	.12	.19*	.02	.08	.04	.15	-.09	-
19. Organizational Tenure	-.09	.02	-.04	.07	.09	.14	.04	-.03	-.01	.47**
20. Marital Status	-.14	-.02	.03	.04	.00	.07	.02	.00	.08	.05
21. Number of Children	.15	-.19	-.03	-.09	-.09	.23*	-.26**	.03	-.08	.18*
22. Ethnicity	.01	-.05	.34**	.30**	-.13	.02	.13	.03	.05	-.09
23. MPS-Previous Pregnancies	.16	-.19	-.12	-.12	.01	.28**	-.24**	.04	-.06	.21*
24. MPS-Vaginal Bleeding	.04	-.18	.07	-.01	.20*	.02	-.02	.06	-.03	.05
25. MPS-Weight Gain	.00	-.24*	.12	-.04	.04	-.03	-.08	.14	-.01	-.07
26. MPS-Age	-.06	.06	.12	.22*	-.03	.04	.01	.16	-.05	.86**
27. MPS-Labor	-.19*	-.02	.07	.02	.04	-.16	.02	.11	.12	.17
28. MPS-Prior Risk Pregnancies	.00	.10	-.01	.12	.07	.07	-.07	.10	.02	.27**
29. MPS-Cigarette Use	-.02	.04	.03	-.04	.01	-.06	-.07	-.06	.18*	-.18
30. MPS-Alcohol Use	.07	.10	-.07	.09	.01	-.09	.01	.00	-.04	.23**
31. MPS-Blood Pressure	.25**	.03	-.20*	-.30**	.23*	.04	-.03	-.07	-.11	-.08
32. PA	-.52**	.18	.01	.09	-.13	-.10	.43**	.13	.28**	-.05
33. NA	.69**	-.01	.07	.06	-.07	.12	-.22*	-.06	-.24**	.09

TABLE 2 (continued)

Variable	19	20	21	22	23	24	25	26	27	28
19. Organizational Tenure	-									
20. Marital Status	.14	-								
21. Number of Children	.04	-.04	-							
22. Ethnicity	-.16	-.01	-.14	-						
23. MPS-Previous Pregnancies	.15	-.03	.66**	.17	-					
24. MPS-Vaginal Bleeding	.01	-.07	-.11	-.02	-.06	-				
25. MPS-Weight Gain	.09	-.03	-.01	-.11	-.09	.06	-			
26. MPS-Age	.41**	.00	.17	.15	.23**	.12	-.12	-		
27. MPS-Labor	.02	.11	.07	-.08	-.09	.06	.14	.12	-	
28. MPS-Prior Risk Pregnancies	.19*	.06	.22*	.26**	.37**	.22*	-.16	.33**	.00	-
29. MPS-Cigarette Use	-.08	-.19*	-.05	-.04	-.07	.06	.11	-.10	.11	-.04
30. MPS-Alcohol Use	.07	-.05	-.11	-.02	.03	.18*	.07	.22*	-.03	.17
31. MPS-Blood Pressure	-.02	-.01	.03	.04	.07	.02	.01	-.05	-.10	.04
32. PA	-.07	.03	-.11	-.07	-.18*	-.19*	-.01	-.08	.07	-.20*
33. NA	-.07	-.17	.04	-.08	.16	.04	-.03	.14	-.15	.14

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TABLE 2 (continued)

Variable	29	30	31	32	33
29. MPS-Cigarette Use	-				
30. MPS-Alcohol Use	-.05	-			
31. MPS-Blood Pressure	-.05	.05	-		
32. PA	.14	-.16	-.09	.77	
33. NA	-.01	.27**	.15	-.40**	.74

TABLE 3

Regression Results for Main Effects of Pregnancy Specific Stressors on Organizational, Health, and Family Outcomes

Outcome Variable	Predictors	B	$SE\ B$	β	p	R^2
1. Job Satisfaction	Constant	5.46	.47		.00	.24
	Perceived Discrimination	-.58	.13	-.44	.00	
	Pregnancy Disclosure	.09	.11	.08	.40	
	ID Role Conflict	-.18	.16	-.11	.27	
2. Turnover Intentions	Constant	.19	.67		.78	.28
	Perceived Discrimination	.85	.18	.44	.00	
	Pregnancy Disclosure	.34	.16	.19	.03	
	ID Role Conflict	.00	.23	.00	.99	
3. Planned Turnover	Constant	1.90	.39		.00	.06
	Perceived Discrimination	.25	.11	.27	.02	
	Pregnancy Disclosure	-.11	.09	-.13	.22	
	ID Role Conflict	-.23	.13	-.20	.09	
4. Postpartum Depression	Constant	1.90	.36		.00	.06
	Perceived Discrimination	.19	.10	.21	.05	
	Pregnancy Disclosure	.13	.08	.16	.12	
	ID Role Conflict	-.15	.12	-.13	.24	
5. APGAR	Constant	8.54	.66		.00	.01
	Perceived Discrimination	.07	.19	.06	.72	
	Pregnancy Disclosure	-.09	.17	-.07	.60	
	ID Role Conflict	.07	.25	.05	.77	
6. Birthweight	Constant	7.70	.59		.00	.05
	Perceived Discrimination	-.34	.16	-.23	.04	
	Pregnancy Disclosure	-.14	.14	-.10	.32	
	ID Role Conflict	.24	.20	.13	.24	
7. Gestational Age	Constant	39.09	.85		.00	.08
	Perceived Discrimination	-.37	.23	-.17	.12	
	Pregnancy Disclosure	-.49	.20	-.24	.02	
	ID Role Conflict	.54	.29	.21	.06	
8. Doctor Visits	Constant	2.77	.79		.00	.10
	Perceived Discrimination	-.11	.21	-.06	.62	
	Pregnancy Disclosure	.18	.19	.10	.33	
	ID Role Conflict	-.11	.27	-.05	.68	

TABLE 3 (Continued)

Regression Results for Main Effects of Pregnancy Specific Stressors on Organizational, Health, and Family Outcomes

Outcome Variable	Predictors	B	$SE\ B$	β	p	R^2
9. Work-Family Conflict	Constant	1.02	.46		.03	.14
	Perceived Discrimination	.27	.12	.22	.03	
	Pregnancy Disclosure	.21	.11	.19	.05	
	ID Role Conflict	.08	.16	.06	.59	
10. Family Satisfaction	Constant	3.99	.40		.00	.00
	Perceived Discrimination	-.04	.11	-.04	.70	
	Pregnancy Disclosure	.02	.09	.02	.86	
	ID Role Conflict	.07	.14	.06	.59	

TABLE 4

Regression Results for Job Tension as Mediator of
Perceived Discrimination and Job Satisfaction

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Job Tension)				
Constant	1.98	.24	8.35	<.01
Perceived Discrimination	.49	.12	4.06	<.01
Dependent variable model (Job Satisfaction)				
Constant	4.58	.83	5.55	.00
Job Tension	-.11	.08	-1.29	.20
Perceived Discrimination	-.49	.13	-3.74	.00
Pregnancy Disclosure	.16	.11	1.41	.16
ID Role Conflict	-.14	.16	-.86	.39
Age	.02	.02	.92	.36
Org. Tenure	-.03	.03	-1.10	.27
PA	.11	.09	1.21	.23
NA	-.03	.12	-.25	.80
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	-.05	.04	-.15	.01

Note. N = 123. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence.

TABLE 5

**Regression Results for Perceived Stress as Mediator of
Perceived Discrimination and Job Satisfaction**

Predictor	B	SE	t	p
Mediator model (Perceived Stress)				
Constant	2.42	.14	17.22	<.01
Perceived Discrimination	.17	.07	2.38	.02
Dependent variable model (Job Satisfaction)				
Constant	5.02	.92	5.46	.00
Perceived Stress	-.18	.15	-1.23	.22
Perceived Discrimination	-.49	.13	-3.76	.00
Pregnancy Disclosure	.16	.11	1.43	.15
ID Role Conflict	-.18	.16	-1.16	.25
Age	.02	.02	.85	.40
Org. Tenure	-.03	.03	-1.22	.22
PA	.08	.09	.90	.37
NA	-.01	.12	-.04	.97
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	-.03	.03	-.12	.01

Note. $N = 123$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence.

TABLE 6

Regression Results for Job Tension as Mediator of
Pregnancy Disclosure and Job Satisfaction

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Job Tension)				
Constant	2.12	.29	7.32	<.01
Pregnancy Disclosure	.31	.11	2.78	<.01
Dependent variable model (Job Satisfaction)				
Constant	4.58	.83	5.55	.00
Job Tension	-.11	.08	-1.29	.20
Pregnancy Disclosure	.16	.11	1.41	.16
Perceived Discrimination	-.49	.13	-3.74	.00
ID Role Conflict	-.14	.16	-.86	.39
Age	.02	.02	.92	.36
Org. Tenure	-.03	.03	-1.10	.27
PA	.11	.09	1.21	.23
NA	-.03	.12	-.25	.80
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	-.03	.03	-.10	.01

Note. $N = 123$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence.

TABLE 7

Regression Results for Perceived Stress as Mediator of
Pregnancy Disclosure and Job Satisfaction

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Perceived Stress)				
Constant	2.40	.17	14.42	<.01
Pregnancy Disclosure	.13	.06	2.07	.04
Dependent variable model (Job Satisfaction)				
Constant	5.02	.92	5.46	.00
Perceived Stress	-.18	.15	-1.23	.22
Pregnancy Disclosure	.16	.11	1.43	.15
Perceived Discrimination	-.49	.13	-3.76	.00
ID Role Conflict	-.18	.16	-1.16	.25
Age	.02	.02	.85	.40
Org. Tenure	-.03	.03	-1.22	.22
PA	.08	.09	.90	.37
NA	-.01	.12	-.04	.97
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	-.02	.03	-.09	.00

Note. $N = 123$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence.

TABLE 8

Regression Results for Job Tension as Mediator of
ID Role Conflict and Job Satisfaction

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Job Tension)				
Constant	.91	.52	1.76	.08
ID Role Conflict	.55	.14	3.86	<.01
Dependent variable model (Job Satisfaction)				
Constant	4.58	.83	5.55	.00
Job Tension	-.11	.08	-1.29	.20
ID Role Conflict	-.14	.16	-.86	.39
Perceived Discrimination	-.49	.13	-3.74	.00
Pregnancy Disclosure	.16	.11	1.41	.16
Age	.02	.02	.92	.36
Org. Tenure	-.03	.03	-1.10	.27
PA	.11	.09	1.21	.23
NA	-.03	.12	-.25	.80
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	-.06	.05	-.17	.02

Note. $N = 123$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence.

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TABLE 9

Regression Results for Perceived Stress as Mediator of
ID Role Conflict and Job Satisfaction

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Perceived Stress)				
Constant	2.48	.31	7.96	<.01
ID Role Conflict	.07	.09	.83	.41
Dependent variable model (Job Satisfaction)				
Constant	5.02	.92	5.46	.00
Perceived Stress	-.18	.15	-1.23	.22
ID Role Conflict	-.18	.16	-1.16	.25
Perceived Discrimination	-.49	.13	-3.76	.00
Pregnancy Disclosure	.16	.11	1.43	.15
Age	.02	.02	.85	.40
Org. Tenure	-.03	.03	-1.22	.22
PA	.08	.09	.90	.37
NA	-.01	.12	-.04	.97
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	-.01	.02	-.09	.01

Note. $N = 123$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence.

TABLE 10

**Regression Results for Job Tension as Mediator of
Perceived Discrimination and Turnover Intentions**

Predictor	B	SE	t	p
Mediator model (Job Tension)				
Constant	1.98	.24	8.35	<.01
Perceived Discrimination	.49	.12	4.06	<.01
Dependent variable model (Turnover Intentions)				
Constant	1.46	1.17	1.25	.21
Job Tension	.35	.12	2.94	.00
Perceived Discrimination	.70	.19	3.78	.00
Pregnancy Disclosure	.26	.16	1.67	.10
ID Role Conflict	-.04	.23	-.20	.84
Age	-.04	.03	-1.29	.20
Org. Tenure	-.02	.04	-.45	.65
PA	-.21	.13	-1.64	.10
NA	.11	.17	.63	.53
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	.17	.07	.05	.34

Note. $N = 123$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence.

TABLE 11

**Regression Results for Perceived Stress as Mediator of
Perceived Discrimination and Turnover Intentions**

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Perceived Stress)				
Constant	2.42	.14	17.22	<.01
Perceived Discrimination	.17	.07	2.38	.02
Dependent variable model (Turnover Intentions)				
Constant	1.88	1.34	1.40	.16
Perceived Stress	-.09	.22	-.40	.69
Perceived Discrimination	.84	.19	4.36	.00
Pregnancy Disclosure	.31	.16	1.93	.06
ID Role Conflict	.03	.23	.15	.88
Age	-.04	.03	-1.16	.25
Org. Tenure	.00	.04	-.13	.90
PA	-.22	.14	-1.61	.11
NA	.13	.18	.74	.46
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	-.01	.04	-.11	.05

Note. N = 123. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence.

TABLE 12

Regression Results for Job Tension as Mediator of
Pregnancy Disclosure and Turnover Intentions

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Job Tension)				
Constant	2.12	.29	7.32	<.01
Pregnancy Disclosure	.31	.11	2.78	<.01
Dependent variable model (Turnover Intentions)				
Constant	1.46	1.17	1.25	.21
Job Tension	.35	.12	2.94	.00
Pregnancy Disclosure	.26	.16	1.67	.10
Perceived Discrimination	.70	.19	3.78	.00
ID Role Conflict	-.04	.23	-.20	.84
Age	-.04	.03	-1.29	.20
Org. Tenure	-.02	.04	-.45	.65
PA	-.21	.13	-1.64	.10
NA	.11	.17	.63	.53
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	.11	.05	.02	.25

Note. N = 123. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence.

TABLE 13

Regression Results for Perceived Stress as Mediator of
Pregnancy Disclosure and Turnover Intentions

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Perceived Stress)				
Constant	2.40	.17	14.42	<.01
Pregnancy Disclosure	.13	.06	2.07	.04
Dependent variable model (Turnover Intentions)				
Constant	1.88	1.34	1.40	.16
Perceived Stress	-.09	.22	-.40	.69
Pregnancy Disclosure	.31	.16	1.93	.06
Perceived Discrimination	.84	.19	4.36	.00
ID Role Conflict	.03	.23	.15	.88
Age	-.04	.03	-1.16	.25
Org. Tenure	.00	.04	-.13	.90
PA	-.22	.14	-1.61	.11
NA	.13	.18	.74	.46
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	-.01	.03	-.09	.04

Note. $N = 123$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence.

TABLE 14

**Regression Results for Job Tension as Mediator of
ID Role Conflict and Turnover Intentions**

Predictor	B	SE	t	p
Mediator model (Job Tension)				
Constant	.91	.52	1.76	.08
ID Role Conflict	.55	.14	3.86	<.01
Dependent variable model (Turnover Intentions)				
Constant	1.46	1.17	1.25	.21
Job Tension	.35	.12	2.94	.00
ID Role Conflict	-.04	.23	-.20	.84
Perceived Discrimination	.70	.19	3.78	.00
Pregnancy Disclosure	.26	.16	1.67	.10
Age	-.04	.03	-1.29	.20
Org. Tenure	-.02	.04	-.45	.65
PA	-.21	.13	-1.64	.10
NA	.11	.17	.63	.53
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	.19	.08	.07	.38

Note. $N = 123$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence.

TABLE 15

Regression Results for Perceived Stress as Mediator of ID Role Conflict and Turnover Intentions

Predictor	B	SE	t	p
Mediator model (Perceived Stress)				
Constant	2.48	.31	7.96	<.01
ID Role Conflict	.07	.09	.83	.41
Dependent variable model (Turnover Intentions)				
Constant	1.88	1.34	1.40	.16
Perceived Stress	-.09	.22	-.40	.69
ID Role Conflict	.03	.23	.15	.88
Perceived Discrimination	.84	.19	4.36	.00
Pregnancy Disclosure	.31	.16	1.93	.06
Age	-.04	.03	-1.16	.25
Org. Tenure	.00	.04	-.13	.90
PA	-.22	.14	-1.61	.11
NA	.13	.18	.74	.46
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	-.01	.02	-.09	.02

Note. N = 123. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence.

TABLE 16

Regression Results for Job Tension as Mediator of
Perceived Discrimination and Planned Turnover

Predictor	B	SE	t	p
Mediator model (Job Tension)				
Constant	1.98	.24	8.35	<.01
Perceived Discrimination	.49	.12	4.06	<.01
Dependent variable model (Planned Turnover)				
Constant	1.59	.64	2.47	.01
Job Tension	.08	.07	1.26	.21
Perceived Discrimination	.21	.10	2.05	.04
Pregnancy Disclosure	-.08	.09	-.88	.38
ID Role Conflict	-.22	.12	-1.77	.08
Age	-.02	.02	-1.13	.26
Org. Tenure	.00	.02	.04	.97
PA	.09	.07	1.33	.19
NA	.15	.09	1.61	.11
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	.04	.03	-.01	.12

Note. $N = 123$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Planned Turnover (Do you plan to return to work?); 1=Yes, 2=Maybe, 3=No.

TABLE 17

**Regression Results for Perceived Stress as Mediator of
Perceived Discrimination and Planned Turnover**

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Perceived Stress)				
Constant	2.42	.14	17.22	<.01
Perceived Discrimination	.17	.07	2.38	.02
Dependent variable model (Planned Turnover)				
Constant	1.63	.72	2.27	.03
Perceived Stress	.00	.12	.02	.99
Perceived Discrimination	.24	.10	2.31	.02
Pregnancy Disclosure	-.07	.09	-.76	.45
ID Role Conflict	-.20	.12	-1.59	.11
Age	-.02	.02	-1.08	.28
Org. Tenure	.00	.02	.17	.87
PA	.09	.07	1.31	.19
NA	.15	.10	1.59	.11
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	.00	.02	-.04	.04

Note. N = 123. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Planned Turnover (Do you plan to return to work?); 1=Yes, 2=Maybe, 3=No.

