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Negotiating Work–Family Balance among Intensive Care Unit Nurses from the Managerial Perspective of Head Nurses: A Qualitative Descriptive Study

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ABSTRACT

Background: Intensive care unit (ICU) nurses experience persistent work–family tensions due to high-acuity care demands, rigid shift systems, and emotional labor, particularly among nurses who are also mothers. While organizational support has been widely examined, limited attention has been given to how work–family balance is negotiated and enacted within everyday managerial practice at the unit level. This study aimed to explore how ICU head nurses conceptualize, interpret, and exercise managerial discretion in supporting work–family balance within structural and institutional constraints. **Methods:** A qualitative descriptive study design was used. Seven ICU head nurses (N = 7) from seven hospitals in Borneo, Indonesia, were purposively recruited based on their managerial responsibilities. Data was collected through in-depth semi-structured interviews and analyzed using reflexive thematic analysis. **Results:** Three interconnected themes emerged: (1) Framing work–family balance as a contextual managerial dilemma characterized by structural and emotional complexity, differentiated needs, and tensions between professional accountability and flexibility; (2) Experiencing competing role demands under structural constraints, including scheduling rigidity, persistent maternal guilt, and the need to sustain professional vigilance amid personal distress; and (3) Enacting managerial negotiation within organizational constraints through conditional schedule adaptations, relational leadership, and structured shift-swapping mechanisms. **Conclusion:** Work–family balance in ICU settings is not achieved solely through formal policies but through ongoing managerial negotiation embedded in everyday practice. These findings highlight the pivotal role of head nurses as mediators of job demands and caregiving responsibilities and underscore the need for institutional structures that legitimize sustainable managerial discretion.

Keywords: ICU Nurses; Managerial Perspective; Nurse–Mothers; Work–Family Balance

INTRODUCTION

Intensive care units (ICUs) are high-acuity clinical environments characterized by complex, time-critical care demands, rotating shift systems, and sustained emotional labor (Chen *et al*., 2023). These structural conditions expose nurses to elevated risks of stress and burnout, particularly for those who are also mothers and must simultaneously manage caregiving responsibilities at home (Devakani *et al*., 2025; Matlakala, 2023). Empirical evidence indicates that nurse–mothers experience heightened emotional strain, guilt, and persistent work–family imbalance due to rigid schedules and high cognitive and emotional demands (Ghahramani *et al*., 2025; Ong *et al*., 2023; Wu *et al*., 2022).

Within Asian cultural contexts, including Indonesia, gendered expectations further intensify these

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pressures, as women are often expected to remain primary caregivers regardless of professional demands (Derianty, 2024; Hwang & Yu, 2021). Consequently, work–family imbalance in ICU settings cannot be fully understood merely as an individual coping failure, but should be conceptualized as a structurally and culturally mediated phenomenon (Yoo & Shim, 2022).

Drawing on the Role Strain Theory (Goode, 1960), work–family imbalance emerges when simultaneous role expectations exceed available personal and organizational resources. In ICU settings, nurse–mothers face compounded strain because professional vigilance and emotional regulation requirements coexist with caregiving responsibilities at home. This tension has been linked to burnout, reduced job satisfaction, and compromised care quality (Hanoum *et al*., 2024; Wu *et al*., 2024).

Organizational responses such as flexible scheduling, supportive leadership, and family-friendly policies are associated with improved well-being and commitment among nurses (Larsman *et al*., 2024; Pahlevan *et al*., 2018). However, existing studies often treat organizational support as a stable resource without examining how it is enacted, negotiated, or constrained in everyday clinical practice. This leaves a gap in understanding the micro-level managerial processes through which work–family balance is practically supported in high-acuity settings.

Head nurses play a pivotal role in translating institutional policies into operational decisions related to staffing, scheduling, and emotional support. Although previous studies acknowledge their importance in mitigating work–family conflict (Baljani *et al*., 2023; Kennedy & Eldredge, 2021), managerial support is frequently treated as uniformly available rather than as a discretionary and context-dependent practice. Little is known about how head nurses interpret work–family balance, exercise discretion, or manage competing demands under structural constraints such as staff shortages, regulatory requirements, and patient safety imperatives.

