FINAL THESIS

“We Are More Than Just Nurses”: Working Mothers in Nursing and the Effects of COVID-19.

by
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Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of Master of Art in Sociology

Middle Tennessee State University
May 2022

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ABSTRACT

The COVID-19 pandemic has spread across the world, resulting in various social, economic, and health outcomes. As infection rates increased and government shutdowns were implemented, there have been many changes in society, particularly for working mothers. Research shows socialized gendered roles tend to be reinstated during disasters and crises (Leigh 2020), and like a disaster or crisis, this pandemic is accompanied by vulnerability and uncertainty. My thesis looked at the added responsibilities and stress this pandemic has had on mothers working in healthcare through a gender lens. I investigate the added demands on these mothers in the home and at work, along with their mental health, burnout, and their overall sense of belonging which are reflected in my findings. My thesis centered on mothers' experiences during the global pandemic, specifically the many ways it has affected their personal and professional lives. My aim is to use this study to explore gender, family, and the workplace (specifically healthcare) amidst COVID-19.

Keywords: COVID-19, Healthcare, Gendered Organizations

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> It is like a hangover. It is like a nursing hangover. It is just constant exhaustion. Yea, I mean, no sleep is ever enough. Not that I couldn't have any anyways because I have four kids to take care of. No amount of coffee or just never enough time in the days to do everything. [ICU nurse and mother of two young children]

As a mother, I have had many sleepless nights, up with sick children at all hours, seemingly never getting a day of rest for myself. I am constantly juggling my schedule around my children, whether it be school or work. When I get off work, I come home to see what still needs to be done for the evening. There is laundry that has been sitting in my dryer for two days, a cold cup of coffee in my microwave that I forgot about, and my youngest child is exhausted and crying about how he doesn't want to get ready for school.

Working full-time as a healthcare professional has also had its ups and downs over the years. I have had to miss holidays because I was working long hours away from my family, and my days off would be spent trying to catch up on everything at home. This is what 'normal' looks like for me, as a mother.

COVID changed everything; shifting expectations and demands have resulted in a new normal. This new normal includes even more demands on me because I am a mother. There is always worry and fear for one's children, and, since this pandemic, COVID has put my fears on high alert. I constantly worry about their health, both physically and mentally. Between the school closures, the government shutdown, and working in healthcare, I feel exhausted.

> We have lost family members in the same family. We have lost a brother and a sister. A husband and a wife. The younger they are, the harder it is. It's been hard. There has been a lot of crying. [ICU nurse and mother of two]

The unknown was terrifying. The emotional turmoil that has come with the demands of being both a frontline worker and a mother has also been terrifying. Trying to keep up with the physical demands of working on the frontlines and expected to still come home to help their families is exhausting. Moreover, healthcare workers are experiencing PTSD and anxiety stemming from all the loss and devastation that has occurred over the last two years. These women workers are not only the primary caretakers at home, but at work too, having to take on the role of family members for these patients since their loved ones cannot be with them, as they are holding their hands during their final moments, and then having to rush into the next patient's room. These workers are given no time to grieve or process the patient that they lost. They are working in a vulnerable situation where the job is to help those who are sick, in a pandemic where we have no control and there is an unwavering feeling of helplessness.

INTRODUCTION

> It was just a lot of sadness all day everyday...the emotional burden that I am bringing home is different (RN, ICU, Mother of two).

COVID-19 has brought devastation across the United States, and globally since the beginning of 2020. The Center for Disease Control reported over seventy-nine million individuals have tested positive for COVID in the United States since the beginning of the outbreak (CDC 2022). There has not been a global pandemic since the swine flu, and COVID is far exceeding the swine flu pandemic in its number of deaths and uncertainty in the spread. Healthcare systems around the country initially struggled to provide care for these ill patients. In the past two years, legislators across the country have implemented mask mandates, approved a government shutdown, converted grade school education to online learning platforms temporarily, and mass-produced COVID vaccines. COVID is revealing economic and social issues, especially for working mothers in the context of the United States.

Prior to COVID, mothers were disadvantaged in the workforce due to gender inequality and due to their obligations at home and outside of their jobs (Hochschild 2012). Researchers, like Bornstein, have conducted multiple studies on gender inequality in the workplace in sociology and other disciplines; likewise, there is a wealth of literature on the challenges that working mothers face. For instance, the motherhood penalty is a concept that describes the attitude that mothers are not competent or as committed to their work compared to fathers and compared to women without children due to their familial obligations (Bornstein

2012). Bornstein's research is especially relevant now because there are more mothers working outside of the home. This bias towards mothers affects their abilities to be able to negotiate pay, as well as their likelihood to advance in their careers (Folbre 2018).

Literature shows women are expected to be the dominant homemaker even if they are working as much outside of the home, if not more than their partners, taking on the "second shift" (Hochschild 2012). The second shift refers to the work women do in the home after they come from their paid work, also referenced as being unpaid work. These working mothers are portrayed to be "Super Moms" or "Wonder Woman." These titles are supposed to seem uplifting and empowering, but really show the gender bias and benevolent sexism towards mothers in the workforce (Hochschild 2012).

Mothers make up a large portion of the workforce in the United States, and economists and other social commentators worry about how the economy will be affected if these mothers decide to suspend their paid working hours and assume the role of sole caretaker (Leigh, 2020). This seemed probable if the virus transmission rate did not decrease and vaccination rates increase, because of issues surrounding childcare and school closures. These are some factors that could certainly affect the profession of nursing in a negative way and the economy overall, as nursing is the second highest employer of working mothers in the United States. This could have presented our country with substantial difficulties if we lost a number of these mothers in the workforce (Department of Labor 2017). Now that the vaccine has been implemented and COVID numbers

are decreasing, research should look at the burnout and turnover rates that could be a repercussion for these mothers after working throughout the height of the COVID pandemic. This is another factor that could result in an economic crisis. If these mothers were to leave the healthcare profession due to burnout, we could see a large dip in staffing among healthcare facilities, along with similar negative economic effects. This adds to my purpose for investigating this topic of research.

Since we have known for decades the disadvantages that working mothers have endured, I wondered if there were additional disadvantages that the pandemic specifically engendered, particularly for working mothers who are employed in jobs deemed essential, such as health care providers. I work as a Surgical First Assistant, and though I am not constantly around COVID-positive patients, there is always a chance of exposure. In informal conversations with my coworkers, who are mothers like myself, I noticed themes of negative emotions, especially as it pertained to the added workload, stress, and anxiety, resulting from COVID. My experiences during the pandemic made me curious about the experiences of other mothers, specifically mothers working as Registered Nurses (RN). Nurses are at the frontline of the pandemic taking direct care of COVID patients. They act as patients' advocates and provide care throughout a patient's entire hospital stay.

Following this, I argue that examining working mothers in the nursing profession is worth investigating because like other essential workers, they have worked throughout the entirety of this pandemic. However, what's especially interesting to me is that it is likely that their domestic responsibilities increased. I

know their risk of exposure has increased (based on working in health care), and their job requires them to engage in some sort of care work (which is also gendered) for employment. Bedside nursing involves a level of care that revolves around close patient interaction. Depending upon patient needs, nurses could assist in minimal care or help with full care. Typically, minimal care patients can do most everything for themselves. The nurse will consistently check in on them, give them any medications that may have been ordered for them, help deliver their meals, and anything the patient may call out for. On the other hand, full care patients need more assistance with daily things such as ambulating (walking), using the restroom, bathing, eating, taking medications, etc. (which are patients commonly seen in intensive care units). This is what I mean by care work in the nursing profession.

They are not only likely expected to take on more of the caregiving roles at home, but they also work as a caregiver during a global health crisis. Nurses cared for sick individuals with COVID who were typically full care patients. Thus, I argue that these workers have been affected by the pandemic differently from individuals working outside of the healthcare setting.

Statement of the Problem

Being in a profession that is in high demand during this crisis as well as a profession where working from home is not a probable option, how do other factors such as childcare and school closures, distance learning, and domestic responsibilities at home affect these mothers? Current research finds that mothers feel overwhelmed along with experiencing several other emotions (fear,

exhaustion, anger, sadness) with their children transitioning to remote learning and due to the paucity of childcare, exacerbated in part by the risk of transmission (Rinaldo and Whalen 2020). Indeed, I found a similar theme in my research.

Moreover, I wanted to see how their lives have been affected since the outbreak, and if they were taking on unpaid caretaker roles along with working as a caretaker (i.e., a nurse). If so, what are those experiences? Rinaldo and Whalen (2020) discuss how mothers in the United States are more likely to take on the role of managing their children's distance learning, are more likely to reduce their paid work hours (or quit their jobs) and are being interrupted more while working at home. Based on the findings from Rinaldo and Whalen (2020), and significant literature on gender inequality in the home and workplace, I investigated how gendered stressors in the home and workplace might be similar, different, or exacerbated for mothers working as nurses, in comparison to the literature on mothers outside of the healthcare profession, particularly mothers with children 18 years of age and under.