TABLE 18

Regression Results for Job Tension as Mediator of
Pregnancy Disclosure and Planned Turnover

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Job Tension)				
Constant	2.12	.29	7.32	<.01
Pregnancy Disclosure	.31	.11	2.78	<.01
Dependent variable model (Planned Turnover)				
Constant	1.59	.64	2.47	.01
Job Tension	.08	.07	1.26	.21
Pregnancy Disclosure	-.08	.09	-.88	.38
Perceived Discrimination	.21	.10	2.05	.04
ID Role Conflict	-.22	.12	-1.77	.08
Age	-.02	.02	-1.13	.26
Org. Tenure	.00	.02	.04	.97
PA	.09	.07	1.33	.19
NA	.15	.09	1.61	.11
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	.03	.02	-.01	.09

Note. $N = 123$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Planned Turnover (Do you plan to return to work?); 1=Yes, 2=Maybe, 3=No.

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TABLE 19

**Regression Results for Perceived Stress as Mediator of
Pregnancy Disclosure and Planned Turnover**

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Perceived Stress)				
Constant	2.40	.17	14.42	<.01
Pregnancy Disclosure	.13	.06	2.07	.04
Dependent variable model (Planned Turnover)				
Constant	1.63	.72	2.27	.03
Perceived Stress	.00	.12	.02	.99
Pregnancy Disclosure	-.07	.09	-.76	.45
Perceived Discrimination	.24	.10	2.31	.02
ID Role Conflict	-.20	.12	-1.59	.11
Age	-.02	.02	-1.08	.28
Org. Tenure	.00	.02	.17	.87
PA	.09	.07	1.31	.19
NA	.15	.10	1.59	.11
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	.00	.02	-.03	.04

Note. *N* = 123. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Planned Turnover (Do you plan to return to work?); 1=Yes, 2=Maybe, 3=No.

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TABLE 20

**Regression Results for Job Tension as Mediator of
ID Role Conflict and Planned Turnover**

Predictor	B	SE	t	p
Mediator model (Job Tension)				
Constant	.91	.52	1.76	.08
ID Role Conflict	.55	.14	3.86	<.01
Dependent variable model (Planned Turnover)				
Constant	1.59	.64	2.47	.01
Job Tension	.08	.07	1.26	.21
ID Role Conflict	-.22	.12	-1.77	.08
Perceived Discrimination	.21	.10	2.05	.04
Pregnancy Disclosure	-.08	.09	-.88	.38
Age	-.02	.02	-1.13	.26
Org. Tenure	.00	.02	.04	.97
PA	.09	.07	1.33	.19
NA	.15	.09	1.61	.11
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	.05	.03	-.01	.13

Note. N = 123. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Planned Turnover (Do you plan to return to work?); 1=Yes, 2=Maybe, 3=No.

TABLE 21

Regression Results for Perceived Stress as Mediator of
ID Role Conflict and Planned Turnover

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Perceived Stress)				
Constant	2.48	.31	7.96	<.01
ID Role Conflict	.07	.09	.83	.41
Dependent variable model (Planned Turnover)				
Constant	1.63	.72	2.27	.03
Perceived Stress	.00	.12	.02	.99
ID Role Conflict	-.20	.12	-1.59	.11
Perceived Discrimination	.24	.10	2.31	.02
Pregnancy Disclosure	-.07	.09	-.76	.45
Age	-.02	.02	-1.08	.28
Org. Tenure	.00	.02	.17	.87
PA	.09	.07	1.31	.19
NA	.15	.10	1.59	.11
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	.00	.01	-.02	.03

Note. N = 123. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Planned Turnover (Do you plan to return to work?); 1=Yes, 2=Maybe, 3=No.

TABLE 22

Regression Results for Job Tension as Mediator of
Perceived Discrimination and Postpartum Depression

Predictor	B	SE	t	p
Mediator model (Job Tension)				
Constant	1.86	.24	7.87	.00
Perceived Discrimination	.53	.12	4.47	.00
Dependent variable model (Postpartum Depression)				
Constant	1.65	.42	3.89	.00
Job Tension	.09	.05	1.96	.05
Perceived Discrimination	.13	.07	2.00	.05
Pregnancy Disclosure	.06	.06	1.06	.29
ID Role Conflict	-.17	.08	-2.16	.03
Ethnicity	.22	.14	1.53	.13
MPS-Previous Pregnancies	.06	.05	1.03	.30
MPS-Vaginal Bleeding	.00	.05	.09	.93
MPS-Weight Gain	-.01	.03	-.48	.64
MPS-Age	-.07	.07	-1.06	.29
MPS-Labor	-.04	.03	-1.09	.28
MPS-Prior Risk				
Pregnancies	-.03	.04	-.76	.45
MPS-Cigarette Use	.07	.09	.72	.48
MPS-Alcohol Use	-.05	.03	-1.72	.09
MPS-Blood Pressure	.10	.04	2.46	.02
PA	-.22	.05	-4.76	.00
NA	.54	.06	8.46	.00
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	.05	.02	.01	.11

Note. $N = 118$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 23

**Regression Results for Perceived Stress as Mediator of
Perceived Discrimination and Postpartum Depression**

Predictor	B	SE	t	p
Mediator model (Perceived Stress)				
Constant	2.39	.14	16.53	.00
Perceived Discrimination	.18	.07	2.44	.02
Dependent variable model (Postpartum Depression)				
Constant	.93	.45	2.08	.04
Perceived Stress	.29	.08	3.73	.00
Perceived Discrimination	.12	.06	1.96	.05
Pregnancy Disclosure	.05	.05	.97	.33
ID Role Conflict	-.11	.08	-1.52	.13
Ethnicity	.16	.14	1.14	.26
MPS-Previous Pregnancies	.03	.05	.53	.60
MPS-Vaginal Bleeding	-.02	.05	-.53	.60
MPS-Weight Gain	-.01	.03	-.41	.68
MPS-Age	-.04	.06	-.61	.54
MPS-Labor	-.03	.03	-.83	.41
MPS-Prior Risk Pregnancies	-.03	.04	-.71	.48
MPS-Cigarette Use	.11	.09	1.23	.22
MPS-Alcohol Use	-.04	.03	-1.67	.10
MPS-Blood Pressure	.07	.04	1.78	.08
PA	-.19	.05	-4.25	.00
NA	.49	.06	8.02	.00
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	.05	.02	.01	.11

Note. N = 118. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 24

Regression Results for Job Tension as Mediator of
Pregnancy Disclosure and Postpartum Depression

Predictor	B	SE	t	p
Mediator model (Job Tension)				
Constant	1.98	.29	6.76	.00
Pregnancy Disclosure	.35	.11	3.09	.00
Dependent variable model (Postpartum Depression)				
Constant	1.65	.42	3.89	.00
Job Tension	.09	.05	1.96	.05
Pregnancy Disclosure	.06	.06	1.06	.29
Perceived Discrimination	.13	.07	2.00	.05
ID Role Conflict	-.17	.08	-2.16	.03
Ethnicity	.22	.14	1.53	.13
MPS-Previous Pregnancies	.06	.05	1.03	.30
MPS-Vaginal Bleeding	.00	.05	.09	.93
MPS-Weight Gain	-.01	.03	-.48	.64
MPS-Age	-.07	.07	-1.06	.29
MPS-Labor	-.04	.03	-1.09	.28
MPS-Prior Risk Pregnancies	-.03	.04	-.76	.45
MPS-Cigarette Use	.07	.09	.72	.48
MPS-Alcohol Use	-.05	.03	-1.72	.09
MPS-Blood Pressure	.10	.04	2.46	.02
PA	-.22	.05	-4.76	.00
NA	.54	.06	8.46	.00
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	.03	.02	.00	.08

Note. $N = 118$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

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TABLE 25

**Regression Results for Perceived Stress as Mediator of
Pregnancy Disclosure and Postpartum Depression**

Predictor	B	SE	t	p
Mediator model (Perceived Stress)				
Constant	2.37	.17	13.65	.00
Pregnancy Disclosure	.14	.07	2.12	.04
Dependent variable model (Postpartum Depression)				
Constant	.93	.45	2.08	.04
Perceived Stress	.29	.08	3.73	.00
Pregnancy Disclosure	.05	.05	.97	.33
Perceived Discrimination	.12	.06	1.96	.05
ID Role Conflict	-.11	.08	-1.52	.13
Ethnicity	.16	.14	1.14	.26
MPS-Previous Pregnancies	.03	.05	.53	.60
MPS-Vaginal Bleeding	-.02	.05	-.53	.60
MPS-Weight Gain	-.01	.03	-.41	.68
MPS-Age	-.04	.06	-.61	.54
MPS-Labor	-.03	.03	-.83	.41
MPS-Prior Risk Pregnancies	-.03	.04	-.71	.48
MPS-Cigarette Use	.11	.09	1.23	.22
MPS-Alcohol Use	-.04	.03	-1.67	.10
MPS-Blood Pressure	.07	.04	1.78	.08
PA	-.19	.05	-4.25	.00
NA	.49	.06	8.02	.00
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	.04	.02	.01	.10

Note. N = 118. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 26

Regression Results for Job Tension as Mediator of
ID Role Conflict and Postpartum Depression

Predictor	B	SE	t	p
Mediator model (Job Tension)				
Constant	.69	.52	1.34	.18
ID Role Conflict	.60	.14	4.25	.00
Dependent variable model (Postpartum Depression)				
Constant	1.65	.42	3.89	.00
Job Tension	.09	.05	1.96	.05
ID Role Conflict	-.17	.08	-2.16	.03
Perceived Discrimination	.13	.07	2.00	.05
Pregnancy Disclosure	.06	.06	1.06	.29
Ethnicity	.22	.14	1.53	.13
MPS-Previous Pregnancies	.06	.05	1.03	.30
MPS-Vaginal Bleeding	.00	.05	.09	.93
MPS-Weight Gain	-.01	.03	-.48	.64
MPS-Age	-.07	.07	-1.06	.29
MPS-Labor	-.04	.03	-1.09	.28
MPS-Prior Risk Pregnancies	-.03	.04	-.76	.45
MPS-Cigarette Use	.07	.09	.72	.48
MPS-Alcohol Use	-.05	.03	-1.72	.09
MPS-Blood Pressure	.10	.04	2.46	.02
PA	-.22	.05	-4.76	.00
NA	.54	.06	8.46	.00
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	.05	.03	.01	.12

Note. $N = 118$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

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TABLE 27

**Regression Results for Perceived Stress as Mediator of
ID Role Conflict and Postpartum Depression**

Predictor	B	SE	t	p
Mediator model (Perceived Stress)				
Constant	2.43	.32	7.59	.00
ID Role Conflict	.08	.09	.93	.36
Dependent variable model (Postpartum Depression)				
Constant	.93	.45	2.08	.04
Perceived Stress	.29	.08	3.73	.00
ID Role Conflict	-.11	.08	-1.52	.13
Perceived Discrimination	.12	.06	1.96	.05
Pregnancy Disclosure	.05	.05	.97	.33
Ethnicity	.16	.14	1.14	.26
MPS-Previous Pregnancies	.03	.05	.53	.60
MPS-Vaginal Bleeding	-.02	.05	-.53	.60
MPS-Weight Gain	-.01	.03	-.41	.68
MPS-Age	-.04	.06	-.61	.54
MPS-Labor	-.03	.03	-.83	.41
MPS-Prior Risk				
Pregnancies	-.03	.04	-.71	.48
MPS-Cigarette Use	.11	.09	1.23	.22
MPS-Alcohol Use	-.04	.03	-1.67	.10
MPS-Blood Pressure	.07	.04	1.78	.08
PA	-.19	.05	-4.25	.00
NA	.49	.06	8.02	.00
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	.02	.02	-.02	.08

Note. $N = 118$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 28

Regression Results for Job Tension as Mediator of
Perceived Discrimination and APGAR

Predictor	B	SE	t	p
Mediator model (Job Tension)				
Constant	1.77	.28	6.35	.00
Perceived Discrimination	.61	.14	4.49	.00
Dependent variable model (APGAR)				
Constant	7.87	1.23	6.39	.00
Job Tension	-.17	.15	-1.19	.24
Perceived Discrimination	.19	.20	.93	.36
Pregnancy Disclosure	-.01	.19	-.06	.95
ID Role Conflict	.24	.26	.92	.36
Ethnicity	-.02	.41	-.06	.96
MPS-Previous Pregnancies	-.41	.14	-2.87	.01
MPS-Vaginal Bleeding	-.23	.14	-1.65	.11
MPS-Weight Gain	-.15	.10	-1.52	.14
MPS-Age	.06	.18	.34	.73
MPS-Labor	-.03	.10	-.29	.77
MPS-Prior Risk Pregnancies	.26	.19	1.37	.18
MPS-Cigarette Use	.22	.24	.92	.36
MPS-Alcohol Use	.09	.08	1.07	.29
MPS-Blood Pressure	.11	.12	.93	.36
PA	.19	.13	1.40	.17
NA	.02	.21	.10	.92
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	-.11	.11	-.42	.05

Note. $N = 71$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

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TABLE 29

**Regression Results for Perceived Stress as Mediator of
Perceived Discrimination and APGAR**

Predictor	B	SE	t	p
Mediator model (Perceived Stress)				
Constant	2.22	.17	12.82	.00
Perceived Discrimination	.25	.09	2.96	.00
Dependent variable model (APGAR)				
Constant	8.97	1.40	6.43	.00
Perceived Stress	-.37	.25	-1.48	.14
Perceived Discrimination	.19	.20	.99	.33
Pregnancy Disclosure	.02	.19	.09	.93
ID Role Conflict	.13	.25	.49	.62
Ethnicity	.09	.42	.22	.83
MPS-Previous Pregnancies	-.37	.14	-2.55	.01
MPS-Vaginal Bleeding	-.20	.14	-1.46	.15
MPS-Weight Gain	-.19	.09	-2.15	.04
MPS-Age	.00	.18	-.01	.99
MPS-Labor	-.03	.10	-.34	.74
MPS-Prior Risk				
Pregnancies	.30	.19	1.57	.12
MPS-Cigarette Use	.19	.24	.79	.43
MPS-Alcohol Use	.06	.08	.79	.43
MPS-Blood Pressure	.13	.12	1.08	.29
PA	.14	.14	1.03	.31
NA	.07	.21	.32	.75
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	-.09	.08	-.33	.01

Note. N = 71. Unstandardized regression coefficients reported. Confidence intervals based on
95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 30

Regression Results for Job Tension as Mediator of
Pregnancy Disclosure and APGAR

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Job Tension)				
Constant	2.28	.41	5.53	.00
Pregnancy Disclosure	.26	.16	1.67	.10
Dependent variable model (APGAR)				
Constant	7.87	1.23	6.39	.00
Job Tension	-.17	.15	-1.19	.24
Pregnancy Disclosure	-.01	.19	-.06	.95
Perceived Discrimination	.19	.20	.93	.36
ID Role Conflict	.24	.26	.92	.36
Ethnicity	-.02	.41	-.06	.96
MPS-Previous Pregnancies	-.41	.14	-2.87	.01
MPS-Vaginal Bleeding	-.23	.14	-1.65	.11
MPS-Weight Gain	-.15	.10	-1.52	.14
MPS-Age	.06	.18	.34	.73
MPS-Labor	-.03	.10	-.29	.77
MPS-Prior Risk				
Pregnancies	.26	.19	1.37	.18
MPS-Cigarette Use	.22	.24	.92	.36
MPS-Alcohol Use	.09	.08	1.07	.29
MPS-Blood Pressure	.11	.12	.93	.36
PA	.19	.13	1.40	.17
NA	.02	.21	.10	.92
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	-.05	.05	-.24	.02

Note. N = 71. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 31

Regression Results for Perceived Stress as Mediator of
Pregnancy Disclosure and APGAR

Predictor	B	SE	t	p
Mediator model (Perceived Stress)				
Constant	2.39	.24	9.91	.00
Pregnancy Disclosure	.13	.09	1.36	.18
Dependent variable model (APGAR)				
Constant	8.97	1.40	6.43	.00
Perceived Stress	-.37	.25	-1.48	.14
Pregnancy Disclosure	.02	.19	.09	.93
Perceived Discrimination	.19	.20	.99	.33
ID Role Conflict	.13	.25	.49	.62
Ethnicity	.09	.42	.22	.83
MPS-Previous Pregnancies	-.37	.14	-2.55	.01
MPS-Vaginal Bleeding	-.20	.14	-1.46	.15
MPS-Weight Gain	-.19	.09	-2.15	.04
MPS-Age	.00	.18	-.01	.99
MPS-Labor	-.03	.10	-.34	.74
MPS-Prior Risk				
Pregnancies	.30	.19	1.57	.12
MPS-Cigarette Use	.19	.24	.79	.43
MPS-Alcohol Use	.06	.08	.79	.43
MPS-Blood Pressure	.13	.12	1.08	.29
PA	.14	.14	1.03	.31
NA	.07	.21	.32	.75
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	-.05	.05	-.23	.01

Note. $N = 71$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 32

**Regression Results for Job Tension as Mediator of
ID Role Conflict and APGAR**

Predictor	B	SE	t	p
Mediator model (Job Tension)				
Constant	.47	.62	.75	.45
ID Role Conflict	.68	.17	4.03	.00
Dependent variable model (APGAR)				
Constant	7.87	1.23	6.39	.00
Job Tension	-.17	.15	-1.19	.24
ID Role Conflict	.24	.26	.92	.36
Perceived Discrimination	.19	.20	.93	.36
Pregnancy Disclosure	-.01	.19	-.06	.95
Ethnicity	-.02	.41	-.06	.96
MPS-Previous Pregnancies	-.41	.14	-2.87	.01
MPS-Vaginal Bleeding	-.23	.14	-1.65	.11
MPS-Weight Gain	-.15	.10	-1.52	.14
MPS-Age	.06	.18	.34	.73
MPS-Labor	-.03	.10	-.29	.77
MPS-Prior Risk				
Pregnancies	.26	.19	1.37	.18
MPS-Cigarette Use	.22	.24	.92	.36
MPS-Alcohol Use	.09	.08	1.07	.29
MPS-Blood Pressure	.11	.12	.93	.36
PA	.19	.13	1.40	.17
NA	.02	.21	.10	.92
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	-.12	.12	-.43	.06

Note. N = 71. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 33

Regression Results for Perceived Stress as Mediator of
ID Role Conflict and APGAR