Drawing on the Job Demands–Resources (JD-R) model (Demerouti *et al*., 2001) and Organizational Support Theory (Eisenberger *et al*., 1986), this study conceptualizes work–family balance as a negotiated managerial process rather than a fixed individual outcome. Positioned at the intersection of job demands and available resources, head nurses must continuously reconcile organizational efficiency with staff well-being through discretionary decisions related to staffing, scheduling, and emotional support. While prior research has predominantly examined work–family balance from the perspective of frontline nurses or policy-level support structures, limited attention has been given to how managerial discretion is enacted in daily ICU practice—particularly in low- and middle-income country contexts where structural constraints may intensify negotiation processes. Therefore, this study aimed to explore the perspectives of ICU head nurses on work–family balance among ICU nurses, with particular attention to nurses who are also mothers. Specifically, it was examined how head nurses interpret work–family balance, negotiate competing demands, and implement contextually adaptive strategies within structural constraints. By foregrounding managerial negotiation at the unit level, this qualitative descriptive study contributes to a process-oriented and context-sensitive understanding of how work–family balance is operationalized in high-acuity clinical environments, offering insights for leadership development and organizational policy refinement.

METHODOLOGY

Study Design

This study used a qualitative descriptive design to explore how ICU head nurses understood, interpreted, and managed work–family balance among ICU nurses, particularly among those with caregiving responsibilities as mothers. Qualitative descriptive methodology is appropriate when the aim is to provide a comprehensive summary of events in everyday terms and to generate practice-oriented insights grounded in participants' experiences (Sandelowski, 2000; Kim *et al*., 2017). This design was selected to generate a contextualized and practice-oriented understanding of managerial experiences in ICU settings.

Setting and Participants

This study was conducted in seven intensive care units (ICUs) across seven hospitals in Borneo, Indonesia, comprising five public secondary referral hospitals and two private tertiary hospitals providing adult critical care services. Purposive sampling was used to recruit ICU head nurses who held formal managerial responsibilities for staff scheduling, workload distribution, and staff welfare.

Inclusion criteria were as follows: (1) At least two years of prior ICU clinical experience; (2) Having held a formal ICU head nurse (or equivalent) managerial position for a minimum of six months; (3) Direct responsibility for staff scheduling and supervision; and (4) Willingness to participate. Nursing managers without ICU managerial responsibilities were excluded.

Seven ICU head nurses participated (N=7) Participants ranged in age from 31 to 48 years (mean age 38.7 years) and had between 3 and 13 years of ICU work experience. Sample size was determined through data saturation, which was defined as the point at which additional interviews no longer produced new insights into managerial challenges, practices, or interpretations of work–family balance (Van Rijnsoever, 2017). Saturation was assessed through an ongoing comparison of interview transcripts and analytical memos.

Researcher Characteristics and Reflexivity

This study was conducted by a multidisciplinary study team comprising doctoral students in psychology, faculty members in psychology, and faculty members in nursing, enabling analytical sensitivity to both psychological processes and nursing management realities. To enhance reflexivity, the first author maintained a reflexive journal throughout data collection and analysis to document assumptions, emotional responses, and interpretive decisions. Regular team discussions were held to reflect on the researcher's positionality and minimize potential interpretive bias.

Data Collection

Data were collected using semi-structured, in-depth interviews to explore ICU head nurses' managerial experiences and perspectives regarding work–family balance among ICU nurses, particularly those with caregiving responsibilities as mothers. An interview guide was developed by the first author based on a review of relevant literature on work–family balance, nursing leadership, managerial support, and study objectives.

The final interview guide consisted of three main open-ended questions that served as thematic anchors rather than fixed scripts (Table 1). These guiding questions were designed to initiate reflection and narration while allowing flexibility for the interviewer to explore the participants' experiences in depth.

Table 1: Semi-structured Interview Guide

No	Main questions
1.	How do you understand the concept of work–family balance among ICU nurses?
2.	Based on your experience as a head nurse, what challenges do ICU nurses—particularly those who are mothers —face in balancing work and family responsibilities?
3.	What strategies or managerial approaches do you apply to support ICU nurses in managing work–family balance? *Probing:* Can you give an example?

Individual face-to-face interviews were conducted at times convenient for participants and lasted approximately 45–50 min., which is considered adequate for in-depth qualitative exploration without causing participant fatigue (McGrath *et al*., 2019). All the interviews were audio-recorded with consent and transcribed verbatim for analysis.