These women's job requires them to put themselves in vulnerable situations to care for extremely ill patients. I argue that mothers who are nurses likely have endured increased physical demands at work, increased conflicting emotions, and likely suffered from mental health issues. I specifically examined Registered Nurses because of their role in caring for COVID-positive patients, and as aforementioned, since nursing is the second largest employer for mothers in the United States (Department of Labor 2017).

My research questions included: (1) what are the challenges of working mothers who are nurses during the COVID pandemic? (2) have these women experienced an increase in labor performed in the domestic sphere, and if so, what? (3) what additional hardships have these mothers had at work and home since the outbreak? (4) what physical and/or mental strain has the pandemic engendered for these women? I addressed my research questions by using a qualitative approach and conducting interviews with ten working mothers in the nursing profession. I recruited participants from the social media platform, FACEBOOK. In the interviews, I asked these mothers about their experiences since the outbreak of the COVID pandemic. I have found themes throughout these interviews that I discuss further in my findings section.

THEORETICAL FRAMEWORK

Gendered Organizations

In this section, I outline my theoretical framework which draws from Acker's (1990) theory of gendered organizations. After summarizing Acker's work, I offer a review of other research that uses this framework, and I conclude the section by discussing how I think this informs my research.

Acker (1990) laid the theoretical framework on gendered organizations, suggesting that we think of different structures as being "gendered." The symbols of gender and the process of gender identity affect the structure of the labor market and relations in the workplace (Acker 1990). Acker's theory indicates that a "gendered" organization bases different distinctions and terms between males and females, or masculine and feminine. This can include different advantages or disadvantages, as well as exploitation and control (Acker 1990). This theory assists in framing my study, looking at the gender stigma of unpaid care work and women working in paid care work.

An example Acker provides involves looking at what our culture would imagine a top business leader to look like; I imagine a white, middle-aged man who exudes power and control. Socially, this is an acceptable image when given this description of an individual. I bring in this specific example from Acker's theory because this "business leader" position is seen as a "masculine" position that would be viewed as "best suited" for someone with those attributes (e.g., a man). The same can be viewed when looking at jobs such as teaching, or nursing. These professions have nurturing or caretaking qualities that have the gendered view of being a more "feminine" type of career which is observed as being best suited for women and mothers (Britton and Logan 2008). Acker breaks

down the view of masculinity and femininity in the workplace which created a framework to understand how occupations and organizations operate from a gender logic.

Cockburn and Britton use similar arguments built from Acker's theory, with their studies on gendered organizations. Cockburn (1983) looked at male workers' view of masculinity being associated with their technical skills and the threat to masculinity if women were to obtain those same skill sets. They discuss how gender infiltrates our careers and creates a stigma about the type of individuals filling specific jobs. Looking at this ideology from a caregiving perspective, the skill sets associated with this profession can be viewed as nurturing-based and can be perceived as a threat to men. Men in these "feminine" positions are shown to be given more of the leadership role and excel promotionally over their female subordinates, also referred to as riding the "glass escalator" (Britton 2008; Williams 1992). Sociologist Christine Williams (1992) coined the term glass escalator which detailed the phenomenon of men getting promoted and being in leadership positions in female-dominated occupations such as nursing and teaching. This glass escalator propels men towards upper management positions such as principals, superintendents, and charge nurses. As we see in Britton's discussion of men having higher positions, nurses are subject to lower perception but are performing a substantial amount of the caretaking duties over their male counterparts in the workplace.

Britton (2008) noted that to adopt Acker's theory, there would need to be a paradigm shift in organizational forms, where bureaucratical hierarchy is abolished, and caretaking, or care work is viewed as a higher economical production. Britton breaks into Acker's theory in more depth, and the example that was previously stated by Acker about the ideal "business leader" can be used to validate Britton's argument. Looking at the

ideal “business leader,” class and race were used to describe the common image that society would use for this individual. He is upper-class and white.

Acker’s theory is relevant when looking at my participants for this study. Nursing is one of the highest employers for working mothers (Department of Labor 2017). This profession is seen as a “gendered profession” due to the nurturing and caring aspects of the job. Nurses take care of patients in vulnerable situations, and in a personable manner. Caretaking roles are seen in a lower positionality based on the bureaucratical hierarchy.

Acker’s theory pertains to my research of mothers who are working in the nursing profession because their profession is viewed as a caretaking “gendered” profession, along with being primary caretakers in their homes. These mothers are working a paid caretaking job, and then going home to do their “second shift” position as an unpaid caretaker (Hochschild 2012). Healthcare demands a lot from these nurses, both physically, and emotionally, especially since the outbreak of the pandemic. I tied this theory with literature that looks at mothers working in care work, their roles during disasters, and their roles during COVID. This lays the framework for my thesis, looking at the added demands that these mothers have faced since the outbreak of COVID.

LITERATURE REVIEW

In this section, I discuss relevant literature from studies similar in focus to my research topic. The themes that I found included: women working in care work, women's roles during disasters, and mothers' roles during COVID-19.

Women Working in Care Work

I found that many studies have examined gender in the workplace and its correlation with Acker's 1990 theory of "gendered organizations." Research shows that on average, women spend twice as much time as their male counterparts on activities associated with caring for individuals. Folbre (2018) used Acker's theory of gendered organizations when looking at the femininity of care work and gender identity. Throughout generations, women have been viewed as being the sole caretaker or homemaker.

Women in previous decades have and are still expected to be the individuals who take on most of the family care work in the home. Paid care work is valued both socially and morally, but it receives low economical rewards in the labor market and the home (Folbre 2018). Folbre (2018) asked the question: is care work rewarded less because women tend to do it, or do women earn lower rewards than men because they specialize in care work?

One perspective of this gendered phenomenon is caretaking careers are paid less because the role is filled predominantly by women, and its association with quintessentially gendered roles of mothers (Cunningham, Charlesworth, and Baines 2016). This ideology correlates with the "care penalty" that targets mothers in the workplace, viewing them as being less competent to fulfill their job duties because of the

outside [family] factors that they have. Studies show that in double-income families, mothers in lower-paying, care-based jobs are conforming to their jobs to accommodate their families (Cunningham et al. 2016). This brings both an economic and social strain for the mothers having to conform to these familial needs.

Seldberg (2013) looked at the experiences of nurses' work intensifications using an ethnographic approach. Seldberg cites Connell's (1987) work writing that nursing has been conceptualized as "an element of the sexual division of labor, an occupation blending a particular version of femininity with the technical requirements of the job" (Seldberg 2013). Overall, this research evaluated the disadvantages that nurses face at work daily. These disadvantages included having to take on larger patient loads (per management) with limited resources, as well as being expected to provide adequate and personal care for each patient without making mistakes. Though this study did not look at mothers specifically, it detailed the demands of working in the nursing profession, which ties to my research.

Women's Roles During Crises/Disasters

In this section, I discuss how disasters have affected women, what their roles are throughout the course of disasters, and use literature to correlate previous disasters with the current COVID pandemic. Research shows that disasters reflect the social divisions that can already be seen in society and intensifies them (Enarson et al. 2007). Disasters add yet another level of vulnerability that is already rooted in social differences surrounding gender, culture, race, age, class, etc. (Enarson et al. 2007). In her research on the Grand Forks flood, Fothergill (1999) found that mothers were expected to step back from their paid working positions to compensate for the demands in the home. Previous

research highlighted that the added labor in the home potentially increased vulnerability in women pre-disaster, as well as placed additional burdens during the recovery phase post-disaster (Enarson et al. 2007). While disasters are thought of as involving physical destruction to communities, COVID is a global health crisis that has led to different forms of destruction in the community: sickness and death. COVID has created similar panic and uncertainty that resembles emotions during and after disasters, as well as an intense focus on preventing the spread of the virus.

Scholars have argued for decades that disasters and their aftermaths produce gender inequalities. Barton (1969) found that during disasters, mothers were more likely to help in the home while fathers participated more in outside activities to benefit the community. Fothergill's data supported what Barton discussed, showing the demands of the family often put mothers in a situation that kept them in the home, while the fathers are expected to be more involved in community affairs.

Fothergill (1999) conducted interviews with women after the floods occurring in Grand Forks, North Dakota that resulted in an evacuation of the city. While some of the women in the community participated in physical labor outside of the home, many were seen helping the community by preparing food, working with donations at the local shelter, as well as helping with childcare, and taking care of the home (Fothergill 1999). Mothers were predominantly in charge of preparing for disasters as well as putting together relief assistance in the home.

Another concern is for women's overall well-being in the aftermath of disasters. Enarson et al. (2007) investigated how mothering became more difficult in the wake of disasters. The physical conditions became unstable and the reality of survival put mothers

at greater risks because of their nurturing tendency to protect their children at all costs. This is relevant to my research, as previous studies have shown that the vulnerability and fear that are associated with disasters correlate with the COVID pandemic. These mothers must take on more of the domestic responsibilities at home while taking care of COVID patients in the workplace. Mothers working in healthcare pose the possibility of bringing physical harm to their families, in the form of transmitting the virus, as well as personally struggling with the mental turmoil that results from their role during this pandemic.