Predictor	B	SE	t	p
Mediator model (Perceived Stress)				
Constant	2.27	.40	5.70	.00
ID Role Conflict	.12	.11	1.11	.27
Dependent variable model (APGAR)				
Constant	8.97	1.40	6.43	.00
Perceived Stress	-.37	.25	-1.48	.14
ID Role Conflict	.13	.25	.49	.62
Perceived Discrimination	.19	.20	.99	.33
Pregnancy Disclosure	.02	.19	.09	.93
Ethnicity	.09	.42	.22	.83
MPS-Previous Pregnancies	-.37	.14	-2.55	.01
MPS-Vaginal Bleeding	-.20	.14	-1.46	.15
MPS-Weight Gain	-.19	.09	-2.15	.04
MPS-Age	.00	.18	-.01	.99
MPS-Labor	-.03	.10	-.34	.74
MPS-Prior Risk				
Pregnancies	.30	.19	1.57	.12
MPS-Cigarette Use	.19	.24	.79	.43
MPS-Alcohol Use	.06	.08	.79	.43
MPS-Blood Pressure	.13	.12	1.08	.29
PA	.14	.14	1.03	.31
NA	.07	.21	.32	.75
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	-.04	.06	-.25	.02

Note. $N = 71$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 34

**Regression Results for Job Tension as Mediator of
Perceived Discrimination and Birthweight**

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Job Tension)				
Constant	1.86	.24	7.87	.00
Perceived Discrimination	.53	.12	4.47	.00
Dependent variable model (Birthweight)				
Constant	4.97	1.07	4.66	.00
Job Tension	.13	.11	1.14	.26
Perceived Discrimination	-.32	.17	-1.94	.05
Pregnancy Disclosure	-.10	.14	-.74	.46
ID Role Conflict	.13	.20	.67	.51
Ethnicity	1.11	.36	3.12	.00
MPS-Previous Pregnancies	-.11	.14	-.83	.41
MPS-Vaginal Bleeding	.10	.12	.80	.42
MPS-Weight Gain	.09	.07	1.20	.23
MPS-Age	.20	.16	1.24	.22
MPS-Labor	-.01	.08	-.17	.87
MPS-Prior Risk Pregnancies	.05	.11	.48	.63
MPS-Cigarette Use	-.08	.23	-.36	.72
MPS-Alcohol Use	-.14	.07	-1.94	.06
MPS-Blood Pressure	-.21	.10	-2.02	.05
PA	.10	.12	.82	.41
NA	.32	.16	2.03	.04
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	.07	.07	-.05	.20

Note. $N = 118$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 35

**Regression Results for Perceived Stress as Mediator of
Perceived Discrimination and Birthweight**

Predictor	B	SE	t	p
Mediator model (Perceived Stress)				
Constant	2.39	.14	16.53	.00
Perceived Discrimination	.18	.07	2.44	.02
Dependent variable model (Birthweight)				
Constant	5.89	1.16	5.09	.00
Perceived Stress	-.40	.20	-2.00	.05
Perceived Discrimination	-.23	.16	-1.40	.16
Pregnancy Disclosure	-.05	.14	-.32	.75
ID Role Conflict	.12	.20	.63	.53
Ethnicity	1.29	.36	3.64	.00
MPS-Previous Pregnancies	-.05	.14	-.35	.73
MPS-Vaginal Bleeding	.13	.12	1.13	.26
MPS-Weight Gain	.12	.07	1.65	.10
MPS-Age	.19	.16	1.21	.23
MPS-Labor	-.07	.08	-.82	.42
MPS-Prior Risk Pregnancies	.03	.10	.33	.74
MPS-Cigarette Use	-.11	.23	-.48	.63
MPS-Alcohol Use	-.13	.07	-1.89	.06
MPS-Blood Pressure	-.15	.10	-1.48	.14
PA	.05	.12	.47	.64
NA	.37	.16	2.35	.02
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	-.07	.04	-.20	-.01

Note. N = 118. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 36

Regression Results for Job Tension as Mediator of
Pregnancy Disclosure and Birthweight

Predictor	B	SE	t	p
Mediator model (Job Tension)				
Constant	1.98	.29	6.76	.00
Pregnancy Disclosure	.35	.11	3.09	.00
Dependent variable model (Birthweight)				
Constant	4.97	1.07	4.66	.00
Job Tension	.13	.11	1.14	.26
Pregnancy Disclosure	-.10	.14	-.74	.46
Perceived Discrimination	-.32	.17	-1.94	.05
ID Role Conflict	.13	.20	.67	.51
Ethnicity	1.11	.36	3.12	.00
MPS-Previous Pregnancies	-.11	.14	-.83	.41
MPS-Vaginal Bleeding	.10	.12	.80	.42
MPS-Weight Gain	.09	.07	1.20	.23
MPS-Age	.20	.16	1.24	.22
MPS-Labor	-.01	.08	-.17	.87
MPS-Prior Risk				
Pregnancies	.05	.11	.48	.63
MPS-Cigarette Use	-.08	.23	-.36	.72
MPS-Alcohol Use	-.14	.07	-1.94	.06
MPS-Blood Pressure	-.21	.10	-2.02	.05
PA	.10	.12	.82	.41
NA	.32	.16	2.03	.04
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	.05	.05	-.03	.17

Note. N = 118. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 37

**Regression Results for Perceived Stress as Mediator of
Pregnancy Disclosure and Birthweight**

Predictor	B	SE	t	p
Mediator model (Perceived Stress)				
Constant	2.37	.17	13.65	.00
Pregnancy Disclosure	.14	.07	2.12	.04
Dependent variable model (Birthweight)				
Constant	5.89	1.16	5.09	.00
Perceived Stress	-.40	.20	-2.00	.05
Pregnancy Disclosure	-.05	.14	-.32	.75
Perceived Discrimination	-.23	.16	-1.40	.16
ID Role Conflict	.12	.20	.63	.53
Ethnicity	1.29	.36	3.64	.00
MPS-Previous Pregnancies	-.05	.14	-.35	.73
MPS-Vaginal Bleeding	.13	.12	1.13	.26
MPS-Weight Gain	.12	.07	1.65	.10
MPS-Age	.19	.16	1.21	.23
MPS-Labor	-.07	.08	-.82	.42
MPS-Prior Risk				
Pregnancies	.03	.10	.33	.74
MPS-Cigarette Use	-.11	.23	-.48	.63
MPS-Alcohol Use	-.13	.07	-1.89	.06
MPS-Blood Pressure	-.15	.10	-1.48	.14
PA	.05	.12	.47	.64
NA	.37	.16	2.35	.02
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	-.06	.04	-.17	-.01

Note. $N = 118$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 38

Regression Results for Job Tension as Mediator of
ID Role Conflict and Birthweight

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Job Tension)				
Constant	.69	.52	1.34	.18
ID Role Conflict	.60	.14	4.25	.00
Dependent variable model (Birthweight)				
Constant	4.97	1.07	4.66	.00
Job Tension	.13	.11	1.14	.26
ID Role Conflict	.13	.20	.67	.51
Perceived Discrimination	-.32	.17	-1.94	.05
Pregnancy Disclosure	-.10	.14	-.74	.46
Ethnicity	1.11	.36	3.12	.00
MPS-Previous Pregnancies	-.11	.14	-.83	.41
MPS-Vaginal Bleeding	.10	.12	.80	.42
MPS-Weight Gain	.09	.07	1.20	.23
MPS-Age	.20	.16	1.24	.22
MPS-Labor	-.01	.08	-.17	.87
MPS-Prior Risk				
Pregnancies	.05	.11	.48	.63
MPS-Cigarette Use	-.08	.23	-.36	.72
MPS-Alcohol Use	-.14	.07	-1.94	.06
MPS-Blood Pressure	-.21	.10	-2.02	.05
PA	.10	.12	.82	.41
NA	.32	.16	2.03	.04
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	.08	.07	-.06	.24

Note. N = 118. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

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TABLE 39

Regression Results for Perceived Stress as Mediator of ID Role Conflict and Birthweight

Predictor	B	SE	t	p
Mediator model (Perceived Stress)				
Constant	2.43	.32	7.59	.00
ID Role Conflict	.08	.09	.93	.36
Dependent variable model (Birthweight)				
Constant	5.89	1.16	5.09	.00
Perceived Stress	-.40	.20	-2.00	.05
ID Role Conflict	.12	.20	.63	.53
Perceived Discrimination	-.23	.16	-1.40	.16
Pregnancy Disclosure	-.05	.14	-.32	.75
Ethnicity	1.29	.36	3.64	.00
MPS-Previous Pregnancies	-.05	.14	-.35	.73
MPS-Vaginal Bleeding	.13	.12	1.13	.26
MPS-Weight Gain	.12	.07	1.65	.10
MPS-Age	.19	.16	1.21	.23
MPS-Labor	-.07	.08	-.82	.42
MPS-Prior Risk Pregnancies	.03	.10	.33	.74
MPS-Cigarette Use	-.11	.23	-.48	.63
MPS-Alcohol Use	-.13	.07	-1.89	.06
MPS-Blood Pressure	-.15	.10	-1.48	.14
PA	.05	.12	.47	.64
NA	.37	.16	2.35	.02

Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	-.03	.04	-.14	.01

Note. N = 118. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 40

**Regression Results for Job Tension as Mediator of
Perceived Discrimination and Gestational Age**

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Job Tension)				
Constant	1.86	.24	7.87	.00
Perceived Discrimination	.53	.12	4.47	.00
Dependent variable model (Gestational Age)				
Constant	35.48	1.47	24.21	.00
Job Tension	.01	.16	.08	.94
Perceived Discrimination	-.15	.23	-.68	.50
Pregnancy Disclosure	-.33	.20	-1.68	.10
ID Role Conflict	.34	.27	1.23	.22
Ethnicity	1.45	.49	2.95	.00
MPS-Previous Pregnancies	-.31	.19	-1.65	.10
MPS-Vaginal Bleeding	-.07	.16	-.44	.66
MPS-Weight Gain	.00	.10	.04	.97
MPS-Age	.44	.22	1.96	.05
MPS-Labor	-.08	.11	-.74	.46
MPS-Prior Risk Pregnancies	.19	.15	1.33	.19
MPS-Cigarette Use	-.32	.32	-.98	.33
MPS-Alcohol Use	.02	.10	.19	.85
MPS-Blood Pressure	-.47	.14	-3.33	.00
PA	.27	.16	1.69	.09
NA	.38	.22	1.75	.08
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	.01	.08	-.14	.20

Note. N = 118. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 41

**Regression Results for Perceived Stress as Mediator of
Perceived Discrimination and Gestational Age**

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Perceived Stress)				
Constant	2.39	.14	16.53	.00
Perceived Discrimination	.18	.07	2.44	.02
Dependent variable model (Gestational Age)				
Constant	36.13	1.60	22.52	.00
Perceived Stress	-.27	.28	-.98	.33
Perceived Discrimination	-.11	.22	-.51	.61
Pregnancy Disclosure	-.30	.19	-1.56	.12
ID Role Conflict	.31	.27	1.14	.26
Ethnicity	1.54	.49	3.13	.00
MPS-Previous Pregnancies	-.28	.19	-1.44	.15
MPS-Vaginal Bleeding	-.05	.17	-.28	.78
MPS-Weight Gain	.01	.10	.15	.88
MPS-Age	.42	.22	1.90	.06
MPS-Labor	-.11	.11	-.96	.34
MPS-Prior Risk Pregnancies	.19	.15	1.29	.20
MPS-Cigarette Use	-.34	.32	-1.07	.29
MPS-Alcohol Use	.02	.10	.20	.84
MPS-Blood Pressure	-.44	.14	-3.04	.00
PA	.24	.16	1.50	.14
NA	.42	.22	1.90	.06
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	-.05	.06	-.22	.05

Note. N = 118. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

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TABLE 42

Regression Results for Job Tension as Mediator of
Pregnancy Disclosure and Gestational Age

Predictor	B	SE	t	p
Mediator model (Job Tension)				
Constant	1.98	.29	6.76	.00
Pregnancy Disclosure	.35	.11	3.09	.00
Dependent variable model (Gestational Age)				
Constant	35.48	1.47	24.21	.00
Job Tension	.01	.16	.08	.94
Pregnancy Disclosure	-.33	.20	-1.68	.10
Perceived Discrimination	-.15	.23	-.68	.50
ID Role Conflict	.34	.27	1.23	.22
Ethnicity	1.45	.49	2.95	.00
MPS-Previous Pregnancies	-.31	.19	-1.65	.10
MPS-Vaginal Bleeding	-.07	.16	-.44	.66
MPS-Weight Gain	.00	.10	.04	.97
MPS-Age	.44	.22	1.96	.05
MPS-Labor	-.08	.11	-.74	.46
MPS-Prior Risk Pregnancies	.19	.15	1.33	.19
MPS-Cigarette Use	-.32	.32	-.98	.33
MPS-Alcohol Use	.02	.10	.19	.85
MPS-Blood Pressure	-.47	.14	-3.33	.00
PA	.27	.16	1.69	.09
NA	.38	.22	1.75	.08
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	.00	.06	-.09	.15

Note. $N = 118$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 43

Regression Results for Perceived Stress as Mediator of
Pregnancy Disclosure and Gestational Age

Predictor	B	SE	t	p
Mediator model (Perceived Stress)				
Constant	2.37	.17	13.65	.00
Pregnancy Disclosure	.14	.07	2.12	.04
Dependent variable model (Gestational Age)				
Constant	36.13	1.60	22.52	.00
Perceived Stress	-.27	.28	-.98	.33
Pregnancy Disclosure	-.30	.19	-1.56	.12
Perceived Discrimination	-.11	.22	-.51	.61
ID Role Conflict	.31	.27	1.14	.26
Ethnicity	1.54	.49	3.13	.00
MPS-Previous Pregnancies	-.28	.19	-1.44	.15
MPS-Vaginal Bleeding	-.05	.17	-.28	.78
MPS-Weight Gain	.01	.10	.15	.88
MPS-Age	.42	.22	1.90	.06
MPS-Labor	-.11	.11	-.96	.34
MPS-Prior Risk				
Pregnancies	.19	.15	1.29	.20
MPS-Cigarette Use	-.34	.32	-1.07	.29
MPS-Alcohol Use	.02	.10	.20	.84
MPS-Blood Pressure	-.44	.14	-3.04	.00
PA	.24	.16	1.50	.14
NA	.42	.22	1.90	.06
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	-.04	.05	-.19	.03

Note. N = 118. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 44

**Regression Results for Job Tension as Mediator of
ID Role Conflict and Gestational Age**

Predictor	B	SE	t	p
Mediator model (Job Tension)				
Constant	.69	.52	1.34	.18
ID Role Conflict	.60	.14	4.25	.00
Dependent variable model (Gestational Age)				
Constant	35.48	1.47	24.21	.00
Job Tension	.01	.16	.08	.94
ID Role Conflict	.34	.27	1.23	.22
Perceived Discrimination	-.15	.23	-.68	.50
Pregnancy Disclosure	-.33	.20	-1.68	.10
Ethnicity	1.45	.49	2.95	.00
MPS-Previous Pregnancies	-.31	.19	-1.65	.10
MPS-Vaginal Bleeding	-.07	.16	-.44	.66
MPS-Weight Gain	.00	.10	.04	.97
MPS-Age	.44	.22	1.96	.05
MPS-Labor	-.08	.11	-.74	.46
MPS-Prior Risk				
Pregnancies	.19	.15	1.33	.19
MPS-Cigarette Use	-.32	.32	-.98	.33
MPS-Alcohol Use	.02	.10	.19	.85
MPS-Blood Pressure	-.47	.14	-3.33	.00
PA	.27	.16	1.69	.09
NA	.38	.22	1.75	.08
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	.01	.09	-.16	.23

Note. N = 118. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 45

**Regression Results for Perceived Stress as Mediator of
ID Role Conflict and Gestational Age**

Predictor	B	SE	t	p
Mediator model (Perceived Stress)				
Constant	2.43	.32	7.59	.00
ID Role Conflict	.08	.09	.93	.36
Dependent variable model (Gestational Age)				
Constant	36.13	1.60	22.52	.00
Perceived Stress	-.27	.28	-.98	.33
ID Role Conflict	.31	.27	1.14	.26
Perceived Discrimination	-.11	.22	-.51	.61
Pregnancy Disclosure	-.30	.19	-1.56	.12
Ethnicity	1.54	.49	3.13	.00
MPS-Previous Pregnancies	-.28	.19	-1.44	.15
MPS-Vaginal Bleeding	-.05	.17	-.28	.78
MPS-Weight Gain	.01	.10	.15	.88
MPS-Age	.42	.22	1.90	.06
MPS-Labor	-.11	.11	-.96	.34
MPS-Prior Risk Pregnancies	.19	.15	1.29	.20
MPS-Cigarette Use	-.34	.32	-1.07	.29
MPS-Alcohol Use	.02	.10	.20	.84
MPS-Blood Pressure	-.44	.14	-3.04	.00
PA	.24	.16	1.50	.14
NA	.42	.22	1.90	.06
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	-.02	.04	-.16	.03

Note. $N = 118$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

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TABLE 46

**Regression Results for Job Tension as Mediator of
Perceived Discrimination and Doctor Visits**

Predictor	B	SE	t	p
Mediator model (Job Tension)				
Constant	1.86	.24	7.87	.00
Perceived Discrimination	.53	.12	4.47	.00
Dependent variable model (Doctor Visits)				
Constant	4.37	1.50	2.92	.00
Job Tension	.09	.16	.58	.56
Perceived Discrimination	-.16	.23	-.71	.48
Pregnancy Disclosure	.05	.20	.25	.81
ID Role Conflict	-.08	.28	-.27	.78
Ethnicity	-.60	.50	-1.20	.23
MPS-Previous Pregnancies	.02	.19	.08	.94
MPS-Vaginal Bleeding	.27	.17	1.60	.11
MPS-Weight Gain	.01	.11	.12	.90
MPS-Age	-.06	.23	-.27	.79
MPS-Labor	.08	.11	.66	.51
MPS-Prior Risk				
Pregnancies	.02	.15	.15	.88
MPS-Cigarette Use	.07	.33	.22	.83
MPS-Alcohol Use	-.02	.10	-.17	.86
MPS-Blood Pressure	.34	.14	2.39	.02
PA	-.26	.16	-1.60	.11
NA	-.41	.22	-1.81	.07
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	.05	.09	-.11	.24