Data Analysis

Data were analyzed using thematic analysis following Braun and Clarke's (2006, 2021) six-phase approach.

All transcripts were read repeatedly for familiarization, followed by inductive coding that captured both experiential content and managerial meaning-making, including how head nurses balanced flexibility, fairness, and staffing constraints. Codes were compared across cases and clustered using constant comparison to support analytic abstraction beyond descriptive categorization.

Themes were developed iteratively through study team discussions, emphasizing analytic interpretation rather than topical grouping. To enhance rigor, two co-researchers reviewed the coded extracts and emerging themes, with differences resolved through reflexive dialogue. An audit trail consisting of coding memos, theme maps, and reflective journals was maintained to ensure transparency and confirmability. The final themes were reviewed against the full dataset to ensure coherence and analytical depth. The analytical process is illustrated in Figure 1.

Figure 1: Thematic Analysis Process

Credibility

Credibility was ensured using four criteria proposed by Lincoln and Guba (1985). It was enhanced through research triangulation and analytical discussions across the disciplines (psychology and nursing). Transferability was supported by detailed description of the ICU context and participant characteristics. Dependability was ensured through iterative code reviews, memos, and team discussions across the analytic stages. Confirmability was strengthened by maintaining a transparent audit trail, ensuring that interpretations were grounded in participants' accounts rather than in the researcher's assumptions.

Adherence to Standards for Reporting Qualitative Research (SRQR) Guidelines

This research report was prepared in accordance with the SRQR developed by O'Brien *et al*. (2014) to ensure transparency, consistency, and integrity in reporting the qualitative research findings.

Ethical Consideration

Ethical approval was obtained from the Research Ethics Commission of Universitas Tanjungpura, Indonesia with reference number 2968/UN22.9/PT.01.04/2025 on 9th April, 2025. All the participants provided written informed consent and were assured of confidentiality and the right to withdraw.

RESULTS

Seven ICU head nurses participated in this study and provided in-depth accounts of how work–family balance is interpreted and operationalized in high-acuity ICU settings. Participants were aged between 31 and 48 years and had between 3 and 13 years of ICU work experience (Table 2).

Table 2: Participant Characteristics

Participant code	Age (years)	Gender	Work experience in ICU (years)
P1	35	Female	3
P2	31	Female	5
P3	34	Female	6
P4	42	Female	10
P5	37	Female	13
P6	44	Male	6
P7	48	Male	11

Reflexive thematic analysis generated three interconnected themes illustrating how work–family balance in ICU settings is framed, experienced, and enacted through managerial negotiation. These themes were: 1) Framing work–family balance as a contextual managerial dilemma, 2) Experiencing competing role demands

within structural constraints and 3) Enacting managerial negotiation within organizational constraints. Together, these themes indicate that work–family balance is not treated as a fixed policy outcome but as an ongoing process of discretionary judgment, relational leadership, and structural mediation at the unit level.

Table 3: Main Themes and Subthemes Identified from Thematic Analysis

Theme	Subtheme
Framing Work–Family Balance as a Contextual Managerial Dilemma	Structural and Emotional Complexity of ICU Work
	Differentiated Needs and Fairness Tensions
	Balancing Professional Accountability and Flexibility
Experiencing Competing Role Demands under Structural Constraints	Scheduling Rigidity and Caregiving Disruptions
	Persistent Maternal Guilt and Emotional Strain
	Sustaining Professional Vigilance amid Personal Distress
Enacting Managerial Negotiation within Organizational Constraints	Conditional Schedule Adaptations
	Relational Leadership and Emotional Containment
	Shift-Swapping as Structured Flexibility

Theme 1: Framing Work–Family Balance as a Contextual Managerial Dilemma

ICU head nurses framed work–family balance as a contextual managerial dilemma shaped by structural demands, differentiated staff needs, and professional accountability. Rather than presenting work–family balance as solely an individual matter, participants positioned it as embedded in the realities of ICU work and the relational dynamics within their teams.