Economically speaking, Hoffman (1999) saw that in the aftermath of disasters, women were hit with a larger disadvantage financially. Women affected by the disaster had a harder time receiving proper assistance and obtaining disaster compensation. This coincides with the Enarson et al. (2007) research that discussed how women were the ones primarily in charge of taking care of the relief assistance, including all the required documentation needed for government aid. This differs from my research in the aspect nurses are frontline workers, and the importance of their job requires them to be at work. Frontline workers are higher in demand with the COVID outbreak, and I anticipated to see more working hours, resulting in a more stable financial standing for these mothers.

In a more recent study that specifically examines COVID, Rinaldo and Whalen (2020) explored the added demands on mothers since the outbreak of the pandemic. Rinaldo and Whalen (2020) referenced the Ebola and ongoing AIDS epidemic, and the relationship between already existing gender inequalities that are coinciding with gender inequalities created or exacerbated during the COVID pandemic. In the literature on disaster and gender, gender inequality is related to being a mother. There are many

emotions and fears associated with the uncertainty surrounding this pandemic. These mothers have struggled substantially with childcare and flexibility in the workplace.

Rinaldo and Whalen's (2020) study shows that before the pandemic, mothers in the United States were already stressed and showing disadvantages in childcare and finding family-friendly employment. Since the pandemic, there have been school and childcare closures which added to mothers' pre-existing stress levels. Rinaldo and Whalen's interview data revealed that most of the childcare, remote schooling, and domestic tasks have fallen on the mothers. Their findings align with mine as I find that there are added demands on these mothers with the lack of available support.

Mothers' Role During COVID-19

Since the outbreak, there have been school and childcare closures across the United States. These closures have made an impact on mothers both socially and economically, as many families are now two-income dependent. As mentioned previously, Rinaldo and Whalen (2020) observed the added demands that mothers have endured since the outbreak. This study shows that mothers took on more of the domestic and caretaking responsibilities at home, providing the most regarding children's education, with the increase in distance learning. Moreover, Rinaldo and Whalen found that mothers who were assisting in their children's distance learning had to ensure their children completed schoolwork and provide instruction online and at home.

Croda and Grossband (2021) also looked at how women have "paid the price" since the COVID outbreak. This research showed that there were added demands in assisting with children's schooling. These demands result in a mental strain for these working mothers. Croda and Grossband (2021) see these social and economic issues as

more prevalent for mothers with younger children (12 years and under). This coincides with my research and what I expected to learn from the mothers that I interviewed. Moreover, research is beginning to show gender inequalities that are present during the pandemic, but what I find interesting are the studies pertaining to how mothers are coping with new, added demands.

Hochschild (2012) mentions the terms “super mom” and “wonder woman” and how our society uses these terms to portray how powerful mothers are. To give an example, these terms imply that mothers can accomplish any *and* everything while continuing to make it seem simple and effortless. These terms can be damaging though, especially considering the added demands that the pandemic has engendered. Society shows this unrealistic mentality that mothers just *get it done*, painting this as a requirement of being a mother. Moreover, the terms that Hochschild presents are damaging because motherhood is anything but simple and effortless.

In one study, Calarco and colleagues (2020) investigated how the pandemic could be damaging mothers’ well-being. Calarco hypothesized mother’s well-being might have changed because of the unanticipated increase in parenting time. Using a mixed-method research approach, the authors surveyed and interviewed mothers from Indiana during the early stages of COVID. Many of the mothers working from home expressed their feelings of failure; these mothers thought they were failing both at home and work (Calarco at el. 2020). The mothers in Calarco et al’s study additionally worried about how this failure might impact their children’s overall well-being, which led to many of these women have added stress and anxiety with the increased time at home.

In one of Calarco and colleagues' (2020) interviews, they found that mothers were overwhelmed because of the responsibilities of working from home and being with their children every day of the week without a break. The mothers also felt as if they could not accomplish their work tasks resulting from the workload associated with caring for their children throughout the day. Calarco spoke with a mother who worked from home part-time while her spouse worked from home full-time. This mother described her experiences of not being able to get her done because her toddler was always into everything. Her husband's job did not accommodate and due to that lack of flexibility the sole responsibilities fell onto her. These experiences were similar to many of the interviews that Calarco at el. presented in their data. Mothers are feeling overwhelmed with being with their children non-stop every day and feeling that they cannot get anything done because of the increased workload.

As the research on gender and disaster, mothers during COVID are not acknowledged for their increased work during the pandemic. This biased ideology is based on the normative idea that women's labor in the home is an essential part of womanhood, that is, their labor in the home is not seen as "labor," and instead as what is expected of women. This sexist idea is enhanced for mothers, as their primary identity or role is seen by a great faction of society as being a mother—everything else is secondary. Mothers' burdens have increased exponentially while available resources have decreased, such as childcare, during the isolation period of this pandemic (O'Reilly 2020).

Mothers' work flies under the radar due to society's lack of recognition of the importance of care work and appears to be happening in a heightened manner because of COVID. The unpaid care work that mothers are expected to perform has increased. The

added time with their children along with an increase in workload is leading mothers to express more anxiety, frustration, burnout, and exhaustion. This literature review is pertinent to my research because I explored similar emotions and themes with the mothers that I interviewed. I saw similar feelings of anxiousness and frustration, along with burnout associated with working as a frontline worker. I also saw differences in experiences that my mothers had to those in the literature that worked from home.

METHODS AND SETTINGS

In this section, I outline my research design, and I emphasize the factors that make it concordant with the focus of my thesis. I also use this section to introduce my findings chapter. I finish this section with a discussion of autoethnography, my personal experience with this research topic, and how my experiences played a role in choosing this research topic.

Research Design

I utilized a qualitative approach for this study. I interviewed mothers about their experiences since the outbreak of COVID. Hesse-Beiber (2017) describes how in-depth interviews can provide researchers with thoughts, memories, and ideas from the participant's own words. This study design can be beneficial from the aspect that previous studies have shown that women's thoughts and views have been overlooked or omitted by men (Hesse-Beiber 2017). I conducted ten interviews through Zoom, using the social media platform FACEBOOK, as my recruitment method. To meet the criteria for this study, mothers had to be actively working as a registered nurse (RN) in the United States. They also had to have a child or children under the age of 18 at home. I used different FACEBOOK groups specific to nursing, as well as mothers, to actively recruit participants. Participants who responded to the group posts were sent an email with the consent form. Once there was consent the participants were then scheduled for a Zoom interview. IRB approval was received for the research design described above, and the protocol was followed.

Data Collection and Findings

The data for this study was collected through recorded interviews. I used field notes along with the recorded interviews to later transcribe for coding. Most of these interviews took approximately an hour to complete. This was a general time frame; the length of each interview depended on how much the participant wanted to discuss. I used open-ended questions (see Appendix A) that started in a broader format, with general questions followed by probes that guided the participants to provide more detail, ending with demographic questions. These interviews aimed to uncover the participants' experiences during this global health crisis.

I transcribed and coded the recorded zoom interviews to look for themes that emerged. I coded the data using descriptive, analytical, and categorical codes. These codes included analysis and interpretations of the data, and what I used to find the themes across the data. I looked for themes that coincide with extant findings and theory in sociological literature related to this topic. The findings chapter is broken down by these themes and discussed in further detail.

Interview Setting

Looking at the circumstances associated with my research topic and participants, Zoom interviews were the best approach. Since I was open to interviewing women across the United States, in-person interviews would have been difficult. I also considered that my participants are working mothers, which alone can make scheduling difficult, and I wanted to ensure that I would not be burdening anyone willing to participate. Using Zoom allowed me to conduct interviews easily and be more accessible to my participants' schedules. This allowed me to follow COVID protocols and appeared to be the best way to offer safety to my participants.

Positionality & Autoethnography

Ethnographic field research is a study that observes individuals and groups in their everyday lives (Hesse-Beiber 2017). An ethnographer searches for a deep immersion into others' worlds, so the ethnographer can interpret their experiences in a more in-depth manner (Emerson, Fretz & Shaw 1995). Goffman (1989) argues that researchers should fully submerge themselves within a group of individuals' contingencies associated with their social setting, so they can accurately respond to social situations. Autoethnography in the most basic sense, is an ethnography of the self, the researcher, and the authorial subject of the text. For the purposes of this thesis, I simply use my own experiences to try to make sociological sense of my participants' narratives and put the context of my own life into conversation with theirs. Moreover, as Goldschmidt (1977) writes, "there is a sense in which all ethnography is autoethnography" (p. 294).

I also used an autoethnographic approach for my study. I did not need to submerge myself specifically for this research as Goffman suggests, because I have already had these experiences through being a part of this social setting. My interest in this research topic came from my personal experiences during this pandemic as a mother and a healthcare provider. I work as a Surgical First Assistant, and I am also the mother of three children, ages ten, eight, and six. These experiences are what fueled my research interests and prompted me to use an autoethnographic approach. I bring in my autoethnographic section before my analysis section to provide detail about my positionality.

When the pandemic first made its way to the United States, my hospital went into a state of chaos, and it seemed like everyone was experiencing a heightened sense of fear. We had very little information about the virus itself, and all we knew was that it was deadly and spreading rapidly. It was a scary time because we didn't have any answers. Though I do not take direct care of COVID patients every day, I was still at risk of exposure in my department. I worried about getting exposed and not knowing until it was too late and had already brought it home to my family. I worried about how to juggle the changes, professionally and personally, that were going to ensure due to school closures, the cancellation of elective surgeries, distance learning, and the government shutdown. I still have some of these worries, even with the advancements that we have made with the vaccines, and the new knowledge that we have of COVID. I used my autoethnographic section along with my findings from my participants' interviews to bring fruition to the experiences of mothers who have worked on the frontlines of the COVID pandemic.