Note. N = 118. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 47

**Regression Results for Perceived Stress as Mediator of
Perceived Discrimination and Doctor Visits**

Predictor	B	SE	t	p
Mediator model (Perceived Stress)				
Constant	2.39	.14	16.53	.00
Perceived Discrimination	.18	.07	2.44	.02
Dependent variable model (Doctor Visits)				
Constant	3.27	1.63	2.00	.05
Perceived Stress	.45	.28	1.58	.12
Perceived Discrimination	-.19	.23	-.85	.40
Pregnancy Disclosure	.03	.20	.14	.89
ID Role Conflict	.00	.28	-.01	1.00
Ethnicity	-.71	.50	-1.42	.16
MPS-Previous Pregnancies	-.03	.19	-.17	.86
MPS-Vaginal Bleeding	.22	.17	1.33	.19
MPS-Weight Gain	.01	.10	.11	.91
MPS-Age	-.02	.23	-.09	.93
MPS-Labor	.10	.11	.86	.39
MPS-Prior Risk				
Pregnancies	.03	.15	.20	.84
MPS-Cigarette Use	.13	.33	.40	.69
MPS-Alcohol Use	-.01	.10	-.14	.89
MPS-Blood Pressure	.30	.15	2.03	.05
PA	-.22	.16	-1.31	.19
NA	-.47	.22	-2.09	.04
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	.08	.06	-.01	.27

Note. N = 118. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 48

**Regression Results for Job Tension as Mediator of
Pregnancy Disclosure and Doctor Visits**

Predictor	B	SE	t	p
Mediator model (Job Tension)				
Constant	1.98	.29	6.76	.00
Pregnancy Disclosure	.35	.11	3.09	.00
Dependent variable model (Doctor Visits)				
Constant	4.37	1.50	2.92	.00
Job Tension	.09	.16	.58	.56
Pregnancy Disclosure	.05	.20	.25	.81
Perceived Discrimination	-.16	.23	-.71	.48
ID Role Conflict	-.08	.28	-.27	.78
Ethnicity	-.60	.50	-1.20	.23
MPS-Previous Pregnancies	.02	.19	.08	.94
MPS-Vaginal Bleeding	.27	.17	1.60	.11
MPS-Weight Gain	.01	.11	.12	.90
MPS-Age	-.06	.23	-.27	.79
MPS-Labor	.08	.11	.66	.51
MPS-Prior Risk				
Pregnancies	.02	.15	.15	.88
MPS-Cigarette Use	.07	.33	.22	.83
MPS-Alcohol Use	-.02	.10	-.17	.86
MPS-Blood Pressure	.34	.14	2.39	.02
PA	-.26	.16	-1.60	.11
NA	-.41	.22	-1.81	.07
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	.03	.06	-.07	.17

Note. $N = 118$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 49

**Regression Results for Perceived Stress as Mediator of
Pregnancy Disclosure and Doctor Visits**

Predictor	B	SE	t	p
Mediator model (Perceived Stress)				
Constant	2.37	.17	13.65	.00
Pregnancy Disclosure	.14	.07	2.12	.04
Dependent variable model (Doctor Visits)				
Constant	3.27	1.63	2.00	.05
Perceived Stress	.45	.28	1.58	.12
Pregnancy Disclosure	.03	.20	.14	.89
Perceived Discrimination	-.19	.23	-.85	.40
ID Role Conflict	.00	.28	-.01	1.00
Ethnicity	-.71	.50	-1.42	.16
MPS-Previous Pregnancies	-.03	.19	-.17	.86
MPS-Vaginal Bleeding	.22	.17	1.33	.19
MPS-Weight Gain	.01	.10	.11	.91
MPS-Age	-.02	.23	-.09	.93
MPS-Labor	.10	.11	.86	.39
MPS-Prior Risk Pregnancies	.03	.15	.20	.84
MPS-Cigarette Use	.13	.33	.40	.69
MPS-Alcohol Use	-.01	.10	-.14	.89
MPS-Blood Pressure	.30	.15	2.03	.05
PA	-.22	.16	-1.31	.19
NA	-.47	.22	-2.09	.04
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	.06	.06	-.01	.25

Note. $N = 118$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 50

**Regression Results for Job Tension as Mediator of
ID Role Conflict and Doctor Visits**

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Job Tension)				
Constant	.69	.52	1.34	.18
ID Role Conflict	.60	.14	4.25	.00
Dependent variable model (Doctor Visits)				
Constant	4.37	1.50	2.92	.00
Job Tension	.09	.16	.58	.56
ID Role Conflict	-.08	.28	-.27	.78
Perceived Discrimination	-.16	.23	-.71	.48
Pregnancy Disclosure	.05	.20	.25	.81
Ethnicity	-.60	.50	-1.20	.23
MPS-Previous Pregnancies	.02	.19	.08	.94
MPS-Vaginal Bleeding	.27	.17	1.60	.11
MPS-Weight Gain	.01	.11	.12	.90
MPS-Age	-.06	.23	-.27	.79
MPS-Labor	.08	.11	.66	.51
MPS-Prior Risk				
Pregnancies	.02	.15	.15	.88
MPS-Cigarette Use	.07	.33	.22	.83
MPS-Alcohol Use	-.02	.10	-.17	.86
MPS-Blood Pressure	.34	.14	2.39	.02
PA	-.26	.16	-1.60	.11
NA	-.41	.22	-1.81	.07
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	.06	.10	-.12	.28

Note. N = 118. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

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TABLE 51

Regression Results for Perceived Stress as Mediator of
ID Role Conflict and Doctor Visits

Predictor	B	SE	t	p
Mediator model (Perceived Stress)				
Constant	2.43	.32	7.59	.00
ID Role Conflict	.08	.09	.93	.36
Dependent variable model (Doctor Visits)				
Constant	3.27	1.63	2.00	.05
Perceived Stress	.45	.28	1.58	.12
ID Role Conflict	.00	.28	-.01	1.00
Perceived Discrimination	-.19	.23	-.85	.40
Pregnancy Disclosure	.03	.20	.14	.89
Ethnicity	-.71	.50	-1.42	.16
MPS-Previous Pregnancies	-.03	.19	-.17	.86
MPS-Vaginal Bleeding	.22	.17	1.33	.19
MPS-Weight Gain	.01	.10	.11	.91
MPS-Age	-.02	.23	-.09	.93
MPS-Labor	.10	.11	.86	.39
MPS-Prior Risk Pregnancies	.03	.15	.20	.84
MPS-Cigarette Use	.13	.33	.40	.69
MPS-Alcohol Use	-.01	.10	-.14	.89
MPS-Blood Pressure	.30	.15	2.03	.05
PA	-.22	.16	-1.31	.19
NA	-.47	.22	-2.09	.04
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	.04	.05	-.02	.19

Note. $N = 118$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 52

Regression Results for Job Tension as Mediator of
Perceived Discrimination and Work-Family Conflict

Predictor	B	SE	t	p
Mediator model (Job Tension)				
Constant	1.98	.24	8.35	<.01
Perceived Discrimination	.49	.12	4.06	<.01
Dependent variable model (Work-Family Conflict)				
Constant	.53	.68	.78	.44
Job Tension	.31	.08	4.15	.00
Perceived Discrimination	.14	.12	1.16	.25
Pregnancy Disclosure	.12	.10	1.18	.24
ID Role Conflict	-.05	.15	-.31	.76
Marital Status	.15	.11	1.35	.18
Number of Children	.27	.13	2.07	.04
PA	-.07	.08	-.92	.36
NA	.06	.11	.56	.58
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	.15	.06	.06	.29

Note. $N = 123$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

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TABLE 53

**Regression Results for Perceived Stress as Mediator of
Perceived Discrimination and Work-Family Conflict**

Predictor	B	SE	t	p
Mediator model (Perceived Stress)				
Constant	2.42	.14	17.22	<.01
Perceived Discrimination	.17	.07	2.38	.02
Dependent variable model (Work-Family Conflict)				
Constant	.13	.80	.16	.88
Perceived Stress	.26	.14	1.83	.07
Perceived Discrimination	.18	.12	1.49	.14
Pregnancy Disclosure	.14	.11	1.26	.21
ID Role Conflict	.07	.15	.46	.64
Marital Status	.16	.12	1.29	.20
Number of Children	.26	.14	1.93	.06
PA	-.04	.09	-.47	.64
NA	.03	.12	.22	.83
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	.04	.04	.00	.15

Note. $N = 123$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 54

**Regression Results for Job Tension as Mediator of
Pregnancy Disclosure and Work-Family Conflict**

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Job Tension)				
Constant	2.12	.29	7.32	<.01
Pregnancy Disclosure	.31	.11	2.78	<.01
Dependent variable model (Work-Family Conflict)				
Constant	.53	.68	.78	.44
Job Tension	.31	.08	4.15	.00
Pregnancy Disclosure	.12	.10	1.18	.24
Perceived Discrimination	.14	.12	1.16	.25
ID Role Conflict	-.05	.15	-.31	.76
Marital Status	.15	.11	1.35	.18
Number of Children	.27	.13	2.07	.04
PA	-.07	.08	-.92	.36
NA	.06	.11	.56	.58
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	.10	.05	.02	.21

Note. N = 123. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence.

TABLE 55

**Regression Results for Perceived Stress as Mediator of
Pregnancy Disclosure and Work-Family Conflict**

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Perceived Stress)				
Constant	2.40	.17	14.42	<.01
Pregnancy Disclosure	.13	.06	2.07	.04
Dependent variable model (Work-Family Conflict)				
Constant	.13	.80	.16	.88
Perceived Stress	.26	.14	1.83	.07
Pregnancy Disclosure	.14	.11	1.26	.21
Perceived Discrimination	.18	.12	1.49	.14
ID Role Conflict	.07	.15	.46	.64
Marital Status	.16	.12	1.29	.20
Number of Children	.26	.14	1.93	.06
PA	-.04	.09	-.47	.64
NA	.03	.12	.22	.83
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	.04	.03	.00	.11

Note. $N = 123$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence.

TABLE 56

Regression Results for Job Tension as Mediator of ID Role Conflict and Work-Family Conflict

Predictor	B	SE	t	p
Mediator model (Job Tension)				
Constant	.91	.52	1.76	.08
ID Role Conflict	.55	.14	3.86	<.01
Dependent variable model (Work-Family Conflict)				
Constant	.53	.68	.78	.44
Job Tension	.31	.08	4.15	.00
ID Role Conflict	-.05	.15	-.31	.76
Perceived Discrimination	.14	.12	1.16	.25
Pregnancy Disclosure	.12	.10	1.18	.24
Marital Status	.15	.11	1.35	.18
Number of Children	.27	.13	2.07	.04
PA	-.07	.08	-.92	.36
NA	.06	.11	.56	.58
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	.17	.06	.07	.32

Note. $N = 123$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence.

TABLE 57

**Regression Results for Perceived Stress as Mediator of
ID Role Conflict and Work-Family Conflict**

Predictor	B	SE	t	p
Mediator model (Perceived Stress)				
Constant	2.48	.31	7.96	<.01
ID Role Conflict	.07	.09	.83	.41
Dependent variable model (Work-Family Conflict)				
Constant	.13	.80	.16	.88
Perceived Stress	.26	.14	1.83	.07
ID Role Conflict	.07	.15	.46	.64
Perceived Discrimination	.18	.12	1.49	.14
Pregnancy Disclosure	.14	.11	1.26	.21
Marital Status	.16	.12	1.29	.20
Number of Children	.26	.14	1.93	.06
PA	-.04	.09	-.47	.64
NA	.03	.12	.22	.83
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	.02	.03	-.02	.10

Note. $N = 123$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence.

TABLE 58

Regression Results for Job Tension as Mediator of
Perceived Discrimination and Family Satisfaction

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Job Tension)				
Constant	1.98	.24	8.35	.00
Perceived Discrimination	.49	.12	4.06	.00
Dependent variable model (Family Satisfaction)				
Constant	3.59	.58	6.21	.00
Job Tension	-.08	.06	-1.30	.20
Perceived Discrimination	-.05	.10	-.46	.65
Pregnancy Disclosure	.07	.09	.87	.39
ID Role Conflict	.13	.12	1.01	.31
Marital Status	-.02	.10	-.17	.86
Number of Children	-.30	.11	-2.68	.01
PA	.28	.07	4.06	.00
NA	-.07	.09	-.76	.45
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	-.04	.03	-.12	.02

Note. $N = 123$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence.

TABLE 59

Regression Results for Perceived Stress as Mediator of Perceived Discrimination and Family Satisfaction

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Perceived Stress)				
Constant	2.42	.14	17.22	.00
Perceived Discrimination	.17	.07	2.38	.02
Dependent variable model (Family Satisfaction)				
Constant	3.85	.65	5.93	.00
Perceived Stress	-.13	.12	-1.12	.27
Perceived Discrimination	-.05	.10	-.48	.63
Pregnancy Disclosure	.08	.09	.88	.38
ID Role Conflict	.09	.12	.70	.48
Marital Status	-.02	.10	-.18	.86
Number of Children	-.29	.11	-2.61	.01
PA	.27	.07	3.73	.00
NA	-.05	.09	-.56	.58
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	-.02	.02	-.10	.01

Note. $N = 123$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence.

TABLE 60

Regression Results for Job Tension as Mediator of
Pregnancy Disclosure and Family Satisfaction

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Job Tension)				
Constant	2.12	.29	7.32	.00
Pregnancy Disclosure	.31	.11	2.78	.01
Dependent variable model (Family Satisfaction)				
Constant	3.59	.58	6.21	.00
Job Tension	-.08	.06	-1.30	.20
Pregnancy Disclosure	.07	.09	.87	.39
Perceived Discrimination	-.05	.10	-.46	.65
ID Role Conflict	.13	.12	1.01	.31
Marital Status	-.02	.10	-.17	.86
Number of Children	-.30	.11	-2.68	.01
PA	.28	.07	4.06	.00
NA	-.07	.09	-.76	.45
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	-.03	.02	-.09	.01

Note. $N = 123$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence.

TABLE 61

Regression Results for Perceived Stress as Mediator of Pregnancy Disclosure and Family Satisfaction

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Perceived Stress)				
Constant	2.40	.17	14.42	.00
Pregnancy Disclosure	.13	.06	2.07	.04
Dependent variable model (Family Satisfaction)				
Constant	3.85	.65	5.93	.00
Perceived Stress	-.13	.12	-1.12	.27
Pregnancy Disclosure	.08	.09	.88	.38
Perceived Discrimination	-.05	.10	-.48	.63
ID Role Conflict	.09	.12	.70	.48
Marital Status	-.02	.10	-.18	.86
Number of Children	-.29	.11	-2.61	.01
PA	.27	.07	3.73	.00
NA	-.05	.09	-.56	.58
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	-.02	.02	-.08	.01

Note. $N = 123$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence.

TABLE 62

**Regression Results for Job Tension as Mediator of
ID Role Conflict and Family Satisfaction**

Predictor	B	SE	t	p
Mediator model (Job Tension)				
Constant	.91	.52	1.76	.08
ID Role Conflict	.55	.14	3.86	.00
Dependent variable model (Family Satisfaction)				
Constant	3.59	.58	6.21	.00
Job Tension	-.08	.06	-1.30	.20
ID Role Conflict	.13	.12	1.01	.31
Perceived Discrimination	-.05	.10	-.46	.65
Pregnancy Disclosure	.07	.09	.87	.39
Marital Status	-.02	.10	-.17	.86
Number of Children	-.30	.11	-2.68	.01
PA	.28	.07	4.06	.00
NA	-.07	.09	-.76	.45
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Job Tension	-.05	.04	-.14	.02

Note. $N = 123$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence.

TABLE 63

**Regression Results for Perceived Stress as Mediator of
ID Role Conflict and Family Satisfaction**

Predictor	B	SE	t	p
Mediator model (Perceived Stress)				
Constant	2.48	.31	7.96	.00
ID Role Conflict	.07	.09	.83	.41
Dependent variable model (Family Satisfaction)				
Constant	3.85	.65	5.93	.00
Perceived Stress	-.13	.12	-1.12	.27
ID Role Conflict	.09	.12	.70	.48
Perceived Discrimination	-.05	.10	-.48	.63
Pregnancy Disclosure	.08	.09	.88	.38
Marital Status	-.02	.10	-.18	.86
Number of Children	-.29	.11	-2.61	.01
PA	.27	.07	3.73	.00
NA	-.05	.09	-.56	.58
Indirect effect	Effect	Boot SE	Boot LLCI	Boot ULCI
Perceived Stress	-.01	.02	-.07	.01

Note. N = 123. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence.

TABLE 64

Regression Results for Self-Regulation as Moderator of
Perceived Stress and Postpartum Depression

Predictor	*B*	*SE*	*t*	*p*
Dependent variable model (Postpartum Depression)				
Constant	-.94	1.03	-.92	.36
Self-Regulation	.54	.28	1.93	.06
Self-Regulation	1.03	.35	2.99	.00
Perceived Stress X Self-Regulation	-.21	.10	-2.15	.03
Ethnicity	.14	.14	1.00	.32
MPS-Previous Pregnancies	.04	.05	.77	.44
MPS-Vaginal Bleeding	-.01	.05	-.15	.88
MPS-Weight Gain	-.01	.03	-.28	.78
MPS-Age	-.04	.06	-.59	.56
MPS-Labor	-.04	.03	-1.22	.23
MPS-Prior Risk Pregnancies	-.04	.04	-.97	.34
MPS-Cigarette Use	.11	.09	1.18	.24
MPS-Alcohol Use	-.06	.03	-2.18	.03
MPS-Blood Pressure	.07	.04	1.75	.08
PA	-.21	.05	-4.62	.00
NA	.48	.06	7.80	.00

Self-Regulation	Effect	Boot SE	*t*	*p*
Conditional effects at Self-Regulation = M $\pm$ 1 *SD*				
-1 *SD* (2.98)	.41	.09	4.45	.00
M (3.51)	.30	.08	3.71	.00
+1 *SD* (4.04)	.18	.10	1.88	.06

Note. $N = 118$. Unstandardized regression coefficients reported. Ethnicity: 1 = White, 0 = Non-White.