Subtheme 1: Structural and Emotional Complexity of ICU Work

Head nurses described work–family balance as particularly difficult in ICU settings due to the intensity and unpredictability of critical care. Shift systems require sustained physical stamina, emotional regulation, and cognitive focus, which often extend beyond scheduled hours and interfere with family routines. One participant explained:

"Balancing work and family is not easy, especially for ICU nurses who have families. They need to be good at managing their time, but sometimes work is more demanding." (P2)

This suggests that work–family imbalance is perceived as emerging from structural work demands rather than from personal shortcomings. Another head nurse noted:

"Some nurses can manage the balance well, but some have difficulties because work demands in the ICU are very high." (P4)

Although differences in coping capacity were acknowledged, the challenge was consistently anchored in ICU workload intensity, framing balance as context-dependent.

Several head nurses also recognized the hidden labor carried by nurse–mothers after work hours:

"We see how some nurses are really trying hard, going home tired and still continuing their roles as mothers—this shows how complex it really is." (P5)

This reflects awareness of cumulative emotional and caregiving responsibilities extending beyond the hospital.

Subtheme 2: Differentiated Needs and Fairness Tensions

Head nurses differentiated between single and married nurses when allocating shifts and workloads. Single nurses were often perceived as more flexible in taking night shifts and overtime, whereas married nurses requested greater predictability due to caregiving responsibilities. As one participant stated:

"For single nurses, they are more flexible about night shifts or overtime. Married nurses, on the other hand, often ask for a more regular schedule." (P1)

This differentiation indicates that flexibility is negotiated in relation to perceived family roles.

However, such accommodations raised concerns about fairness and unit cohesion. One head nurse explained:

"Married nurses often face different challenges than single nurses. Nurses with family responsibilities may feel more stressed and less focused when their child is sick, which can affect their performance at work." (P2)

Another participant emphasized equity in workload distribution:

"I often get requests from nurses who have families not to have night shifts too often, but we have to be fair to all staff." (P3)

This accounts illustrates how managerial decisions involve balancing differentiated needs with distributive fairness within the unit.

Subtheme 3: Balancing Professional Accountability and Flexibility

Participants described a recurring tension between maintaining professional standards and providing flexibility to nurse–mothers. Flexibility was viewed as important for well-being; however, excessive accommodation was perceived as potentially compromising service quality. As one head nurse noted:

"We have to maintain a balance between the hospital's interests and nurses' welfare. If we are too lax, services can be disrupted, but nurses can be stressed if we are too strict." (P6)

Another participant added:

"Ideally, all nurses would work the same schedule without exception, but we understand that working mothers need flexibility so that they are not overburdened." (P7)

Uniformity was presented as the professional ideal, yet moderated by contextual compassion.

Similarly, limits to flexibility were framed in relation to patient safety:

"We offer tolerance for nurses who are mothers who need occasional leave, but there are still limits because ICU work cannot be left unattended." (P5)

This indicates that flexibility is conditional and bounded by clinical responsibility.

Theme 2: Experiencing Competing Role Demands under Structural Constraints

Head nurses described nurse–mothers as experiencing competing role demands that extend beyond time pressure. The challenges they observed reflected tensions between rigid ICU systems and unpredictable caregiving responsibilities, often creating emotional strain and professional dilemmas that affected daily clinical functioning.

Subtheme 1: Scheduling Rigidity and Caregiving Disruptions

Scheduling conflicts emerged as the most immediate and visible manifestation of competing demands. Head nurses reported that rigid shift rosters frequently clashed with sudden family needs, particularly when children became ill. One participant stated:

"Sometimes there are nurses who suddenly ask for permission because their children are sick. We try to be flexible, but we still have to find a replacement." (P3)

Repeated requests for time off were perceived as creating additional strain within the team:

"Nurses who are also mothers need to manage their schedules because the demands of working in the ICU are no less important. If they ask for leave too often, it affects the rest of the team." (P6)

These accounts indicate that scheduling conflicts reflect structural tensions embedded in ICU work organization rather than merely personal time-management difficulties.

Subtheme 2: Persistent Maternal Guilt and Emotional Strain

Head nurses observed that nurse–mothers frequently experienced guilt, particularly when leaving young or ill children at home. This emotional burden was described as ongoing and sometimes carried into the workplace. One participant explained:

"There are nurses who often tell me that they feel guilty about leaving their children at home, especially when their children are still babies." (P1)

Others noted that guilt intensified when children were ill:

"They also often feel guilty when they cannot be with their children, especially when their children are sick; this certainly adds to their thoughts." (P3)

In several cases, visible emotional distress was reported:

"I once saw a nurse crying because she felt the dilemma between her responsibilities as a mother and also as a nurse." (P6)

These narratives suggest that maternal guilt functions as a persistent emotional load shaping nurses' readiness at work.