June 2020

> I still have not heard anything about the plans for schools starting back in August. The last that I have heard is that they are considering doing a distant learning format. I understand how important it is to keep everyone safe during this time, but I worry about how they are planning to conduct distance learning. I need to know if I need to buy laptops for all three of my children, along with any of the other items they need to start back to school. *Are they going back all day? Will they just do a few hours a day? Will it be live videos with their teachers or recorded videos with assignments? Am I going to have to be their sole resource for education?*

…The school district continues to have meetings but there are no answers. I need to know if I need to speak with my managers about figuring out another work schedule so I can accommodate their schooling.

…To add to all this worry, my children are starting to feel the effects of quarantine. They have had to be home for almost three months, and I am starting to see them struggle with cabin fever. I know that it is bothering them that they cannot see their friends or go out to different places. All these pent-up emotions are being reflected at home.

…My husband tries to help me when he gets home in the evenings, but realistically, I am home more, so many of the domestic roles fall on me and I am struggling to keep up. Having to not only do the normal day-to-day care for my children, but also trying to make the best of the days that we are stuck at home, and not being able to get out, well, it's exhausting.

…And there are things around the house that continuously need to be done. Laundry is a never-ending process. I did the dishes this morning, turned around, and magically it looks like I have not touched a single thing in the sink.

I am tired, I am stressed, I feel completely overwhelmed, and the one thing that I use to help with coping with these feelings [the gym] is closed because of the pandemic. Somedays I wonder if it is ever going to get better, and there are many days, it takes everything in me to get out of bed.

Early August 2020

School is starting back this month. My children's school has decided to try going back in person, but they are also giving parents the option of distance learning. I have been extremely conflicted about what I should do. I am concerned that as soon as I send them back in person that there will be a COVID outbreak, and the schools will close. It is not unreasonable to have this worry because the numbers have only continued to increase over the summer. I worry that if that happens, it will be harder to transition them to distance learning on such short notice.

… [I contemplated my options] … I think it will be best to start my children with distance learning. If it goes well for the first nine weeks, and there are not any serious issues with school exposure, I might consider letting them go back in person. Though I know they need social interaction, and I want them to be able to go back to school in person…especially after being home since March, I just have fears about letting them go back right now. I might be overthinking this, which would not be uncommon for me, but I cannot help but be worried about all this uncertainty.

…I have talked to my husband as well about my feelings on this matter, and though he tries to help with this decision, I know that I will be the one who is primarily in charge of taking care of their schooling. If they go back in person, they will also be required to wear a mask all day. I am not sure if my five-year-old son will be able to handle wearing a mask for the entire school day.

> …It is not that I think that he cannot physically do it, but realistically, what five-year-old boy could honestly be expected to keep a mask properly on their face all day? This is *also* what worries me about distance learning. How can I expect my five-year-old to sit at a computer all day and participate? My daughters are a little older so I know that they will do fine either online or in person. I hope to eventually send them back in person because my eldest daughter is struggling the most emotionally—not having that social interaction that she is familiar with.

Late August 2020

> …My children's school provided us with laptops for each child to use, along with all the school materials that they will need. Their teachers have sent home folders with class schedules, and I can tell it is going to be an interesting nine weeks. None of their schedules match up. Each of my children has different start times and breaks throughout the day. In the first week, we have already had multiple technical difficulties, and my children have had trouble staying focused while sitting at their computers. They also have had a decent amount of work to do outside of their zoom lectures, that I must then upload onto the online forum for the teachers to be able to grade their work. At the end of each week, I must go to the school to pick up their packets of classwork for the following week. I have also had to change my work schedule to accommodate their school needs.

All these events over the last year made me think about other mothers in healthcare who had to be struggling with similar experiences and thoughts. Some of the

participant's experiences resonated with me because I am a mom and a healthcare worker. I brought some of my experiences in through my autoethnographic piece to tie in some of my own experiences during COVID of being both a mom and healthcare provider. This also helped me to better understand the experiences that my participants had during this global health crisis.

Because of my experiences, I decided I wanted to look specifically at nurses, because of their role inpatient care. Nursing is a popular profession for mothers and one of the highest employers for mothers in the United States. This research stemmed from my own experiences, along with hearing my colleagues having similar thoughts and ideas on this growing problem due to COVID-19.

I anticipated that the mothers would narrate that they have taken on the sole caretaker role, and likely that they would discuss how this is the case in comparison to their partners. I also anticipated that I would find this theme even if the women were working a good deal of paid working hours. I anticipated that there would be variation in their answers based on their marital status, age of children, and job description. I explored the themes that I found in my findings chapter. I saw many themes in these interviews that correlated with what I anticipated themes that I was not anticipating.

FINDINGS

In this section, I discuss my finding and how they answer my research questions and fit the overall theoretical frameworks. I present three themes starting with the added hardships these mothers faced during COVID. This section is broken down into two subsections, one specific to participants' home-lives, and the other to their work-lives. I then go into the emotional turmoil and mental health repercussions of being frontline workers and mothers during the pandemic. Finally, I present my findings on burnout, turnover, and the overall sense of belongingness. My findings are set up in a way that looks at the chain of events that these mothers have experienced through multiple peaks of COVID. The added hardships contributed to the emotional turmoil which in tow influenced the mental health repercussions. Hence, emotions resulted in feelings of burnout and added to the turnover rates seen in bedside nursing. Finally looking at how even in the aftermath of everything that these mothers have experienced over the last two years, they still had this desire to help people. These findings helped me to explore the gendered phenomenon of these mothers reinstating the unpaid caretaker role in the domestic sphere while working in a gendered profession on the frontlines of a global pandemic.

ADDED HARDSHIPS

In my interviews, I asked my participants a series of questions that pertained to both their home and work lives. I asked them about their experiences at home and work since the beginning of COVID. In one of my research questions, I wondered if mothers working in the frontlines would face additional hardships. Unsurprisingly, the women discussed the added hardships that occurred in these spheres: work-life and home-life.

Work-Life

I started my interviews by asking my participants about how their experiences at work changed since the beginning of the pandemic. Since my interviews spanned over a couple of months, there were vast developments in the treatment of COVID. The women that I spoke with talked about how their experiences changed throughout the multiple peaks of COVID. At the beginning of the pandemic, they spoke about how their workload became more stressful from not knowing how COVID worked. There was limited information and increasing death rates that made their jobs difficult.

> And it was singlehandedly probably one of the most challenging things I've ever had to face. (RN, ER, mother of two)

Many of the mothers discussed how there were constant changes in PPE (Personal Protective Equipment) policies. This contributed to the constant policy changes that were the result of the uncertainty that came with COVID. There was access to PPE for most of my participants, but many discussed how it was not always the best, and how they had to reuse items such as their N-95 masks (COVID regulated masks). There were limited supplies, but they dealt with what they had available to them. One mother (a charge nurse) talked about conserving PPE supplies stating:

> You're gonna stick it in your locker at the end of the day, and that's going to be yours until it busts and even then, we want you to try to staple it before you get a new one.

She said this in a sarcastic and more joking tone to paint this picture of the unrealistic expectations that were given to them. These women were having to work through this pandemic where they had limited available resources and staff. They were expected to take care of larger patient loads with much sicker patients. Many of my

participants talked about how they worked extra hours or worked longer shifts, but most did not have mandatory overtime. They described their experiences and how these experiences changed over the different waves (or peaks) of the pandemic. During the first wave of COVID, my participants talked about how they were more fearful of not knowing anything about this virus. Many non-emergent departments, such as surgery, were temporarily closed and the nurses from those departments were being floated to help in other departments. I remembered when my surgery department closed, we became runners for the nurses on the floor. We would run to get the things that they needed so they would not have to repeatedly come in and out of COVID patient rooms, limiting possible exposures. As the next few waves of COVID came and went, we got access to more information, along with the vaccine and booster.

Throughout the height of COVID, these mothers were having to constantly gear up in full PPE and remove PPE when going in and out of patient rooms. They were also required to wear masks (specifically N-95s) throughout their entire shifts. The N-95 masks have a tight seal that presses firmly against the nose. I have had to wear these masks when working with COVID patients in the surgery department and they are not comfortable. They can rub against the nose and make them extremely sensitive, if not raw. One of my participants talked about how she had permanent scarring because she had to wear the N-95 mask constantly.

Many of these women also spoke about how they would have to take precautions going into the hospital and when they got home from the hospital. They were having to "decontaminate" in their garages before quickly running through their houses to immediately jump in the shower. Some of these women had access to scrubs that they

could change into once they got to the hospital, so they would not have to wear their scrubs throughout their shifts, but not all of them had this access. These women were having to care for extremely sick patients with a rising death rate. They had an increase in patient numbers, especially for those in the ICU. One of my participants, an ER nurse and mother of two stated:

> Somebody breaks a bone. Oh great, we can fix you, we can send you home. This is fantastic, I can do that. That's wonderful. Or oh, you know you have appendicitis? Well, we can take out your appendix, and yeah, it'd be just fine. But COVID was all about heartbreak.