TABLE 65

**Regression Results for Self-Regulation as Moderator of
Perceived Stress and APGAR**

Predictor	B	SE	t	p
Dependent variable model (APGAR)				
Constant	4.68	3.14	1.49	.14
Self-Regulation	1.38	.89	1.55	.13
Perceived Stress	1.84	1.11	1.66	.10
Perceived Stress X Self-Regulation	-.62	.31	-1.99	.05
Ethnicity	.00	.40	.01	.99
MPS-Previous Pregnancies	-.30	.14	-2.16	.04
MPS-Vaginal Bleeding	-.14	.13	-1.08	.28
MPS-Weight Gain	-.11	.09	-1.17	.25
MPS-Age	.05	.17	.30	.76
MPS-Labor	-.08	.11	-.74	.46
MPS-Prior Risk Pregnancies	.20	.19	1.10	.28
MPS-Cigarette Use	.11	.22	.50	.62
MPS-Alcohol Use	.03	.08	.38	.71
MPS-Blood Pressure	.15	.12	1.24	.22
PA	.10	.15	.66	.51
NA	.01	.20	.07	.94

Self-Regulation	Effect	Boot SE	t	p
Conditional effects at Self-Regulation = M $\pm$ 1 SD				
-1 SD (3.10)	-.07	.27	-.27	.79
M (3.60)	-.38	.24	-1.60	.12
+1 SD (4.10)	-.69	.30	-2.29	.03

Note. $N = 71$. Unstandardized regression coefficients reported. Ethnicity: 1 = White, 0 = Non-White.

TABLE 66

**Regression Results for Resiliency as Moderator of
Job Tension and Work-Family Conflict**

Predictor	B	SE	t	p
Dependent variable model (Work-Family Conflict)				
Constant	-.49	1.05	-.47	.64
Resiliency	.35	.23	1.48	.14
Job Tension	.87	.28	3.18	.00
Job Tension X Resiliency	-.15	.08	-2.00	.05
Marital Status	.17	.11	1.50	.14
Number of Children	.29	.13	2.31	.02
PA	-.05	.08	-.64	.52
NA	.05	.11	.48	.63
Resiliency	Effect	Boot SE	t	p
Conditional effects at Resiliency = M $\pm$ 1 SD				
-1 SD (2.69)	.46	.09	5.05	.00
M (3.51)	.34	.07	4.81	.00
+1 SD (4.32)	.21	.10	2.18	.03

Note. N = 123. Unstandardized regression coefficients reported.

TABLE 67

Summary of Hypotheses Tests

Hypothesis:		Results
H1	Perceived pregnancy discrimination is positively associated with experienced stress.	Supported
H2	Pregnancy disclosure is positively associated with experienced stress.	Supported
H3	Identity-role conflict is positively associated with experienced stress.	Partially Supported
H4	Experienced stress will mediate the relationship between organizational stressors (i.e., perceived pregnancy discrimination, pregnancy disclosure, and identity-role conflict) and adverse work outcomes (e.g., job satisfaction, turnover intentions, and actual turnover).	Partially Supported
H5	Experienced stress will mediate the relationship between organizational stressors (i.e., perceived pregnancy discrimination, pregnancy disclosure, and identity-role conflict) and adverse health outcomes for mother (e.g., postpartum depression) and baby (e.g., low APGAR score, low birthweight, low gestational age, and number of doctor's visits).	Partially Supported
H6	Experienced stress will mediate the relationship between organizational stressors (i.e., perceived pregnancy discrimination, pregnancy disclosure, and identity-role conflict) and family outcomes (i.e., WFC and family satisfaction).	Partially Supported
H7a	Self-regulation will moderate the relationship between experienced stress and organizational outcomes such that high levels of self-regulation attenuate the relationships between experienced stress and adverse organizational outcomes.	Not Supported
H7b	Self-regulation will moderate the relationship between experienced stress and health outcomes such that high levels of self-regulation attenuate the relationships between experienced stress and adverse health outcomes.	Partially Supported
H7c	Self-regulation will moderate the relationship between experienced stress and family outcomes such that high levels of self-regulation attenuate the relationships between experienced stress and adverse family outcomes.	Not Supported
H8a	Resiliency will moderate the relationship between experienced stress and organizational outcomes such that high levels of resiliency attenuate the relationship between experienced stress and adverse organizational outcomes.	Not Supported

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TABLE 67 (Continued)

Hypothesis:		Results
H8b	Resiliency will moderate the relationship between experienced stress and health outcomes such that high levels of resiliency attenuate the relationship between experienced stress and adverse health outcomes.	Not Supported
H8c	Resiliency will moderate the relationship between experienced stress and family outcomes such that high levels of resiliency attenuate the relationship between experienced stress and adverse family outcomes.	Partially Supported

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TABLE 68

**Regression Results for Conditional Indirect Effects
of Perceived Discrimination on Postpartum Depression**

Predictor	B	SE	t	p
Mediator model (Perceived Stress)				
Constant	2.39	.14	16.53	.00
Perceived Discrimination	.18	.07	2.44	.02
Dependent variable model (Post-Partum Depression)				
Constant	-1.03	1.04	-.99	.32
Perceived Stress	1.02	.34	3.01	.00
Perceived Discrimination	.13	.06	2.09	.04
Self-Regulation	.56	.27	2.03	.04
Perceived Stress X Self-Regulation	-.22	.10	-2.28	.02
Pregnancy Disclosure	.06	.05	1.07	.29
ID Role Conflict	-.11	.07	-1.52	.13
Ethnicity	.13	.14	.93	.35
MPS-Previous Pregnancies	.03	.05	.66	.51
MPS-Vaginal Bleeding	-.01	.05	-.14	.89
MPS-Weight Gain	.00	.03	-.05	.96
MPS-Age	-.02	.06	-.30	.77
MPS-Labor	-.03	.03	-1.13	.26
MPS-Prior Risk Pregnancies	-.04	.04	-.91	.36
MPS-Cigarette Use	.10	.09	1.17	.24
MPS-Alcohol Use	-.06	.03	-2.10	.04
MPS-Blood Pressure	.07	.04	1.77	.08
PA	-.20	.05	-4.42	.00
NA	.50	.06	8.18	.00

Self-Regulation	Indirect Effect	Boot SE	Boot LLCI	Boot ULCI
Conditional effects at Self-Regulation = M $\pm$ 1 *SD*				
-1 *SD* (2.98)	.07	.03	.02	.14
M (3.51)	.04	.02	.01	.11
+1 *SD* (4.04)	.02	.02	.00	.08

Note. $N = 118$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 69

**Regression Results for Conditional Indirect Effects
of Pregnancy Disclosure on Postpartum Depression**

Predictor	B	SE	t	p
Mediator model (Perceived Stress)				
Constant	2.37	.17	13.65	.00
Pregnancy Disclosure	.14	.07	2.12	.04
Dependent variable model (Post-Partum Depression)				
Constant	-1.03	1.04	-.99	.32
Perceived Stress	1.02	.34	3.01	.00
Pregnancy Disclosure	.06	.05	1.07	.29
Self-Regulation	.56	.27	2.03	.04
Perceived Stress X Self-Regulation	-.22	.10	-2.28	.02
Perceived Discrimination	.13	.06	2.09	.04
ID Role Conflict	-.11	.07	-1.52	.13
Ethnicity	.13	.14	.93	.35
MPS-Previous Pregnancies	.03	.05	.66	.51
MPS-Vaginal Bleeding	-.01	.05	-.14	.89
MPS-Weight Gain	.00	.03	-.05	.96
MPS-Age	-.02	.06	-.30	.77
MPS-Labor	-.03	.03	-1.13	.26
MPS-Prior Risk Pregnancies	-.04	.04	-.91	.36
MPS-Cigarette Use	.10	.09	1.17	.24
MPS-Alcohol Use	-.06	.03	-2.10	.04
MPS-Blood Pressure	.07	.04	1.77	.08
PA	-.20	.05	-4.42	.00
NA	.50	.06	8.18	.00
Self-Regulation	Indirect Effect	Boot SE	Boot LLCI	Boot ULCI
Conditional effects at Self-Regulation = M $\pm$ 1 SD				
-1 SD (2.98)	.05	.03	.01	.12
M (3.51)	.04	.02	.01	.09
+1 SD (4.04)	.02	.02	.00	.07

Note. N = 118. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 70

**Regression Results for Conditional Indirect Effects
of ID Role Conflict on Postpartum Depression**

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Perceived Stress)				
Constant	2.43	.32	7.59	.00
ID Role Conflict	.08	.09	.93	.36
Dependent variable model (Post-Partum Depression)				
Constant	-1.03	1.04	-.99	.32
Perceived Stress	1.02	.34	3.01	.00
ID Role Conflict	-.11	.07	-1.52	.13
Self-Regulation	.56	.27	2.03	.04
Perceived Stress X Self-Regulation	-.22	.10	-2.28	.02
Perceived Discrimination	.13	.06	2.09	.04
Pregnancy Disclosure	.06	.05	1.07	.29
Ethnicity	.13	.14	.93	.35
MPS-Previous Pregnancies	.03	.05	.66	.51
MPS-Vaginal Bleeding	-.01	.05	-.14	.89
MPS-Weight Gain	.00	.03	-.05	.96
MPS-Age	-.02	.06	-.30	.77
MPS-Labor	-.03	.03	-1.13	.26
MPS-Prior Risk Pregnancies	-.04	.04	-.91	.36
MPS-Cigarette Use	.10	.09	1.17	.24
MPS-Alcohol Use	-.06	.03	-2.10	.04
MPS-Blood Pressure	.07	.04	1.77	.08
PA	-.20	.05	-4.42	.00
NA	.50	.06	8.18	.00

Self-Regulation	Indirect Effect	Boot SE	Boot LLCI	Boot ULCI
Conditional effects at Self-Regulation = M ± 1 *SD*				
-1 *SD* (2.98)	.03	.03	-.02	.10
M (3.51)	.02	.02	-.01	.08
+1 *SD* (4.04)	.01	.02	-.01	.06

Note. $N = 118$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

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TABLE 71

**Regression Results for Conditional Indirect Effects
of Perceived Discrimination on APGAR**

Predictor	B	SE	t	p
Mediator model (Perceived Stress)				
Constant	2.22	.17	12.82	.00
Perceived Discrimination	.25	.09	2.96	.00
Dependent variable model (APGAR)				
Constant	3.13	3.26	.96	.34
Perceived Stress	1.96	1.10	1.78	.08
Perceived Discrimination	.18	.19	.97	.33
Self-Regulation	1.58	.89	1.78	.08
Perceived Stress X Self-Regulation	-.68	.31	-2.21	.03
Pregnancy Disclosure	.03	.18	.16	.87
ID Role Conflict	.16	.24	.67	.50
Ethnicity	-.03	.41	-.09	.93
MPS-Previous Pregnancies	-.34	.14	-2.42	.02
MPS-Vaginal Bleeding	-.15	.14	-1.10	.28
MPS-Weight Gain	-.11	.09	-1.21	.23
MPS-Age	.09	.17	.52	.61
MPS-Labor	-.10	.11	-.89	.38
MPS-Prior Risk Pregnancies	.18	.19	.99	.33
MPS-Cigarette Use	.19	.23	.84	.40
MPS-Alcohol Use	.03	.08	.32	.75
MPS-Blood Pressure	.17	.12	1.38	.17
PA	.09	.14	.60	.55
NA	.07	.20	.33	.74

Self-Regulation	Indirect Effect	Boot SE	Boot LLCI	Boot ULCI
Conditional effects at Self-Regulation = M $\pm$ 1 SD				
-1 SD (3.10)	-.04	.07	-.27	.06
M (3.60)	-.12	.08	-.36	.00
+1 SD (4.10)	-.21	.13	-.51	.00

Note. N = 71. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 72

**Regression Results for Conditional Indirect Effects
of Pregnancy Disclosure on APGAR**

Predictor	B	SE	t	p
Mediator model (Perceived Stress)				
Constant	2.39	.24	9.91	.00
Pregnancy Disclosure	.13	.09	1.36	.18
Dependent variable model (APGAR)				
Constant	3.13	3.26	.96	.34
Perceived Stress	1.96	1.10	1.78	.08
Pregnancy Disclosure	.03	.18	.16	.87
Self-Regulation	1.58	.89	1.78	.08
Perceived Stress X Self-Regulation	-.68	.31	-2.21	.03
Perceived Discrimination	.18	.19	.97	.33
ID Role Conflict	.16	.24	.67	.50
Ethnicity	-.03	.41	-.09	.93
MPS-Previous Pregnancies	-.34	.14	-2.42	.02
MPS-Vaginal Bleeding	-.15	.14	-1.10	.28
MPS-Weight Gain	-.11	.09	-1.21	.23
MPS-Age	.09	.17	.52	.61
MPS-Labor	-.10	.11	-.89	.38
MPS-Prior Risk Pregnancies	.18	.19	.99	.33
MPS-Cigarette Use	.19	.23	.84	.40
MPS-Alcohol Use	.03	.08	.32	.75
MPS-Blood Pressure	.17	.12	1.38	.17
PA	.09	.14	.60	.55
NA	.07	.20	.33	.74
Self-Regulation	Indirect Effect	Boot SE	Boot LLCI	Boot ULCI
Conditional effects at Self-Regulation = M $\pm$ 1 SD				
-1 SD (3.10)	-.02	.04	-.18	.03
M (3.60)	-.06	.06	-.25	.01
+1 SD (4.10)	-.10	.09	-.37	.02

Note. N = 71. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 73

**Regression Results for Conditional Indirect Effects
of ID Role Conflict on APGAR**

Predictor	B	SE	t	p
Mediator model (Perceived Stress)				
Constant	2.27	.40	5.70	.00
ID Role Conflict	.12	.11	1.11	.27
Dependent variable model (APGAR)				
Constant	3.13	3.26	.96	.34
Perceived Stress	1.96	1.10	1.78	.08
ID Role Conflict	.16	.24	.67	.50
Self-Regulation	1.58	.89	1.78	.08
Perceived Stress X Self-Regulation	-.68	.31	-2.21	.03
Perceived Discrimination	.18	.19	.97	.33
Pregnancy Disclosure	.03	.18	.16	.87
Ethnicity	-.03	.41	-.09	.93
MPS-Previous Pregnancies	-.34	.14	-2.42	.02
MPS-Vaginal Bleeding	-.15	.14	-1.10	.28
MPS-Weight Gain	-.11	.09	-1.21	.23
MPS-Age	.09	.17	.52	.61
MPS-Labor	-.10	.11	-.89	.38
MPS-Prior Risk Pregnancies	.18	.19	.99	.33
MPS-Cigarette Use	.19	.23	.84	.40
MPS-Alcohol Use	.03	.08	.32	.75
MPS-Blood Pressure	.17	.12	1.38	.17
PA	.09	.14	.60	.55
NA	.07	.20	.33	.74

Self-Regulation	Indirect Effect	Boot SE	Boot LLCI	Boot ULCI
Conditional effects at Self-Regulation = M ± 1 *SD*				
-1 *SD* (3.10)	-.02	.05	-.20	.03
M (3.60)	-.06	.06	-.28	.01
+1 *SD* (4.10)	-.10	.10	-.42	.02

Note. $N = 71$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence. Ethnicity: 1 = White, 0 = Non-White.

TABLE 74

**Regression Results for Conditional Indirect Effects
of Perceived Discrimination on Work-Family Conflict**

Predictor	*B*	*SE*	*t*	*p*
Mediator model (Job Tension)				
Constant	1.98	.24	8.35	.00
Perceived Discrimination	.49	.12	4.06	.00
Dependent variable model (Work-Family Conflict)				
Constant	-1.39	1.17	-1.19	.24
Job Tension	.93	.28	3.37	.00
Perceived Discrimination	.15	.11	1.29	.20
Resiliency	.46	.24	1.91	.06
Job Tension X Resiliency	-.19	.08	-2.37	.02
Pregnancy Disclosure	.14	.10	1.41	.16
ID Role Conflict	-.04	.14	-.30	.76
Marital Status	.17	.11	1.51	.13
Number of Children	.28	.13	2.23	.03
PA	-.02	.08	-.29	.77
NA	.09	.11	.86	.39
Resiliency	Indirect Effect	Boot SE	Boot LLCI	Boot ULCI
Conditional effects at Resiliency = M $\pm$ 1 *SD*				
-1 *SD* (2.69)	.21	.07	.09	.38
M (3.51)	.14	.05	.06	.26
+1 *SD* (4.32)	.06	.05	-.03	.19

Note. $N = 123$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence.

TABLE 75

**Regression Results for Conditional Indirect Effects
of Pregnancy Disclosure on Work-Family Conflict**

Predictor	B	SE	t	p
Mediator model (Job Tension)				
Constant	2.12	.29	7.32	.00
Pregnancy Disclosure	.31	.11	2.78	.01
Dependent variable model (Work-Family Conflict)				
Constant	-1.39	1.17	-1.19	.24
Job Tension	.93	.28	3.37	.00
Pregnancy Disclosure	.14	.10	1.41	.16
Resiliency	.46	.24	1.91	.06
Job Tension X Resiliency	-.19	.08	-2.37	.02
Perceived Discrimination	.15	.11	1.29	.20
ID Role Conflict	-.04	.14	-.30	.76
Marital Status	.17	.11	1.51	.13
Number of Children	.28	.13	2.23	.03
PA	-.02	.08	-.29	.77
NA	.09	.11	.86	.39
Resiliency	Indirect Effect	Boot SE	Boot LLCI	Boot ULCI
Conditional effects at Resiliency = M $\pm$ 1 SD				
-1 SD (2.69)	.14	.06	.03	.28
M (3.51)	.09	.04	.02	.20
+1 SD (4.32)	.04	.04	-.01	.15

Note. $N = 123$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence.

TABLE 76

**Regression Results for Conditional Indirect Effects
of ID Role Conflict on Work-Family Conflict**

Predictor	B	SE	t	p
Mediator model (Job Tension)				
Constant	.91	.52	1.76	.08
ID Role Conflict	.55	.14	3.86	.00
Dependent variable model (Work-Family Conflict)				
Constant	-1.39	1.17	-1.19	.24
Job Tension	.93	.28	3.37	.00
ID Role Conflict	-.04	.14	-.30	.76
Resiliency	.46	.24	1.91	.06
Job Tension X Resiliency	-.19	.08	-2.37	.02
Perceived Discrimination	.15	.11	1.29	.20
Pregnancy Disclosure	.14	.10	1.41	.16
Marital Status	.17	.11	1.51	.13
Number of Children	.28	.13	2.23	.03
PA	-.02	.08	-.29	.77
NA	.09	.11	.86	.39
Resiliency	Indirect Effect	Boot SE	Boot LLCI	Boot ULCI
Conditional effects at Resiliency = M $\pm$ 1 *SD*				
-1 *SD* (2.69)	.24	.08	.11	.43
M (3.51)	.16	.06	.07	.30
+1 *SD* (4.32)	.07	.06	-.03	.22

Note. $N = 123$. Unstandardized regression coefficients reported. Confidence intervals based on 95% confidence.