Subtheme 3: Sustaining Professional Vigilance amid Personal Distress

Another challenge described by head nurses was the expectation that nurse–mothers maintain professional focus despite unresolved personal concerns. ICU work requires sustained attention and rapid clinical judgment, leaving limited cognitive space for emotional distraction. One head nurse explained:

"There are nurses who come here already tired or worried because of problems at home. However, they have to stay alert because any mistake can endanger the patient." (P2)

This highlights the high-stakes environment in which emotional fragmentation cannot easily be accommodated.

Some nurses reportedly concealed their emotional distress:

"Some nurses said they feel like they have to wear a mask—pretending to be okay so they can do their job properly." (P3)

"You can tell they are trying to focus, but their minds are still partly at home." (P5)

These accounts suggest that maintaining professional vigilance often involves emotional suppression, adding another layer of invisible labor to nurse–mothers' experiences.

Theme 3: Enacting Managerial Negotiation within Organizational Constraints

ICU head nurses described their role as central in mediating tensions between organizational demands and nurses' caregiving responsibilities. Rather than relying solely on formal policies, they enacted practical and relational strategies continuously negotiated within staffing limitations and patient safety requirements.

Subtheme 1: Conditional Schedule Adaptations

The most frequently reported strategy involved adjusting shift schedules to accommodate nurses with caregiving responsibilities. Head nurses described offering greater predictability and flexibility in allocation, particularly for mothers with young children, while maintaining ICU staffing needs.

"We try to provide flexibility in work schedules to avoid overburdening nurses who have families." (P4)

"Sometimes we adjust the shift cycle or offer morning shifts more frequently to mothers with young children." (P6)

However, flexibility was described as conditional rather than guaranteed. Participants noted that staff shortages and fluctuating patient acuity limited the extent of schedule adjustments. As a result, adaptations required case-by-case managerial judgment rather than automatic approval.

Subtheme 2: Relational Leadership and Emotional Containment

Beyond scheduling adjustments, head nurses emphasized emotional support as a key managerial practice. They described making themselves available for conversations, listening to concerns, and encouraging open communication.

"I always make myself available if any nurses want to talk or express their struggles in balancing work and family." (P2)

"We encourage open discussions so that nurses feel comfortable sharing their difficulties, and we can find solutions together." (P5)

These accounts suggest that emotional containment and relational accessibility function as informal buffering mechanisms in high-pressure environments.

"We strive to create a supportive work environment where nurses feel heard and encouraged in dealing with their challenges." (P6)

Such relational practices reflect efforts to mitigate emotional strain without compromising professional accountability.

Subtheme 3: Shift-Swapping as Structured Flexibility

Another frequently mentioned strategy was enabling shift-swapping among nurses to address urgent family needs without disrupting ICU operations.

"We allow nurses to swap shifts with their colleagues as long as ICU staffing needs are met." (P3)

Shift-swapping was particularly useful during sudden family emergencies.

"If someone needs urgent leave, they must find a replacement before requesting time off to ensure ICU services continue smoothly." (P5)

"To switch shifts due to family obligations, we try to accommodate it as long as patient care remains unaffected." (P6)

"We allow shift-swapping, but we must ensure that patient care remains unaffected." (P7)

Taken together, these strategies illustrate how managerial discretion functions as a situational resource, mediating competing demands within structurally constrained ICU systems.

DISCUSSION

This study extends existing work–family literature by conceptualizing work–family balance in ICU settings not as an individual outcome or policy-driven condition, but as a negotiated managerial process enacted through discretionary decision-making under structural constraints. Rather than locating imbalance solely within nurses' coping capacities, the findings highlight how balance is continuously mediated at the unit level by head nurses operating within high-acuity environments.