These mothers were constantly surrounded by heartbreak and sadness at work while being pushed to their breaking point. The physical demands that they dealt with while working during COVID added to this emotional turmoil which contributed to mental health repercussions. I talk about this more directly in the next section of my findings.

Home-Life

Not only were my participants working on the frontlines of the pandemic, but they also had dependents at home that required their attention when they were not at work. These women had to juggle dealing with COVID daily and balancing their home lives. At the beginning of the pandemic, many schools closed for the remainder of the 2019-2020 academic school year. As many authors have discussed (Barton 1969, Fothergill 1999), during times of crisis and disasters, women are relegated to traditional domestic responsibilities, and they often are responsible for most everything in the domestic sphere. This is prevalent in my research as my participants spoke about how they were

the ones primarily in charge of domestic responsibilities including distance learning and childcare.

I anticipated seeing these women taking on more of the labor in the home and being solely in charge of their children's schooling; I did see this theme throughout my interviews but there were some important variations. I did not account for the differences between married and single-parent homes. As well as the differences depending upon their children's ages. The mothers from a single-parent household described how they were the sole caretaker in their home. These women talked about how they did not have any other person to rely on, and everything ultimately fell on them. They talked about how not having this other supportive adult in the home with them added this other stressor to their plates. A few of these women were more recently divorced and they talked about having to navigate those changes while having to work through this pandemic and care for their children.

The mothers that I interviewed who are married talked about how they were also the ones primarily in charge of everything at home. They were able to get help from their spouses if needed, but they were the ones who barred the brunt of the household responsibilities. Specifically looking at the domestic responsibilities of daily household chores, (such as laundry, dishes, childcare) and with children's distance learning. One of the mothers (married) with younger children (preschool and elementary school ages) described her daily routine stating:

> From sunup to sundown, it's wake up, make sure the kids have breakfast, do their schoolwork, get them off to school, and go through everything for the day. My daughter is doing video-led classes, which is making it a lot easier in my life right now. Because I can kind of clean and do laundry and you know, do all the mom things in between her doing classes.

Something that I found specifically interesting in this passage was the term "mom things." This term was used to describe labor being done at home, such as laundry and cleaning. Participants referred to some iteration of this when recollecting their attempt to juggle the household labor while assisting in their kid's homeschooling. Looking at how COVID has somewhat reinstated these gendered roles it was interesting to see these daily tasks being designated in a gendered manner, as well as how these tasks are being correlated as a requirement of being a mother. Many of these mothers stated that their standards for their homes declined with the stress and work that came from COVID.

Not keeping up with the quality in the domestic sphere as they had before the pandemic. One mother talked about how she always folded the laundry as soon as it finished in the dryer. It was something that she was adamant about, describing herself as being "OCD" about it. Since the pandemic, she now has a clean clothes pile on a chair in her bedroom that she just throws her clean clothes on. She said this was something she was not proud of but with all the stress that came with being a mother and nurse working during the pandemic, that fell on her list of priorities.

Participants' experiences with distant learning varied depending on the age of the children. The children's age also influenced the degree to which the women felt as if they were responsible for their children's education. It was interesting hearing the differences in how distance learning went for these mothers depending on the age of their children.

I was able to relate to many of them in their experiences with having to help with kids' schooling at home. My children were also having to do distance learning for a

period. Their schedules for classes and assignments were difficult to keep up with and my children had to have an adult available to help with this. One of the biggest differences that I saw through my interviews was the type of assistance that was needed depending on the ages of my participant's children. Those who reported having younger children (elementary school ages) had to do more of the computer-based assistance. An ER nurse with two elementary school-aged children described her experience with distance learning stating:

> It involved an extensive amount of parental involvement. And at the end of the week, you had to scan in upwards of 50 sheets. Yeah, into the system. So, then the teacher could see them in Google Classrooms.

The mothers who had older children (middle to high school ages) had the harder tasks of helping with these more difficult subjects with less teacher involvement. These mothers also described their children as having more difficulties with the social adjustment that COVID brought. They lost the socialization that came with being able to be around other students and friends at school. One participant (a nursing educator for the ICU department) with high school-aged children discussed her daughter's struggle with returning to in person-in-person class because of losing socialization during distance learning:

> She [daughter] misses friends, she misses school, and we've had a really good summer playing with friends, but she told me last night she is really worried that she won't know how to be in school anymore.

These kids were old enough to understand more of what was going on in the community. According to my participants, older children were not only worried about their mothers working on the frontlines, but also internalized and were directly affected by the uncertainty that the pandemic wrought. Being old enough to better understand the

rates of mortality surrounding COVID, the severity of being infected, and the loss of socialization contributed to what my participants said were their older children increased emotional needs. Their mothers talked about how they had more anxiety when reentering schools, and how they believed their children needed to go back for their mental health.

All the mothers that I interviewed struggled with balancing their work and home lives during COVID. Their experiences varied on their marital status, along with their children's age ranges. Similarly, they had added physical demands as well as stressors that contributed to this emotional turmoil and their overall mental health struggles. The next section looks at the themes of emotions that I was in my interviews and the resulting mental health repercussions.

EMOTIONAL TURMOIL AND MENTAL HEALTH REPERCUSSIONS

The added hardships that my participants endured at the hands of being both a frontline workers and mother during the pandemic, brought forth a set of emotions that they said contributed to their mental health repercussions. In this section, I specifically look at the themes of emotions that I saw including fear, sadness and heartbreak, and anger. Looking at how this emotional turmoil among my participants equated to increased anxiety and PTSD.

Emotional Turmoil

Working in healthcare has its typical challenges in that we are caring for patients during vulnerable situations. Some shifts will be harder than others and will likely foster difficult emotions that can be a burden to those working in the healthcare setting. However, COVID brought an amplified wave of emotional turmoil that had a lasting

impact on many of my participants. One participant, an ER nurse, stated, "You get a cold, you're like okay, am I gonna die?"

This quote references how in the beginning we were still learning all the possible symptoms of COVID, and many of these symptoms mimicked that of a common cold or the flu. Before the pandemic, many people would not think much about these illnesses, and they would take over-the-counter medications and continue as any other usual day. Everything changed with COVID. While the symptoms are often like that of the common cold or flu, the mortality rate has been astronomical. I remember feeling that I was hearing about new symptoms that were being added to the list for COVID every other day. This brings forth a new and unfamiliar worry if someone gets a fever, stuffy nose, or sore throat. It then posed the question one of my participant's reflected on which was, "Is this just one of these small common illnesses or could this end my life?" This ER nurse is talking about how COVID made her start seeing her mortality in sharper focus.

Worry and newfound vulnerability lead to one of the more profound emotions that I saw while talking with my participants about COVID: fear. These mothers voiced their fear of the unknown, fear for themselves, along with fear for their families as they had to navigate blindly through the pandemic with the mortality rate rising at an alarming speed. Many of my participants described working during COVID as being one of the most trying things they have had to do. There was this constant fear for everyone surrounding them.

The mothers described how they were having to take all these extra precautions to try to protect their families while serving on the frontlines. This contributed to conflicting feelings. On the one hand, many of these mothers talked about how they did not want to

be around their families because of the fear of unintentionally exposing them. On the other hand, they were having these torn feelings about not being with family after seeing several patients dying without the chance to have their families by their side. It was a constant battle of emotions: they wanted to be with their families, but there was this lingering fear of unintentionally harming their families by indulging in their own emotional needs. Many of the mothers that I spoke with referred to these feelings as "mom guilt". They associated their guilt of not being able to do everything and the constant struggle with balancing their emotional needs at home and work with this guilt specifically linked to being a mom.

> COVID was all about being put in these terrible situations where you're telling somebody, I'm sorry your loved one's dying, but you can only spend 15 minutes because you might catch COVID (ER nurse).

In this quote, the untenable situation that these nurses had to tread is that they wanted to both be caring towards those who were losing loved ones, but they also had to worry about their families and the risk of their own lives. It's customary in our culture to visit loved ones who are ill or on hospice care (end of their life care). Even if there is nothing that a loved one can physically do, many people still want to be emotionally there for their loved one and do not want their loved one to die alone. With COVID, especially during the first phase of COVID, there was so much uncertainty. The only thing that we knew was that it was extremely contagious, and it was quickly taking lives.

The mothers I interviewed talked about how difficult it was for families to not have the ability to be with their loved ones. These women had the hard job of having to inform patients' family members that they could not visit their loved ones because they could not chance the possibility of exposing them to COVID. My participants talked

about the heartache and sadness that came with seeing so many COVID patients having to essentially die alone.

> I literally would just go home and cry because I'm like, all my patients are dying, and I can't do anything about it. (ICU, OR nurse).

As healthcare workers, we know that exposure to death and dying can come with the profession, but not usually to the extent that COVID brought forth. In my interviews, these mothers spoke about how there was so much death surrounding them. COVID made it difficult for them to see the good things that they enjoyed about nursing because they were constantly surrounded by this unnerving sadness. This emotional turmoil comes through in this quote, where this participant talked about her experience while working in the ICU and the heartache that came with caring for these dying patients.