TABLE 77

Post Hoc Analysis: Perceived Pregnancy Discrimination Bivariate Relationships

Variable	*M*	*SD*	*N*	1	2	3	4	5	6	7
1. Perceived Pregnancy Discrimination	1.89	.67	124	-						
2. Physical Job Demands	2.29	.53	124	.51**	-					
3. Visibility of Pregnancy	5.93	1.15	123	.02	-.03	-				
4. Revealed Pregnancy (Weeks)	10.84	4.32	122	-.09	-.21*	-.10	-			
5. Supervisor Gender	.44	.50	123	-.05	-.15	.10	.05	-		
6. Supervisor Parental Status	.78	.42	122	.02	-.01	-.06	.05	-.08	-	
7. Organizational Level	3.25	1.21	110	.02	-.02	-.06	.06	-.25**	-.11	-

Notes: Supervisor Gender 1=Male, 0=Female; Supervisor Parental Status 1=Parent, 0=Not a Parent
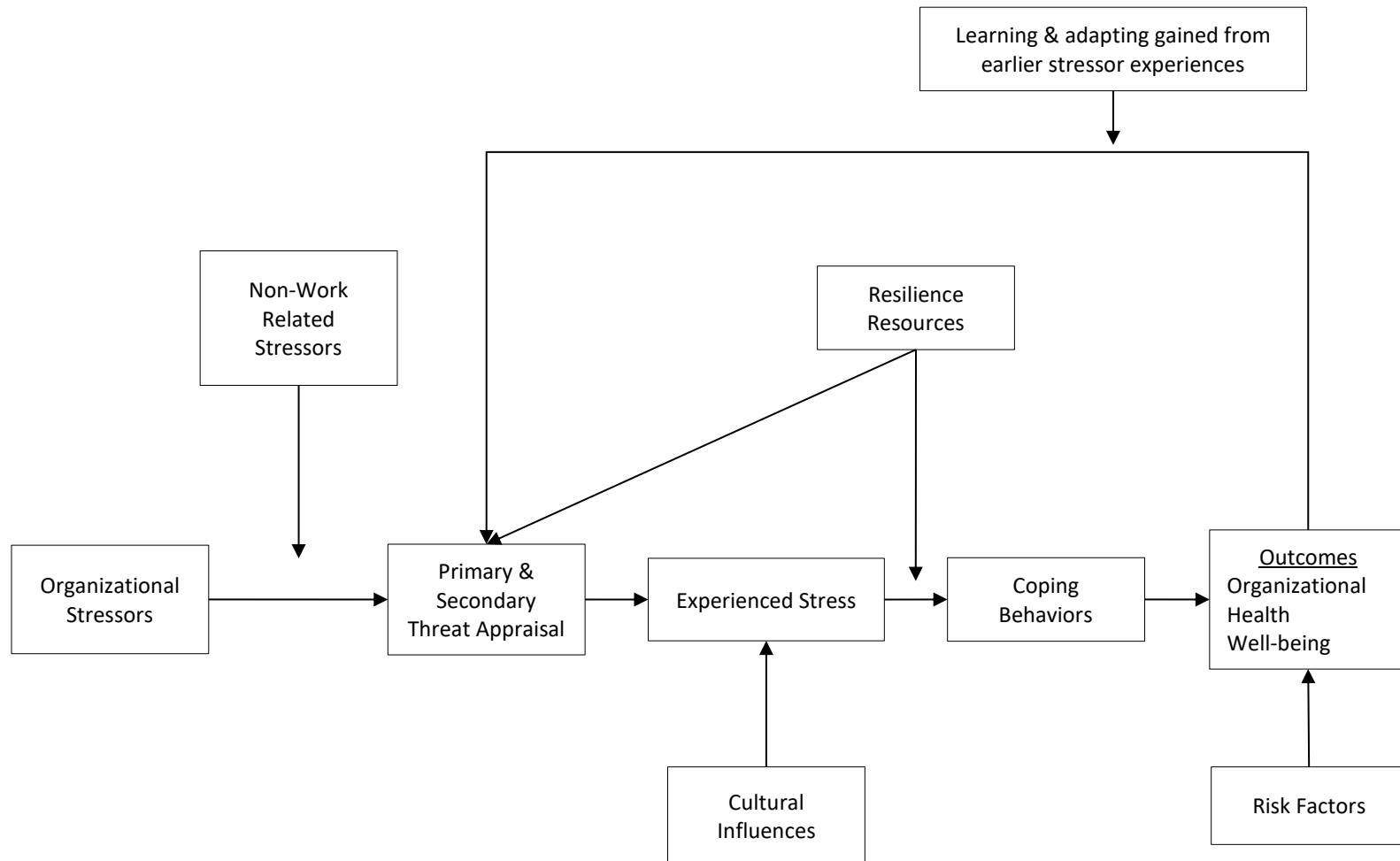
FIGURE 1

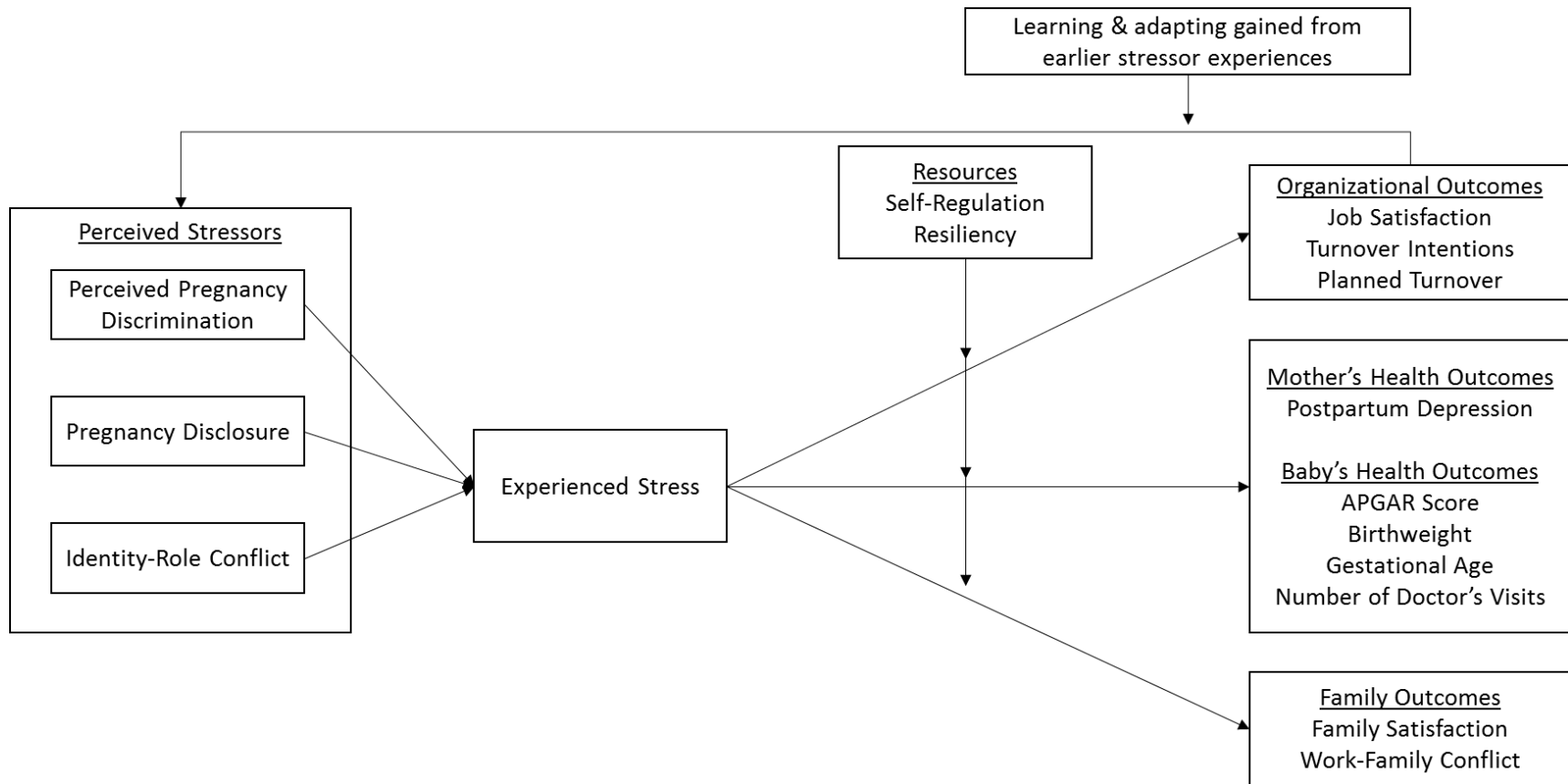**A Conceptual Model of Stress during Pregnancy**

FIGURE 2

A Model of Job Stress during Pregnancy
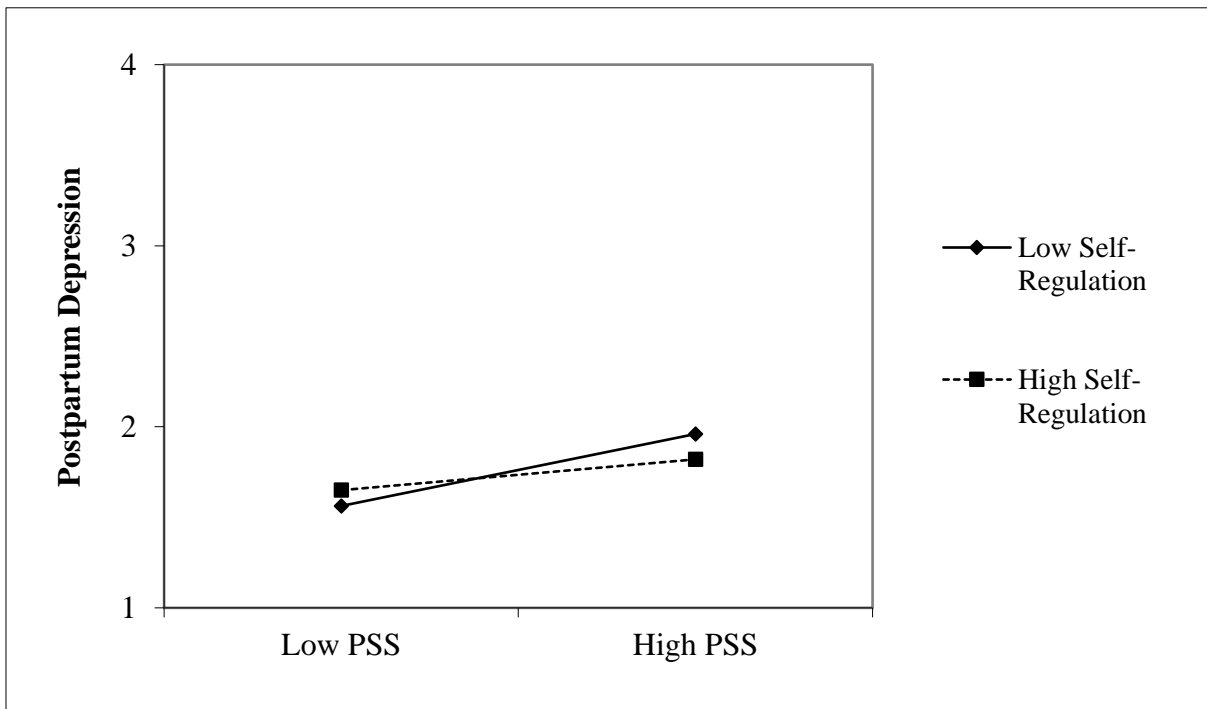
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FIGURE 3

Interactive Effects of Self-Regulation and Perceived Stress on Postpartum Depression
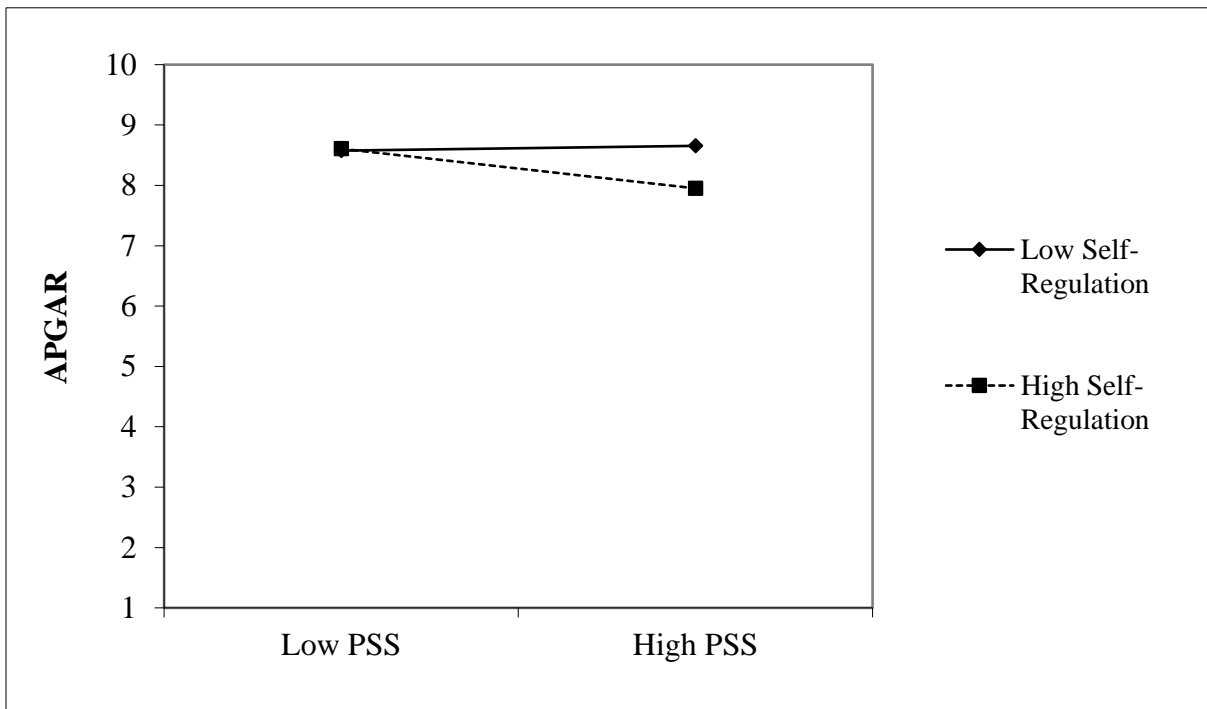
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FIGURE 4

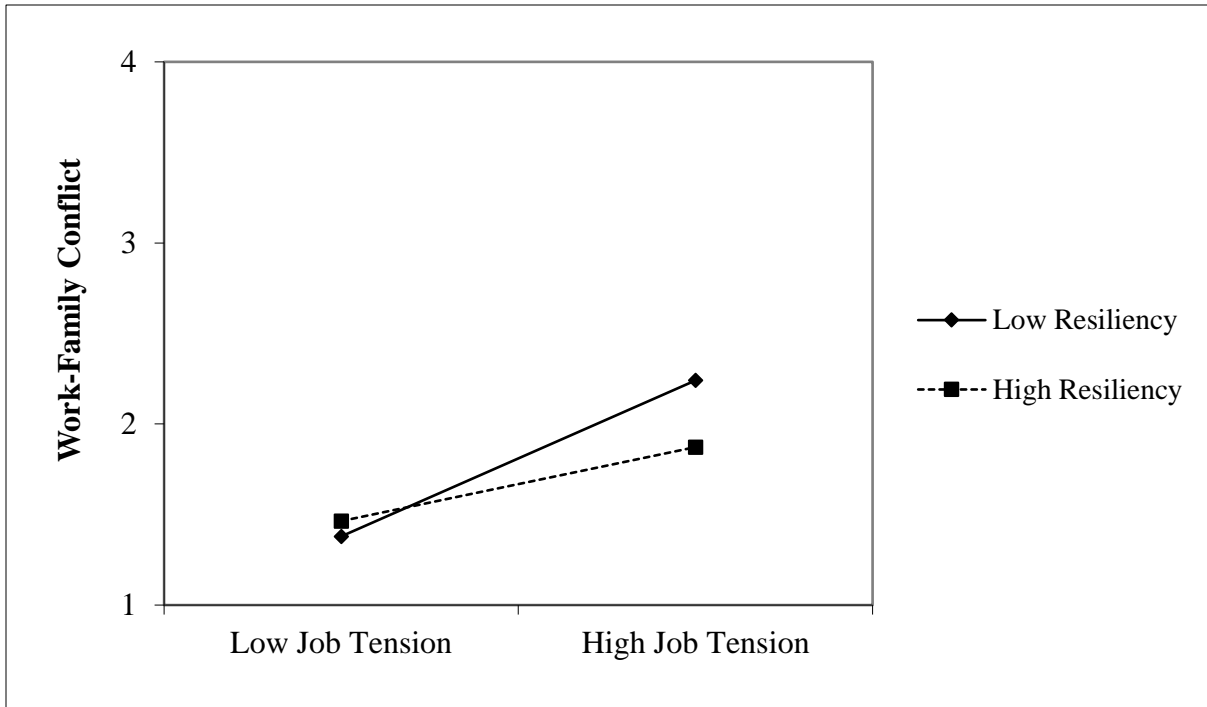**Interactive Effects of Self-Regulation and Perceived Stress on APGAR**