ICU head nurses occupy a pivotal position in translating institutional policies into everyday operational decisions. However, their capacity to provide flexibility is constrained by rigid scheduling systems, staffing shortages, and patient safety imperatives. Consistent with research showing that shift-based ICU environments intensify work–family conflict and emotional strain (Chen *et al*., 2023; Wu *et al*., 2024), the present findings suggest that such strain is structurally embedded rather than purely individual. What distinguishes this study is its emphasis on managerial discretion as a mediating mechanism within these constraints.

From the perspective of the Job Demands–Resources (JD-R) model (Bakker & Demerouti, 2017; Demerouti *et al*., 2001), ICU contexts are characterized by persistently high job demands that are not always matched by sufficient organizational resources. When formal structural support is limited, head nurses mobilize informal and relational resources—such as conditional schedule adaptations and emotional accessibility—to buffer competing demands. In this sense, managerial discretion functions as a situational resource rather than a stable institutional provision.

While prior studies have documented maternal guilt and emotional strain among nurse–mothers (Matheson *et al*., 2019; Öke Karakaya *et al*., 2021), the present findings illuminate how these emotional burdens are intertwined with rigid ICU systems that limit temporal flexibility. Interpreted through Role Strain Theory (Goode, 1960), competing role expectations exceed available structural resources, positioning head nurses as intermediaries who negotiate strain rather than eliminate it.

The adaptive strategies identified—shift-swapping, conditional scheduling, and relational leadership—align with literature emphasizing the importance of supportive nurse leadership in high-stress environments (Adams *et al*., 2019; Baljani *et al*., 2023). However, this study advances that literature by demonstrating that such strategies are contingent and bounded by patient safety requirements and staffing adequacy. Flexibility in ICU settings therefore emerges less from formalized family-friendly policies and more from localized negotiation embedded in everyday managerial practice.

Although organizational support has been shown to reduce work–family conflict (Xu & Zhao, 2024), the present findings suggest that perceived support is constructed through daily managerial enactment rather than policy availability alone. This interpretation extends Organizational Support Theory (Eisenberger *et al*., 1986) by foregrounding the micro-level processes through which support is made visible and meaningful in high-acuity clinical systems.

Beyond scheduling flexibility, this study highlights the limited availability of structured psychosocial support for ICU nurses. While informal emotional containment by head nurses may buffer acute distress, sustainable work–family balance requires alignment between managerial discretion and institutional infrastructure. Without structural reinforcement, discretionary flexibility remains fragile and dependent on individual leadership capacity.

Overall, the findings suggest that managerial discretion operates as a micro-level governance mechanism within structurally constrained ICU systems. By shifting attention from individual coping and formal policy to negotiated managerial practice, this study contributes a process-oriented and context-sensitive understanding of how work–family balance is operationalized in high-acuity healthcare environments

Limitations

This study has several limitations. The small, purposefully selected sample of seven ICU head nurses limits transferability and may underrepresent divergent or contested managerial practices. Participants' managerial perspective may also have shaped their narratives, introducing potential social desirability bias, with potential social desirability or acquiescence bias, leading to an emphasis on supportive actions over structural constraints. Additionally, the exclusive focus on head nurses' perspectives limits triangulation with frontline nurses' experiences, and the limited data collection period may not fully capture the evolving nature of work–family negotiations in ICU settings. Despite these limitations, analytical rigor was strengthened through

researcher triangulation, reflexive team discussions, and systematic thematic analysis, ensuring that interpretations remained grounded in the data.

CONCLUSION

This study demonstrates that work–family balance among ICU nurses with caregiving responsibilities is not a fixed organizational outcome but a negotiated managerial process enacted within structurally constrained clinical systems. Rather than being secured solely through formal policies, balance is continuously shaped through discretionary judgment, relational leadership, and situational decision-making at the unit level. By shifting the analytical focus from individual coping to managerial negotiation, this study advances a process-oriented and context-sensitive understanding of work–family balance in high-acuity healthcare environments. The findings suggest that managerial flexibility is contingent upon structural conditions, including staffing adequacy and institutional tolerance for discretion. Sustainable support for nurse–mothers therefore requires alignment between frontline managerial practices and broader organizational infrastructures. Future research should incorporate nurses' perspectives to triangulate managerial accounts, examine how negotiation dynamics evolve across different institutional contexts, and explore the long-term interaction between formal policies and everyday managerial discretion in sustaining workforce well-being and patient care quality.

Conflict of Interest

The authors declare that they have no competing interests.

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