In many cases, these women were having to step in as their patient's families because their patients could not have their loved ones there and that had a lasting impact on them. These nurses saw patterns amongst the sickest of COVID patients and were able to sense when a prognosis was not going to be a good one. In many situations, there was nothing these women could do for their patients, and these women said their patients were scared to death. The feeling of helplessness added to the sadness and heartbreak surrounding caring for COVID patients.

One participant spoke about an instance when they stepped in to help a patient calling out for help. She saw the signs that this patient was getting ready to code (go into cardiac arrest) but was quickly informed of there do not resuscitate (DNR) status. She spoke about how she had to sit there helplessly with this patient whom she could not help

due to medical orders. She described it as being one of the most horrible things she has had to experience stating:

> It was like [they] were in a tub of water with [their] eyes open. [They] made these sounds like [they] were drowning and gurgling until [they] stiffened and passed away.

It is through experiences like these throughout COVID that these mothers were having to survive while they worked on the front every day. Many of these mothers spoke about how it was hard to not bring this emotional baggage home with them, and how this sadness would affect them even once they were home. The sadness that came from watching such horrific deaths, sometimes multiple deaths in a shift, along with the guilt that came from not being able to do more, weighed these nurses down immensely. There were times in my interviews when these mothers were getting emotional just recollecting the horrific events that they endured.

These mothers were expected to continue to keep up this “well structured” persona in their homes even though internally, all they wanted to do was decompress and try to comprehend how they were feeling after dealing with the horrors they endured at work. It can even go on to correlate further with Hochschild’s (2012) work on labeling mothers as “super moms” and “wonder women”. Our society has put this emphasis on women, especially mothers, as having this tenacity that makes them almost superhuman, when in fact they have pain and emotions like any other human being. There is a limit to how much any individual can take, and these mothers have described how they felt they were at their limits and being asked to push past those arbitrary limits time and time again. It brings in this gendered notion that mothers are capable of handling situations at a level far above the capacity of other individuals in our society solely because they are a

mother, bringing forth this unrealistic expectation that can be seen in my interviews. I find this interesting because it is contradicting in the sense that mothers have faced inequalities in the workplace due to employers worrying about their familial obligations. However, in the case of these mothers in nursing, they are referenced as “healthcare heroes” which is a label that is similar to the one Hochschild references as “supermom”. They are expected to be able to handle the added hardships that are being piled onto them even amid a global pandemic.

I was able to empathize with my participants during these moments and what they had endured. As healthcare workers, we are viewed as professionals who can compose themselves during tense situations. I found it interesting that participants apologized for showing emotion when in fact, we are just like any other human. These women were apologizing for having basic human emotions after experiencing traumatic events from working on the frontline of this global pandemic. In many of my interviews, my participants asked for a minute to recompose themselves from crying while reencountering their experiences and felt bad for crying. One participant referenced her time at the peak of the pandemic stating:

> There were times where it just felt like you were in battle, like just codes going off, you know, like codes happening all around you, everyone’s coding a patient. Multiple codes at the same time and going down the line and intubating everybody, not having a lunch break, nurse, no extra hands. (ICU nurse)

This quote again paints just a small picture of the sadness and heartbreak that these mothers were facing daily as they battled this pandemic head-on. They then went home and provided labor and emotional support for their families which necessitated extra labor in and of itself due to remote learning and stay-at-home orders. Moreover,

they still had to juggle their paid and unpaid care jobs. Many of my participants discussed the emotional needs that they felt responsible for meeting for their families when they got home, especially the mothers who had older children. Several of my participants talked about their kids being affected mentally due to their lack of socialization. Their children's overall well-being during the pandemic was yet another layer of fear that these women had to deal with. These women were not able to just come home and completely decompress after their emotionally challenging day at work.

The mothers in my sample had other individuals who depended on them just as much at home as they did at work. This again goes back to the "second shift" concept previously mentioned. These mothers were working under unfathomable conditions at work. Then they would come home to begin their second shift, the "unpaid" care job. The mothers were bringing home the sadness and heartache that they were seeing daily without the capability to decompress or cope with those emotions. This coincides with what Croda and Grossband (2021) were discussing when they say that women have *paid the price* during COVID. Croda and Grossband saw that the added demands in helping with distance learning and extra childcare were leaving a lasting mental strain on working mothers, the difference being unlike the participants in their study, mine was on the frontlines of this pandemic. The added demands between work and the domestic sphere have had a rippling effect on these mothers, resulting in a lasting mental strain.

Another emotion that many of my participants spoke about was anger and the frustration that came specifically from the media and the public. These women described how emotionally challenging it had been to constantly care for such sick individuals during COVID and the emotional baggage that comes home with them daily. They would

often follow up by talking about how upsetting it was that many people in the community were unaware of just how difficult the pandemic has been for nurses, both physically and emotionally. If a COVID patient required a ventilation system, they had to be rotated to a prone position (when a patient is on their stomach). To do this, it usually took six to eight nurses to position the patient and could take up to an hour to position them. One of my participants said this was hard on their backs and shoulders because they were unable to use proper lifting form in the process and so they were having to lift improperly putting themselves at risk of injuries. This was an example of some of the physical strain that these nurses endured while caring for multiple COVID patients.

I was able to relate to my participants on the feelings of anger and frustration. Friends and people in the community were constantly trying to negate the severity of this virus, refusing to wear masks, trying to take the medicine out of the equation and make it political. Hearing those around you who have not experienced it first-hand talk about how COVID is fake and passing on false information was very difficult. One of my participants spoke specifically on this stating:

> The public telling you that COVID is fake. It has ruined my relationships with a lot of people that have been posting on social media. Nonsense, that they know nothing about. It is like, I will never forgive them for that, and I will not respect them. (ICU nurse)

When this discussion came up in the interview, I noticed many of the women got extremely emotional and it showed in their physical demeanor. I was able to see that they were getting distraught recollecting how the public perceived the pandemic. They were visibly upset that they were in the frontlines every day, putting themselves, and their families front and center for potential exposure, and people around them dismissed them

and their experiences. Another participant gave an example of her feelings of anger around the public saying:

> Because how dare you, it is such a slap to the face to all of these people who have lost their lives, or lost family members. All of these healthcare providers are pouring their hearts and souls into taking care of these people and you are telling me that I am over-exaggerating or telling me that it isn't real.

Along with the frustration with the outside community, many of my participants spoke about the negative encounters they had with particularly rude patients. They talked about experiences where they had stable non-COVID patients who would be extremely rude to them. The participants had to care for patients with no understanding of what these women were juggling while trying to take care of them and COVID patients.

> Like we'll have a code going on and somebody's like, it's taken 10 minutes to get some water. Are you freaking kidding me? Like you heard that? Oh yeah, we have 5 nurses and all of them are trying to restart somebody's heart right now. What is wrong with you? (Charge Nurse)

The women gave multiple examples of patients getting short with them and getting impatient over non-emergent needs. Like in the quote above, this participant was giving just one example of how they were being treated by non-critical patients. Not only were these mothers having to deal with the workload increase that came with COVID, but also multiple patients whom they thought, did not care about them. Several of my participants talked about how they began to start getting frustrated with these patients and noticed that their tolerance levels were decreasing. Some of the participants talked about how they had breaking points and told some of these ruder patients just a glimpse of what they were currently dealing with.

> I was like, like, here's the thing, like, I have ya know, 5 isolation patients, and you who's here for abdominal pain that's been going on for three

> weeks that you should have gone to see your primary doctor before. Yeah. Sorry that you had to wait. (ER nurse)

In this quote, this participant stated this patient had waited to seek medical help for an extended period. She acknowledged that her patient was in pain and that they needed medical attention but also discusses the issue of having to deal with patients who were non-emergent and having negative behaviors towards them. These encounters make me wonder if this increase in rude behavior could be due to the lack of acknowledgment for women working in the healthcare profession. Folbre (2018) asked a similar question, "is care work rewarded less because women tend to do it, or do women earn lower rewards than men because they specialize in care work?". Because women's work is devalued in fields like nursing and education, we can likely assume that the increase in rude patients is likely the function of how everyone's nerves are raw because of what we as a society have been through and because women in care work professions are devalued.

Mental Health Repercussions

I anticipated participants narrating an increase in mental health issues. According to my participants, the emotional turmoil along with the hardships that they endured, contributed negatively to their mental health leaving a lasting impact. During my interviews, I asked these mothers if they had experienced an increase in mental health issues since working through the pandemic. Most of my participants talked openly about their struggles with increased anxiety as well as PTSD because of their experiences on the frontlines.

Several of my participants talked about having to take anxiety medications at some point throughout the height of the pandemic. They spoke about how it was a mixture of everything both at home and at work that made this impact on their mental health. The fear that they felt for themselves, and their loved ones came with this unnerving wave of stress. A few examples that contributed to this fear included exposing their families, catching COVID themselves, and losing loved ones to COVID. Along with the fear, these mothers had the emotional demands at work (that I discussed previously), as well as seeing this larger scale of deaths among their patients. Enarson et al. (2007) looked at how mothers were at greater risk in the wake of disasters because their nurturing qualities would push these mothers into survival mode. My participants talked about their fears when it came to the risk they were putting their families at.