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FIGURE 5

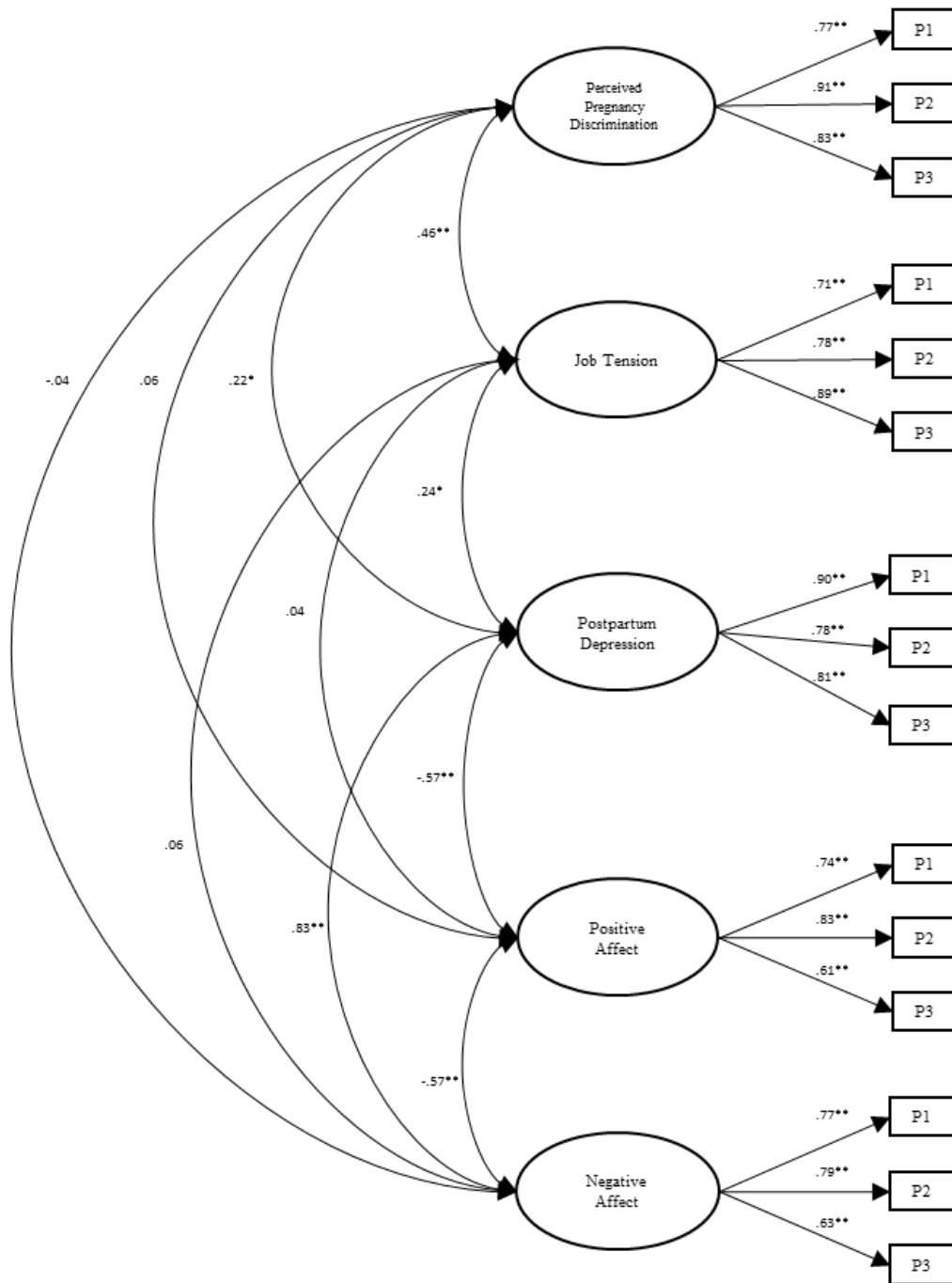**Interactive Effects of Resiliency and Job Tension on Work-Family Conflict**

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FIGURE 6

Post Hoc Analysis: CFA with Standardized Results

Notes: Standardized solution, *N* = 121; Parcels are denoted by the letter P; *p<.05; **p<.01; χ^2 [80] = 148.24; RMSEA = .08; CFI = .93; TLI = .90; SRMR = .06
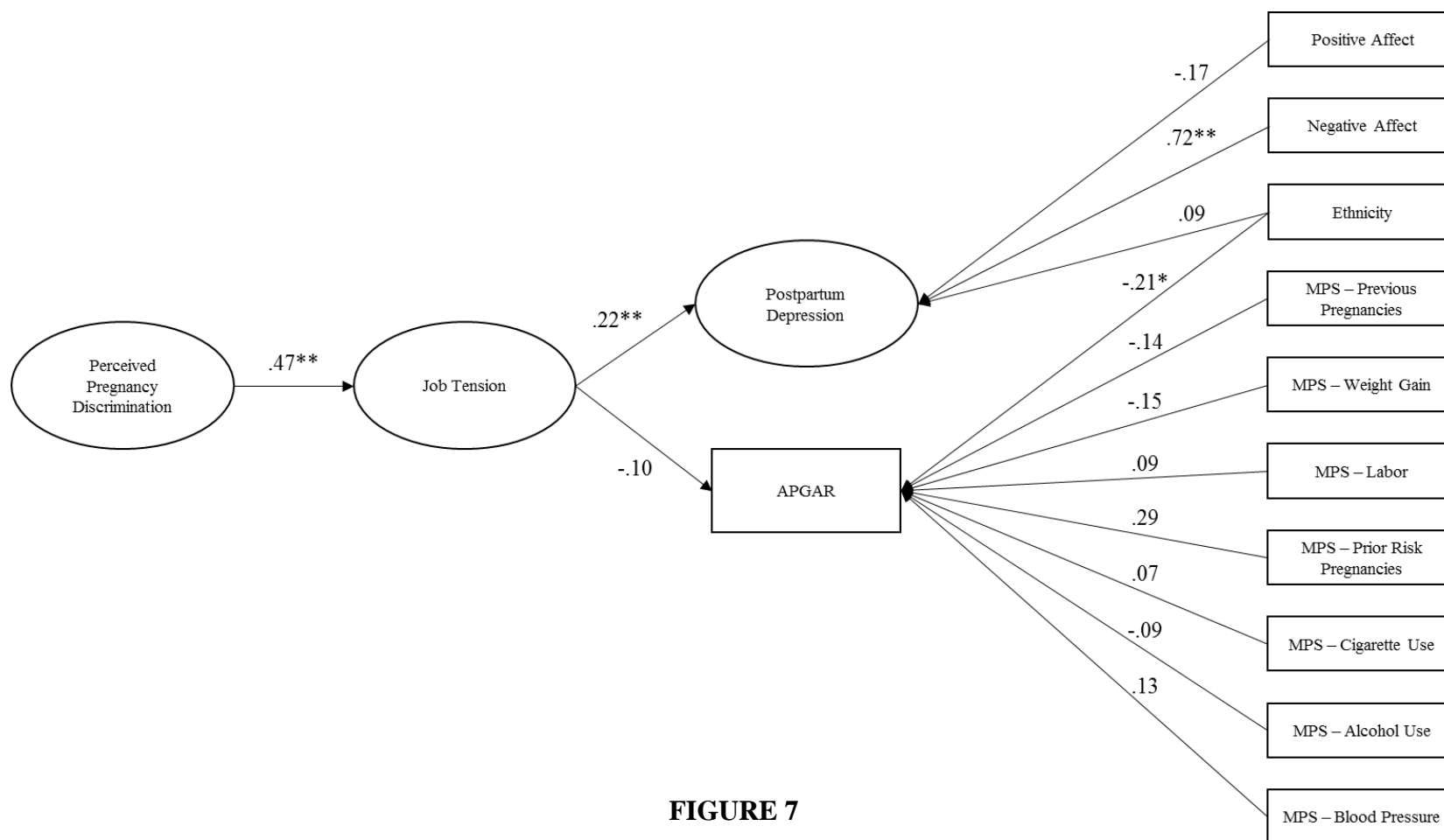
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FIGURE 7

Post Hoc Analysis: Structural Equation Model of Perceived Pregnancy Discrimination

Notes: Standardized solution, *N* = 116; *p<.05; **p<.01; χ^2 [215] = 355; RMSEA = .07; CFI = .87; TLI = .85; SRMR = .09

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APPENDIX A

SURVEY MEASURES – TIME 1

This research is a three-part study and you will be contacted two more times (i.e., in four weeks, and after your baby has been born) to fill out short follow-up surveys. Do you agree to participate in all three surveys?

Please provide your email address: _____

How many weeks pregnant are you? _____

What is your current role?

      a. Stay at home mom
      b. Student
      c. Work from inside the home
      d. Work outside the home

On average, how many hours do you work per week? _____

Please indicate the extent to which you agree or disagree with each of the following statements.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	**2**	**3**	**4**	**5**

Perceived Discrimination (James et al., 1994)

I am sometimes unfairly singled out because of my pregnant status.	**1 2 3 4 5**
Prejudice toward pregnant workers exists where I work.	**1 2 3 4 5**
At work I feel socially isolated because of my pregnant status.	**1 2 3 4 5**
At work pregnant employees receive fewer opportunities.	**1 2 3 4 5**
There is no pregnancy discrimination on my present job.	**1 2 3 4 5**
At work people are intolerant of those who are pregnant.	**1 2 3 4 5**
Supervisors scrutinize the work of pregnant employees more than that of members of non-pregnant employees.	**1 2 3 4 5**
At work I am treated poorly because of my pregnant status.	**1 2 3 4 5**
Where I work promotions and rewards are influenced by pregnant status.	**1 2 3 4 5**

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Pregnancy Disclosure (Little et al., 2015)

I tried to hide my physical signs of pregnancy.	**1 2 3 4 5**
I tried to hide my physical symptoms of pregnancy (i.e., morning sickness, increased bathroom visits, etc.).	**1 2 3 4 5**
I avoid meeting with people in person to hide my pregnancy.	**1 2 3 4 5**
I hid my belly.	**1 2 3 4 5**
I downplay my pregnancy at work.	**1 2 3 4 5**
I only talk about my pregnancy when asked by someone else.	**1 2 3 4 5**
My coworkers know I am pregnant but I discourage talk about my pregnancy at work.	**1 2 3 4 5**
I don't talk about my pregnancy or babies very much at work.	**1 2 3 4 5**

Identity-Role Conflict (Little et al., 2015)

I want others to know I am the same person.	**1 2 3 4 5**
I want others to know that who I am at work is the same as before the pregnancy.	**1 2 3 4 5**
I want others to know that I am as capable as before I was pregnant.	**1 2 3 4 5**
I want to be seen as a professional	**1 2 3 4 5**
I don't want coworkers to think of me as unprofessional because of my pregnancy.	**1 2 3 4 5**
I want people to take me seriously as a professional.	**1 2 3 4 5**
I worry I might be fired, demoted or passed up for a promotion due to my pregnancy.	**1 2 3 4 5**
I worry about the negative career consequences as a result of my pregnancy.	**1 2 3 4 5**
I worry about losing the income and benefits associated with my job.	**1 2 3 4 5**
I worry that coworkers might think I plan to quit.	**1 2 3 4 5**
I worry that coworkers think I would like to stay home with the baby after s/he was born.	**1 2 3 4 5**
I want others at work to know I am not going anywhere.	**1 2 3 4 5**

Never	Almost Never	Sometimes	Fairly Often	Very Often
1	**2**	**3**	**4**	**5**

How often have you been treated differently than other employees because of your pregnancy?
Please provide an example:

How often has your supervisor(s) made inappropriate comments about your pregnancy?
Please provide an example:

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How often have your coworkers made inappropriate comments about your pregnancy?
Please provide an example:

How often have you been denied special accommodations at work due to a pregnancy-related medical condition?
Please provide an example:

Please read each item and then mark the appropriate answer. Indicate to what extent you have felt this way during the past week.

Very Slightly or Not at All	A Little	Moderately	Quite a Bit	Extremely
1	**2**	**3**	**4**	**5**

Positive Affectivity (4 items; Watson, Clark, & Tellegen, 1988)

Inspired.	**1**	**2**	**3**	**4**	**5**
Excited.	**1**	**2**	**3**	**4**	**5**
Strong.	**1**	**2**	**3**	**4**	**5**
Active.	**1**	**2**	**3**	**4**	**5**

Negative Affectivity (4 items; Watson, Clark, & Tellegen, 1988)

Distressed.	**1**	**2**	**3**	**4**	**5**
Upset.	**1**	**2**	**3**	**4**	**5**
Afraid.	**1**	**2**	**3**	**4**	**5**
Jittery.	**1**	**2**	**3**	**4**	**5**

The remaining questions are <u>for statistical purposes only</u>. I assure you that you will not be identified using this data.

1. What is your age?

2. What is your relationship status:
   a. Single
   b. In a serious relationship
   c. Married
   d. Other (please specify): _____

3. How long have you been married/in a serious relationship?
   a. Years: _____
   b. Months:_____

4. Do you have children (other than the one you are expecting)?
   a. No
   b. Yes, one

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c. Yes, two
d. Yes, three
e. Yes, four or more

5. What is your ethnicity?
    a. White
    b. Black, African American
    c. Hispanic, Latino, or Spanish origin
    d. American Indian
    e. Asian
    f. Asian Indian
    g. Pacific Islander
    h. Middle Eastern
    i. Other (please specify): _____

6. What is the highest level of education you have attained?
    a. Did not complete high school
    b. High school diploma or equivalent
    c. Some college
    d. Associate's degree
    e. Bachelor's degree
    f. Master's degree
    g. Law degree, Medical degree, or Doctorate
    h. Other (please specify): _____

7. What is your household annual income?

8. When did you begin working for your current organization?
    a. Month:_____
    b. Year: _____

9. When did you begin working in your current position?
    a. Month: _____
    b. Year: _____

10. What is your approximate level in your organization?
    a. Top management
    b. Upper management
    c. Middle management
    d. Staff/Associate level
    e. Entry level
    f. Professional (accountant, lawyer, doctor, etc.)

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g. Other (please specify): _____

11. Does your organization offer paid maternity leave?

    a. If so, how many weeks?

    b. If not, how many weeks of unpaid leave does your organization provide?

12. When do you plan to take maternity leave?
    a. Month
    b. Day
    c. Year
    d. I do not plan to take maternity leave.

13. When do you plan to return from maternity leave?
    a. Month
    b. Day
    c. Year
    d. I do not plan to return to work after my baby is born.

14. How many weeks pregnant were you when you disclosed your pregnancy to your:
    a. Family
    b. Coworkers
    c. Supervisor

15. Please use the space below to add any additional information:

SURVEY MEASURES – TIME 2

Please indicate the extent to which you agree or disagree with each of the statements below.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	**2**	**3**	**4**	**5**

Job Tension (House & Rizzo, 1972)

My job tends to directly affect my health.	**1 2 3 4 5**
I work under a great deal of tension.	**1 2 3 4 5**
I have felt fidgety or nervous as a result of my job.	**1 2 3 4 5**
If I had a different job, my health would probably improve.	**1 2 3 4 5**
Problems associated with my job have kept me awake at night.	**1 2 3 4 5**
I have felt nervous before attending meetings in the company.	**1 2 3 4 5**
I often "take my job home with me" in the sense that I think about it when doing other things.	**1 2 3 4 5**

Resiliency (Smith et al., 2008)

I tend to bounce back quickly after hard times.	**1 2 3 4 5**
I have a hard time making it through stressful events.	**1 2 3 4 5**
It does not take me long to recover from a stressful event.	**1 2 3 4 5**
It is hard for me to snap back when something bad happens.	**1 2 3 4 5**
I usually come through difficult times with little trouble.	**1 2 3 4 5**
I tend to take a long time to get over set-backs in my life.	**1 2 3 4 5**

Using the scale provided, please indicate how much each of the following statements reflects how you typically are.

Not at all like me	A Little Bit Like Me	Moderately Like Me	Very Much Like Me	Exactly Like Me
1	**2**	**3**	**4**	**5**

Self-Regulation (Tangney, Baumeister, & Boone, 2004)

I am good at resisting temptation.	**1 2 3 4 5**
I have a hard time breaking bad habits.	**1 2 3 4 5**
I am lazy.	**1 2 3 4 5**
I say inappropriate things.	**1 2 3 4 5**
I do certain things that are bad for me, if they are fun.	**1 2 3 4 5**
I refuse things that are bad for me.	**1 2 3 4 5**
I wish I had more self-discipline.	**1 2 3 4 5**
People would say that I have iron self-discipline.	**1 2 3 4 5**
Pleasure and fun sometimes keep me from getting work done.	**1 2 3 4 5**

I have trouble concentrating.	**1 2 3 4 5**
I am able to work effectively toward long-term goals.	**1 2 3 4 5**
Sometimes I can't stop myself from doing something, even if I know it is wrong.	**1 2 3 4 5**
I often act without thinking through all the alternatives.	**1 2 3 4 5**

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate *how often* you felt or thought a certain way. Although some of the questions are similar, there are differences between them and you should treat each one as a separate question. The best approach is to answer each question fairly quickly. That is, don't try and count up the number of times you felt a particular way, but rather indicate the alternative that seems like a reasonable estimate.

For each question choose from the following alternatives:

Never	Almost Never	Sometimes	Fairly Often	Very Often
1	**2**	**3**	**4**	**5**

Perceived Stress Scale (Cohen et al., 1983)

In the last month, how often have you been upset because of something that happened unexpectedly?	**1 2 3 4 5**
In the last month, how often have you felt that you were unable to control the important things in life?	**1 2 3 4 5**
In the last month, how often have you felt nervous and "stressed"?	**1 2 3 4 5**
In the last month, how often have you dealt successfully with irritating life hassles?	**1 2 3 4 5**
In the last month, how often have you felt that you were effectively coping with important changes that were occurring in your life?	**1 2 3 4 5**
In the last month, how often have you felt confident about your ability to handle your personal problems?	**1 2 3 4 5**
In the last month, how often have you felt that things were going your way?	**1 2 3 4 5**
In the last month, how often have you found that you could not cope with all the things that you had to do?	**1 2 3 4 5**
In the last month, how often have you been able to control irritations in your life?	**1 2 3 4 5**
In the last month, how often have you felt that you were on top of things?	**1 2 3 4 5**
In the last month, how often have you been angered because of things that happened that were outside of your control?	**1 2 3 4 5**
In the last month, how often have you found yourself thinking about things that you have to accomplish?	**1 2 3 4 5**
In the last month, how often have you been able to control the way you spend your time?	**1 2 3 4 5**
In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	**1 2 3 4 5**

Please read each item and then mark the appropriate answer. Indicate to what extent you have felt this way during the past week.