My participants contributed their increased anxiety to the emotional burdens that they were faced with while working during COVID. These mothers also described how they were dealing with PTSD from the horrors that they saw during the height of the pandemic. I had mentioned earlier that exposure to death and dying is something that is not uncommon for those working in the medical profession, I have seen death during my experiences in healthcare, but not to extent that came with this pandemic. Many of these women talked about how they were seeing patients their age, and younger, who were predominantly healthy, dying from COVID. A few of these women recalled having nightmares that were triggered by their PTSD. The trauma from seeing an abundance of death over a short time frame, along with the emotional burdens, and added hardships, made a negative impact on these mothers' mental health.

BURNOUT, TURNOVER, AND THE OVERALL SENSE OF BELONGINGNESS

A theme that I found consistently across my interviews was the burnout amongst my participants and the discussion of turnover rates for bedside nurses that they described as an aftermath of COVID. In the previous sections of my findings, I talked about the added hardships and stressors that my participants endured while working in COVID. These hardships led to this emotional burden that left a lasting impact on these mothers which waned into feelings of burnout. One of my participants stated: “But COVID fundamentally changed me, and I don’t think I could be a bedside nurse for much longer than four more years.” This mother is currently in school for her Master’s degree (MSN) and we talked about how COVID caused her and her colleagues to experience burnout. She also went on to say, “And the worst part about COVID is that it decreased the okay moments of nursing.”

The constant stress and harsh working conditions with limited support for the work they were doing made an impact on these women. What I found most interesting is that even though all my participants talked about these feelings of burnout and spoke about the large turnover rates, nine out of ten of them said they do not plan to leave the nursing profession. They described their work as a nurse as being “their calling”. They had this sense of belonging regarding working in the nursing profession. Many of the participants discussed in this way, “Okay, what else would I do if I wasn’t a nurse?” which draws attention to how they saw their profession as a calling.

Many of them spoke about how they have this need or desire to help others, and this is the core of what nurses do. They give the most personable care to those in the community who are in extremely vulnerable situations. Nurses see us at our sickest, and

in the case of COVID, they were the ones that were with patients during their last moments. It is these nurturing qualities that give the perception of nursing being a more "feminine" profession. Now some of my participants talked about going into different specialties of nursing that were not bedside nursing (Intensive Care Unit, Cardiac Intensive Care Unit, Med-Surg., etc.). One of the participants talked about her transition from the ICU to working in the surgery department and how that differed from COVID. The decision to change specialties was caused by the exhaustion and burnout that they were feeling while working frontline of the COVID pandemic.

My findings concluded with many of my research questions. My participants were presented with added demands at work and in the domestic sphere. These added hardships brought forth these emotional burdens amongst these mothers. All these events throughout the different peaks of the pandemic had a rippling effect resulting in a decline in mental health for my participants. My participants talked about burnout as an aftermath of their experiences, how this equated to turnover rates across their profession and their belief that they have this overall sense of belonging in the nursing profession.

DISCUSSION AND CONCLUSIONS

DISCUSSION

The purpose of this thesis research was to hear and learn from the experiences of mothers working on the frontlines of COVID. I was able to answer most of my research questions in the process of analyzing the data. My data analysis also brought up new questions that could be explored in future research by interviewing more mothers to get a better understanding of the experiences of mothers working in the nursing profession during COVID and what that entailed.

These mothers spoke about their experiences and additional hardships that they faced both at home and work. There were physical and emotional demands that increased in their jobs. The emotional baggage that they had from their work came home with many of my participants and affected them at home. They experienced added stressors that played a role in the emotional turmoil and mental health strain, resulting in this exhaustion and burnout.

Through my interviews, I was able to see that my participants were the ones who were primarily in charge of the labor in the home. This included daily things such as cleaning, laundry, and caring for the children. They also reported that they were the ones that did the most regarding distance learning. One thing that I did not specifically account for, which I mention in my findings, is the differences based on marital status. One of the big themes that I saw was the women from single-parent households did not have another adult to rely on in the home if they needed them. Another theme that varied was the experiences of distance learning for these mothers. They varied depending on the age groups that their children were. I saw that the younger children needed more technical

assistance and needed an adult to be available to help with all their schooling. The older kids needed more assistance with coursework and tutoring. The mothers with older kids also talked about how they were more affected mentally because of the lack of socialization and because they were old enough to understand what was going on and how dire it was.

When discussing the labor in the home I had one participant describe these tasks as being “mom things.” I found this particularly interesting as it relates to this gendered notion of these caretaking qualities being a requirement of women and specifically mothers. Acker’s (1990) theory of gendered organizations helps us understand that our society associates different qualities of professions with gender. This is corroborated in my findings. As I mentioned earlier, Acker’s (1990) theory explored how society assigns these different qualities with “masculine” and “feminine” traits. When looking at it from this theoretical standpoint, “feminine” qualities are described as being nurturing and caretaking, which are associated with professions such as teaching, and nursing. In those caretaking and nurturing qualities, we see the related expectations that correspond with the title of mother. Mothers have this expectation put on them as being the primary individual who provides domestic care within the home. The mothers I interviewed described their roles at work and home, both having these nurturing or “feminine” aspects.

The caretaking qualities they show at home emulates in their work lives. Therefore, nursing is viewed as a feminine (thus gendered) profession. Women, specifically mothers, occupy many positions in the nursing profession. As my participant stated the domestic responsibilities, or “mom things” contribute to this notion that

caretaking is a requirement for women and mothers and hence, nurses. They described how the labor in the home increased due to distance learning. Looking at distance learning from Acker's (1990) theoretical standpoint, this could be another gendered notion because the aspects that go into teaching fall into those qualities that our society associates with "feminine." This could argue why mothers are the individuals who are primarily in charge of their children's distance learning education.

My participants said their domestic standard for keeping things picked up and cleanliness decreased because they had so much on their plates, they were exhausted and stretched thin. In one of my research questions, I wondered if the labor in the home increased, and as for my participants, the usual domestic responsibilities in the home did not necessarily increase themselves. They had other factors that contributed to the increase in labor at home (e.g., distance learning).

Out of all my research questions, the only aspect that I was not able to address was participants' physical changes brought on by increased negative emotions, the experience of care work during a pandemic, increased demands due to children being at home, and risk of exposure. In my findings, I discussed the mental health strains including increased anxiety and PTSD. However, these mothers reported that for the most part, they did not have any serious physical issues because of COVID, aside from slight weight gain. This does not mean that they did not have any physical changes, but they were not reported during the interview. Out of all the mothers that I interviewed only one participant reported contracting COVID themselves.

There were limitations to this study. I only interviewed ten mothers, however, I still reached data saturation. This research is based on these ten women and their

experiences; however, this opens an avenue for future research. Another limitation was the timeframe for which I did interviews. Over the course of interviewing, we had increasing development to help with fighting COVID, including the vaccine which led to less stress for nurses as their workload decreased. I had some difficulty locating people to talk to me, and I argue that this is due to vaccine availability, and time constraint for these mothers. I was asking them for an hour of their time and my interviews were happening during different peaks of COVID. Another limitation is that my sample is all white. While I can only speculate, I would argue that this is due to my positionality as a white woman and the fact that most of my social networks are primarily and majority white.

CONCLUSION

In my interviews, I found themes that helped me answer my research questions. Based on these themes I was able to see that these women were affected immensely while working during COVID. The physical and emotional demands that came with working on the frontline bled into their homelives. They struggled with the sadness and heartbreak that came with the many losses of COVID. They came home to families that they were putting at risk because of their jobs and they had to switch straight into the "second shift" mindset. These mothers were constantly being pulled in different directions and needed by everyone surrounding them.

This research study posed a lot of new questions that could be looked at further in a future study or dissertation. Questions such as if these heightened emotions could be gendered, in that this increase in fear is seen more with mothers versus fathers. It would be interesting to interview more mothers to get a better saturation of data over a larger

number of participants. This could allow the opportunity to look further at the differences between marital status and children's ages. This was a limitation in this study. Another limitation was that I did not have variation in sexual orientation or race. All my participants reported themselves as heterosexual white women. Having a diverse participant set could help look at nurses working during COVID with an intersectional lens. It would be interesting to examine how gendered roles and notions vary across different cultural backgrounds as well as if these stereotypical gendered roles are reinstated in families of non-heterosexual partnerships.

Interviewing fathers (in the nursing profession) would be a compelling comparison, especially to look at the gendered stereotypes between the different parental roles. These are questions and research avenues that I would like to potentially develop into a dissertation. There are a lot of future research ideas that could come from this research.

This study looked at these mothers' experiences through a gendered lens. Their experiences were not easy, and these mothers hope they are at a place to begin regaining a sense of normalcy again. My goal was to not only bring their experiences as mothers to the forefront, but also as healthcare professionals. Bringing their voices front and center and hearing how this global pandemic has affected them.

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APPENDICES

Appendix A: Interview Guide

These demographic questions will be asked at the end of the interview so I can build a relationship with my participants before.

I. Demographics

1. Age
2. Gender
3. Sexuality
4. Race
5. Number of children
6. Children's ages
7. Partnered or not
8. Gender of partner
9. Rent or own
10. Region of country

II. Home Life Questions

I would like to start with asking you questions about how things have been at home.

8. Tell me how it has been for you as a mother since the pandemic outbreak back in March?
9. Walk me through a typical day at home for you on workdays and on your days off.
10. Tell me about how your children and your partner have been affected since the pandemic outbreak.

11. How have things changed at home since the outbreak? Have you had to take on extra labor at home? Or responsibilities? If so, tell me about them.

12. Who has had to take on more of the domestic role at home?

PROBE: Helping with the kids, and daily household chores
PROBE: How so?

13. What about your partner, have they also had an increase in responsibilities? Have they stepped up to help you with home duties and childcare duties?

14. Were you effected by the childcare or school closures? How was that?

15. Are you child or children having to do distance learning? Tell about the experiences of your children going to school or learning at home since the pandemic occurred?

    PROBE: Who helps more with your child/children's distance learning?

    PROBE: Can you walk me through a day of distance learning with your child/children?

16. Have you contracted covid? If not, has anyone in your family?

PROBE: What were those experiences?

III. Work Related Questions

I would now like to ask you some questions about your job and how it has been since the outbreak.

1. Let's begin with, how long have you been a nurse?

2. Tell me about your experiences working as a nurse since March, or when the pandemic outbreak in the U.S.
   i. PROBE: What was the most challenging?
3. Walk me through a typical workday for you, and then a typical day at home when you get off work or have the day off.
4. How have the demands of your job changed since the COVID-19 outbreak? PROBE: Can you give me detail about the different aspects of your job?
5. Have you had to take on extra hours at work? Have you been asked to work less? PROBE: Can you elaborate on this?
6. How has your experience with getting proper PPE been like? PROBE: Have you had any problems with accessing proper PPE?
7. Describe work challenges that you have you faced because you work in healthcare that you think others not in the medical field don't think about? What difference do you think there are between healthcare workers and non-healthcare workers during this pandemic?

IV. Reflective Questions

17. What have been some of the hardest challenges for you since the beginning of this pandemic?
18. What are some of the fears that you have had since the outbreak?
19. Do you think about leaving the workforce? Why or why not? Do you know others who have left?

V. Mental and Physical Health Questions

Finally, I would like to ask you a couple of questions about your physical and mental health.

20. Have you faced any mental health challenges since pandemic started or mental health issues that have gotten worse? Depression, anxiety, panic, etc.? Tell me about those experience.
21. Have you faced any physical health effects due to extra stress, covid, workload, etc.? If so, tell me about that?

Last Question

22. Is There anything I should have asked but didn't ask?

Appendix B: IRB Approval

IRB

INSTITUTIONAL REVIEW BOARD
Office of Research Compliance,
010A Sam Ingram Building,
2269 Middle Tennessee Blvd Murfreesboro, TN 37129 *FWA: 00005331/IRB Regn. 0003571*

IRBN001 - EXPEDITED PROTOCOL APPROVAL NOTICE

Monday, February 22, 202

Protocol Title	***We Are More Than Just Nurses"; Working Mothers in Nursing and the Effects of COVID-19***
Protocol ID	**21-2109 7v**
Principal Investigator	**Autumn Martin** (Student)
Faculty Advisor	Ashliegh McKinzie
Co-Investigators	NONE
Investigator Email(s)	*Arm7j@mtmail.mtsu.edu; ashleigh.mckinzie@mtsu.edu*
Department	Sociology
Funding	**NONE**

Dear Investigator(s),

The above identified research proposal has been reviewed by the MTSU IRB through the **EXPEDITED** mechanism under 45 CFR 46.110 and 21 CFR 56.110 within the category *(7) Research on individual or group characteristics or behavior*. A summary of the IRB action is tabulated below:

IRB Action	**APPROVED for ONE YEAR**
Date of Expiration	**2/28/2022** *Date of Approval*: 2/22/21 *Recent Amendment*: NONE
Sample Size	TWENTY FIVE (25)
Participant Pool	*Target Population:* Primary Classification: **Healthy Adults (18 or older)** Specific Classification: **Mothers with children under the age of 18**
Type of Interaction	Virtual/Remote/Online interaction ☒ In person or physical interaction – Mandatory COVID-19 Management ☐
Exceptions	1. Verbal consent is permitted with documentation for Zoom interviews. 2. Voice recording is allowed with permission and documentation.
Restrictions	**1. Mandatory ACTIVE Informed Consent.** **2. Other than the exceptions above, identifiable data/artifacts, such as, audio/video data, photographs, handwriting samples, personal address, driving records, social security number, and etc., MUST NOT be collected. Recorded identifiable information must be deidentified as described in the protocol.** **3. Mandatory Final report (refer last page).** **4. CDC guidelines and MTSU safe practice must be followed**
Approved Templates	*IRB Templates:* Zoom Informed Consent and IRB Flyer *Non-MTSU Templates:* Recruitment scripts
Research Inducement	NONE
Comments	NONE

 Post-approval Requirements

The PI and FA must read and abide by the post-approval conditions (Refer "*Quick Links*" in the bottom):

- ***Reporting Adverse Events:*** The PI must report research-related adversities suffered by the participants, deviations from the protocol, misconduct, and etc., within 48 hours from when they were discovered.
- ***Final Report:*** The FA is responsible for submitting a final report to close-out this protocol before **1/31/2022** **(Refer to the Continuing Review section below)**; REMINDERS WILLNOT BE SENT. **Failure to close-out or request for a continuing review may result in penalties** including cancellation of the data collected using this protocol and/or withholding student diploma.
- ***Protocol Amendments***: An IRB approval must be obtained for all types of amendments, such as: addition/removal of subject population or investigating team; sample size increases; changes to the research sites (appropriate permission letter(s) may be needed); alternation to funding; and etc. The proposed amendments must be requested by the FA in an addendum request form. The proposed changes must be consistent with the approval category and they must comply with expedited review requirements
- ***Research Participant Compensation:*** Compensation for research participation must be awarded as proposed in Chapter 6 of the Expedited protocol. The documentation of the monetary compensation must Appendix J and MUST NOT include protocol details when reporting to the MTSU Business Office.
- ***COVID-19:*** Regardless whether this study poses a threat to the participants or not, refer to the COVID-19 Management section for important information for the FA.

Continuing Review (The PI has requested early termination)

Although this protocol can be continued for up to THREE years, The PI has opted to end the study by **1/31/2022**

The PI must close-out this protocol by submitting a final report before 1/31/2022 Failure t out may result in penalties that include cancellation of the data collected using this protoco delays in graduation of the student PI.

Post-approval Protocol Amendments:

The current MTSU IRB policies allow the investigators to implement minor and significant amendments that would fit within this approval category. ***Only TWO procedural amendments will be entertained per year*** *(changes like addition/removal of research personnel are not restricted by this rule).*

Date	Amendment(s)	IRB Comments
NONE	NONE.	NONE

Other Post-approval Actions:

The following actions are done subsequent to the approval of this protocol on request by the PI/FA or on recommendation by the IRB or by both.

Date	IRB Action(s)	IRB Comments
NONE	NONE	NONE

COVID-19 Management:
The PI must follow social distancing guidelines and other practices to avoid viral exposure to the participants and other workers when physical contact with the subjects is made during the study.

- The study must be stopped if a participant or an investigator should test positive for COVID-19 within 14 days of the research interaction. This must be reported to the IRB as an "adverse event."
- The MTSU's "Return-to-work" questionnaire found in Pipeline must be filled by the investigators on the day of the research interaction prior to physical contact.
- PPE must be worn if the participant would be within 6 feet from the each other or with an investigator.
- Physical surfaces that will come in contact with the participants must be sanitized between use
- **FA's Responsibility:** The FA is given the administrative authority to make emergency changes to protect the wellbeing of the participants and student researchers during the COVID-19 pandemic. However, the FA must notify the IRB after such changes have been made. The IRB will audit the changes at a later date and the FA will be instructed to carryout remedial measures if needed.

Data Management & Storage:
All research-related records (signed consent forms, investigator training and etc.) must be retained by the PI or the faculty advisor (if the PI is a student) at the secure location mentioned in the protocol application.

The data must be stored for at least three (3) years after the study is closed. Additional Tennessee State data retention requirement may apply (*refer "Quick Links" for MTSU policy 129 below*). The data may be destroyed in a manner that maintains confidentiality and anonymity of the research subjects.

The MTSU IRB reserves the right to modify/update the approval criteria or change/cancel the terms listed in this letter without prior notice. Be advised that IRB also reserves the right to inspect or audit your records if needed.

Sincerely,

Institutional Review Board
Middle Tennessee State University

Quick Links:

- Post-approval Responsibilities: http://www.mtsu.edu/irb/FAQ/PostApprovalResponsibilities.php
- Expedited Procedures: https://mtsu.edu/irb/ExpeditedProcedures.php
- MTSU Policy 129: Records retention & Disposal: https://www.mtsu.edu/policies/general/129.php