Very Slightly or Not at All	A Little	Moderately	Quite a Bit	Extremely
1	**2**	**3**	**4**	**5**

Positive Affectivity (4 items; Watson, Clark, & Tellegen, 1988)

Inspired.	**1**	**2**	**3**	**4**	**5**
Excited.	**1**	**2**	**3**	**4**	**5**
Strong.	**1**	**2**	**3**	**4**	**5**
Active.	**1**	**2**	**3**	**4**	**5**

Negative Affectivity (4 items; Watson, Clark, & Tellegen, 1988)

Distressed.	**1**	**2**	**3**	**4**	**5**
Upset.	**1**	**2**	**3**	**4**	**5**
Afraid.	**1**	**2**	**3**	**4**	**5**
Jittery.	**1**	**2**	**3**	**4**	**5**

SURVEY MEASURES – TIME 3

When did you deliver your baby? (Month/Date/Year)

Please indicate the extent to which you agree or disagree with each of the following statements.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	**2**	**3**	**4**	**5**

Job Satisfaction (Brayfield & Roth, 1951)

In general, I like working here.	**1**	**2**	**3**	**4**	**5**
All in all, I am satisfied with my job.	**1**	**2**	**3**	**4**	**5**
In general, I don't like my job.	**1**	**2**	**3**	**4**	**5**

Turnover (Cammann et al., 1979)

How likely is it that you will actively look for a new job in the next year?	**1**	**2**	**3**	**4**	**5**
I often think about quitting.	**1**	**2**	**3**	**4**	**5**
I will probably look for a new job in the next year.	**1**	**2**	**3**	**4**	**5**

Satisfaction with Family Life (Zabriskie & Ward, 2013)

In most ways my family life is close to ideal.	**1**	**2**	**3**	**4**	**5**
The conditions of my family life are excellent.	**1**	**2**	**3**	**4**	**5**
I am satisfied with my family life.	**1**	**2**	**3**	**4**	**5**
So far I have gotten the important things I want in my family life.	**1**	**2**	**3**	**4**	**5**
If I could live my family life over, I would change almost nothing.	**1**	**2**	**3**	**4**	**5**

Post-Partum Depression (Cox et al., 1987)

I am able to laugh and see the funny side of things.	**1**	**2**	**3**	**4**	**5**
I look forward with enjoyment to things.	**1**	**2**	**3**	**4**	**5**
I blame myself unnecessarily when things go wrong.	**1**	**2**	**3**	**4**	**5**
I am anxious or worried for no good reason.	**1**	**2**	**3**	**4**	**5**
I feel scared or panicky for no very good reason.	**1**	**2**	**3**	**4**	**5**
Things are getting on top of me.	**1**	**2**	**3**	**4**	**5**
I am so unhappy that I have difficulty sleeping.	**1**	**2**	**3**	**4**	**5**
I feel sad or miserable.	**1**	**2**	**3**	**4**	**5**
I am so unhappy that I cry.	**1**	**2**	**3**	**4**	**5**
The thought of harming myself occurs to me.	**1**	**2**	**3**	**4**	**5**

Work-Family Conflict (Matthews et al., 2010)

I have to miss family activities due to the amount of time I must spend on work responsibilities.	**1**	**2**	**3**	**4**	**5**
I am often so emotionally drained when I get home from work that it prevents me from contributing to my family.	**1**	**2**	**3**	**4**	**5**
The behaviors I perform that make me effective at work do not help me to be a better parent and spouse.	**1**	**2**	**3**	**4**	**5**

Please read each item and then mark the appropriate answer. Indicate to what extent you have felt this way during the past week.

Very Slightly or Not at All	A Little	Moderately	Quite a Bit	Extremely
1	**2**	**3**	**4**	**5**

Positive Affectivity (4 items; Watson, Clark, & Tellegen, 1988)

Inspired.	**1**	**2**	**3**	**4**	**5**
Excited.	**1**	**2**	**3**	**4**	**5**
Strong.	**1**	**2**	**3**	**4**	**5**
Active.	**1**	**2**	**3**	**4**	**5**

Negative Affectivity (4 items; Watson, Clark, & Tellegen, 1988)

Distressed.	**1**	**2**	**3**	**4**	**5**
Upset.	**1**	**2**	**3**	**4**	**5**
Afraid.	**1**	**2**	**3**	**4**	**5**
Jittery.	**1**	**2**	**3**	**4**	**5**

The remaining questions are <u>for statistical purposes only</u>. We assure you that you will not be identified using this data.

1. How many weeks pregnant were you when you delivered your baby?

2. What was your baby's birthweight?
    a. Pounds: _____
    b. Ounces: _____

3. What is your baby's gender?

4. What was your baby's APGAR score?

5. How many times have you taken your baby to the doctor?

6. Have you returned to your previous job?

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a. If not, why?

7. Do you plan to return to your previous job?

8. Reflecting back on your experience at work during pregnancy, what do you feel you have learned?

9. Reflecting back on your experience at work during pregnancy, what do you feel you have learned regarding coping with work stressors?

Maternal Subscale of MPS (Dean & Gray, 1985; Trammell, 2012)
1. How many previous pregnancies have you had?
    a. None
    b. One
    c. Two
    d. Three or more

2. Did you experience any vaginal bleeding during this pregnancy?
    a. None
    b. Some near the end of pregnancy
    c. Some at the beginning of pregnancy
    d. A good deal throughout

3. How much weight did you gain during this pregnancy?
    a. Less than 10 lbs
    b. 11-15 lbs
    c. 16-25 lbs
    d. 26-35 lbs
    e. 36-45 lbs
    f. In excess of 46 lbs

4. What is your age?
    a. Under 15 years
    b. 15-19 years
    c. 20-29 years
    d. 30-34 years
    e. 35-39 years
    f. Over 40 years

5. When did you obtain prenatal care?
    a. 1-3 months after conception

b. 4-6 months after conception
c. 7-8 months after conception
d. After the 8th month

6. Is this a multiple pregnancy?
    a. Yes, twins
    b. Yes, triplets
    c. No

7. How much time was there between your water breaking and labor?
    a. Medication needed to induce labor
    b. Contractions began prior to or at the time
    c. Began naturally (less than 2 hours)
    d. Began naturally (greater than 2 hours)
    e. Not sure

8. How many prior risk pregnancies have you had?
    a. None
    b. One – Full term stillbirth/neonatal death
    c. One or more resulting in normal birth
    d. One – Spontaneous abortion (miscarriage)

9. What was your cigarette use during pregnancy?
    a. None
    b. 1-10 cigarettes
    c. 11-20 cigarettes
    d. 21-30 cigarettes
    e. More than 30 cigarettes

10. How much alcohol did you consume per day during your pregnancy?
    a. None
    b. 1-2 drinks per day
    c. 3-4 drinks per day
    d. More than 5 drinks per day
    e. Other: _____

11. How was your blood pressure during pregnancy?
    a. Blood pressure was normal
    b. Blood pressure was high at end
    c. Had high blood pressure, weight gain, and swelling
    d. Was told I had preeclampsia, hospitalized

APPENDIX C

HUMAN SUBJECTS APPROVAL FORMS

Pilot Study

Florida State
U N I V E R S I T Y

Office of the Vice President for Research
Human Subjects Committee
Tallahassee, Florida 32306-2742
(850) 644-8673 · FAX (850) 644-4392

APPROVAL MEMORANDUM

Date: 03/11/2014

To: Cham McAllister

Address:

Dept.:   COLLEGE OF BUSINESS

From: Thomas L. Jacobson, Chair

Re: Use of Human Subjects in Research
     Organizational Behavior in the Workplace

The application that you submitted to this office in regard to the use of human subjects in the proposal referenced above have been reviewed by the Secretary, the Chair, and two members of the Human Subjects Committee. Your project is determined to be Expedited per 45 CFR § 46.110(7)   and has been approved by an expedited review process.

The Human Subjects Committee has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval does not replace any departmental or other approvals, which may be required.

If you submitted a proposed consent form with your application, the approved stamped consent form is attached to this approval notice. Only the stamped version of the consent form may be used in recruiting research subjects.

If the project has not been completed by 03/10/2015   you must request a renewal of approval for continuation of the project. As a courtesy, a renewal notice will be sent to you prior to your expiration date; however, it is your responsibility as the Principal Investigator to timely request renewal of your approval from the Committee.

You are advised that any change in protocol for this project must be reviewed and approved by the Committee prior to implementation of the proposed change in the protocol. A protocol change/amendment form is required to be submitted for approval by the Committee. In addition, federal regulations require that the Principal Investigator promptly report, in writing any unanticipated problems or adverse events involving risks to research subjects or others.

By copy of this memorandum, the chairman of your department and/or your major professor is reminded that he/she is responsible for being informed concerning research projects involving human subjects in the department, and should review protocols as often as needed to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

This institution has an Assurance on file with the Office for Human Research Protection. The Assurance Number is IRB00000446.

Cc: Wayne Hochwarter   Advisor
HSC No. 2014.12124

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Pilot Study Application

Human Subjects Application For Full IRB and Expedited Exempt Review

1. Project Title and Identification

1.1 Project Title

Organizational Behavior in the Workplace

Project is: Data Collection for Research

1.2 Principal Investigator (PI)

Name(Last name, First name MI): McAllister, Charn Patrick	Highest Earned Degree: Doctorate
Mailing Address:	Phone Number:
	Fax:
University Department: COLLEGE OF BUSINESS	Email:
The training and education completed in the protection of human subjects or human subjects records: CITI	Occupational Position: Student

1.3 Co-Investigators/Research Staff

Name(Last name, First name MI): Hackney, Kaylee ; Co-Investigator	Highest Earned Degree: Master's Degree
Mailing Address:	Phone Number:
	Fax:
University Department: COLLEGE OF BUSINESS	Email:
The training and education completed in the protection of human subjects or human subjects records: CITI	Occupational Position: Student

1.4 Faculty Advisor/Department Chair/Dean Information

Name(Last name, First name MI): Hochwarter, Wayne ; Advisor	Highest Earned Degree:
Mailing Address:	Phone Number:
	Fax:
University Department: COLLEGE OF BUSINESS	Email:
The training and education completed in the protection of human subjects or human subjects records:	Occupational Position:

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Main Study

Florida State
U N I V E R S I T Y

Office of the Vice President For Research
Human Subjects Committee
P. O. Box 3062742
Tallahassee, Florida 32306-2742
(850) 644-8673 · FAX (850) 644-4392

RE-APPROVAL MEMORANDUM

Date: 01/15/2016

To: Kaylee Hackney

Address:

Dept.:   COLLEGE OF BUSINESS

From: Thomas L. Jacobson, Chair

Re: Re-approval of Use of Human subjects in Research:
     Stress during Pregnancy: Health Outcomes of Mothers and Babies

Your request to continue the research project listed above involving human subjects has been approved
by the Human Subjects Committee. If your project has not been completed by 01/11/2017   , you are
must request renewed approval by the Committee.

If you submitted a proposed consent form with your renewal request, the approved stamped consent
form is attached to this re-approval notice. Only the stamped version of the consent form may be used
in recruiting of research subjects. You are reminded that any change in protocol for this project must
be reviewed and approved by the Committee prior to implementation of the proposed change in the
protocol. A protocol change/amendment form is required to be submitted for approval by the
Committee. In addition, federal regulations require that the Principal Investigator promptly report in
writing, any unanticipated problems or adverse events involving risks to research subjects or others.

By copy of this memorandum, the Chairman of your department and/or your major professor are
reminded of their responsibility for being informed concerning research projects involving human
subjects in their department. They are advised to review the protocols as often as necessary to insure
that the project is being conducted in compliance with our institution and with DHHS regulations.

Cc:
HSC No. 2015.17193

Informed Consent Form

Dear Participant,

I am a graduate student under the direction of Dr. Pamela Perrewé in the College of Business at Florida State University. I am conducting a research study to examine stress during pregnancy and its impact on the health of the mother and her baby.

Your participation will involve completing an electronic survey that will likely take approximately 15 minutes to complete. The survey consists of questions about your experiences during pregnancy. Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty. Furthermore, if you choose to withdraw from the study at any time, any data collected from you will not be used. The results of the research study may be published, but your name or any other identifying information will not be used. Participation in this study will be completely confidential to the extent allowed by law.

Are there are foreseeable risks or discomforts to me if I agree to participate in the study? The possible risks are minor psychological discomfort due to the fact that certain survey questions may elicit negative emotions. If at any time during the survey you feel uncomfortable and need to talk to someone, you are encouraged to call the national suicide prevention lifeline at 1-800-273-TALK.

The possible benefit of your participation is supporting research examining how stressors, experienced stress, and support systems impact the health of mothers and babies. If desired, a summary of the results of the study will be provided to you. Additionally, upon completion, you will have the opportunity to be entered in a raffle for a gift card to Babies R Us.

If you have any questions concerning the research study, please feel free to contact me at XXX or my research advisor, Dr. Pamela Perrewé, at XXX. You may also contact the Human Subjects Committee at The Florida State University at (850) 644-8673 if you have additional concerns about this study.

Sincerely,

Kaylee Hackney, Ph.D. Candidate
Department of Management, FSU College of Business

I give my consent to participate in the above study. By checking 'yes' below, you indicate that you understand the information above and agree to participate in the study which includes completing the survey.

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APPENDIX D

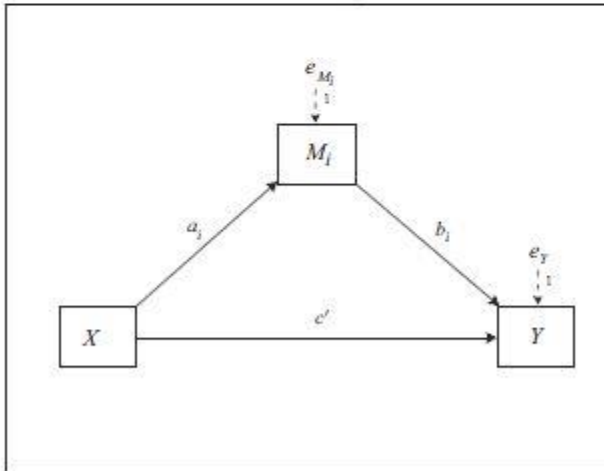# PROCESS MODEL TEMPLATE

Model 1

Conceptual Diagram
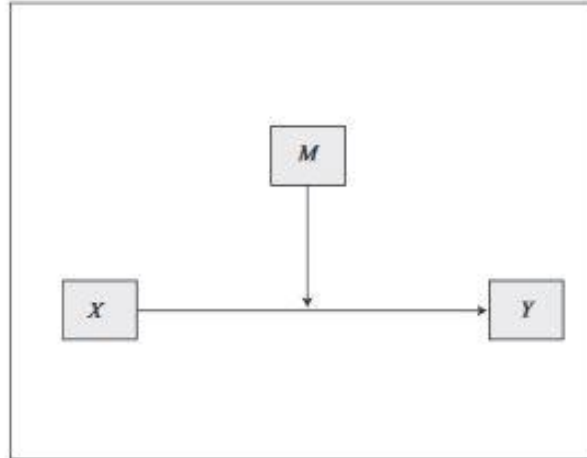
Statistical Diagram
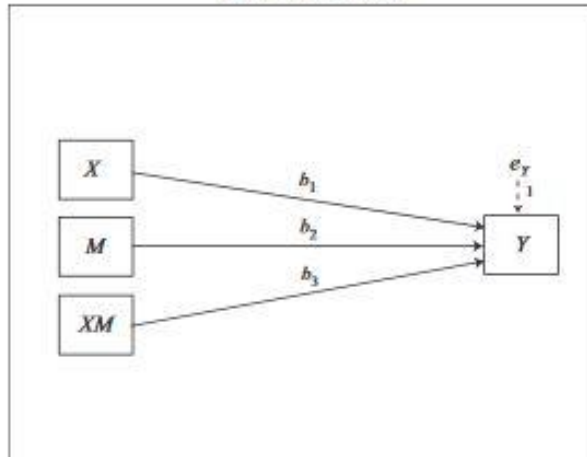
Conditional effect of X on $Y - b_1 + b_3 M$

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Model 4

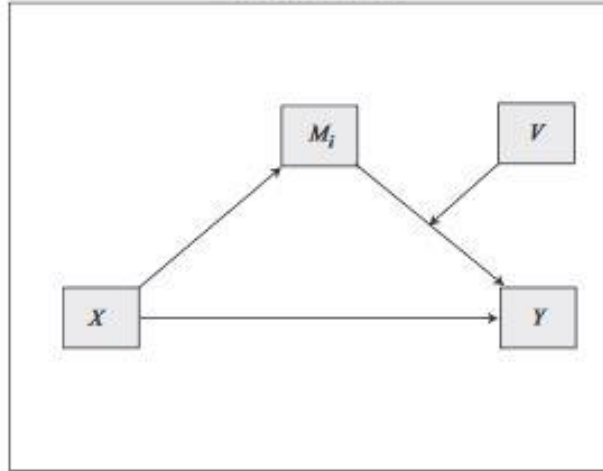### Conceptual Diagram
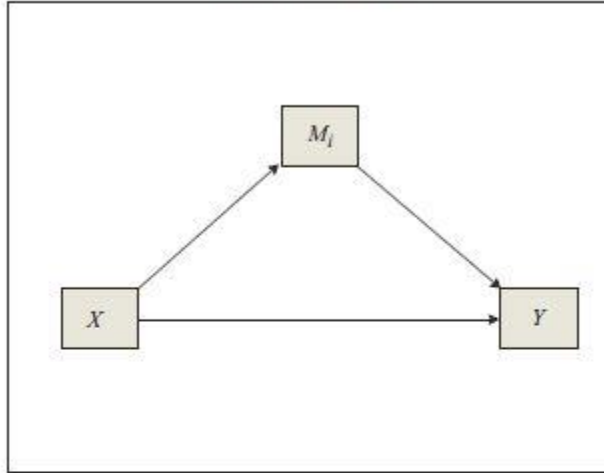
Statistical Diagram

Indirect effect of X on Y through $M_i = a_i b_i$
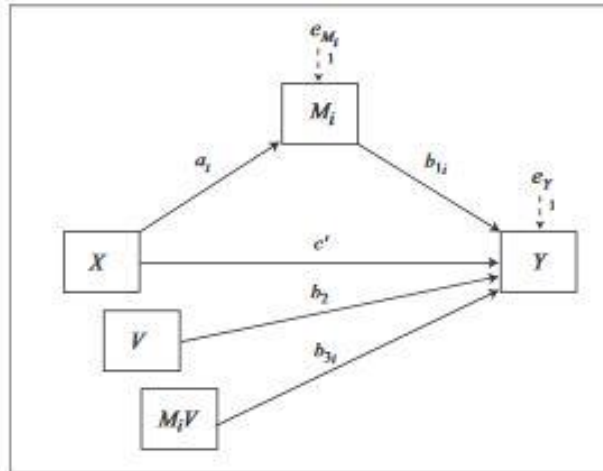
Direct effect of X on $Y = c'$

Note: Model 4 allows up to 10 mediators operating in parallel.

Model 14

Conceptual Diagram

Statistical Diagram

Conditional indirect effect of X on Y through $M_i = a_i(b_{1i} + b_{3i}V)$
Direct effect of X on $Y = c'$

Note: Model 14 allows up to 10 mediators operating in parallel.

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BIOGRAPHICAL SKETCH

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