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**I AM ONLY ONE PERSON: BLACK WOMEN AS CAREGIVERS MAINTAINING THE
WELL-BEING OF THEIR FAMILIES AND COMMUNITIES DURING THE COVID
PANDEMIC**

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Abstract

The start of the COVID-19 pandemic led to an unprecedented international health crisis. Black families in the U.S. were disproportionately impacted by the U.S. response to the pandemic, with the highest rates of contagion and mortality, the highest percentage of frontline workers across industries, and increase in ongoing community challenges (HIV/AIDS epidemic, incarceration, community resources). Frontline workers experienced uniquely demanding work environments with regular exposure, limited flexibility, and the worry about exposing young and/or frail loved ones, specifically in multigenerational homes. For professional Black women in health care settings, many of whom function as head of household or single wage earners for multigenerational households, the impacts of the pandemic shut down created and intensified these challenges. This dissertation uses Ecological Systems Theory, Black Feminist Thought, and a Social Determinants of Health Framework to explore the experiences of Black women who left the paid workforce to become full-time caregivers for dependent children and frail family members. Specifically this dissertation sought to examine:

1. *What impacts did the COVID-19 pandemic and pandemic-related shutdowns have on Black families, particularly on Black women, who were employed full-time in frontline jobs and responsible for family caregiving?*
2. *How did Black women understand and experience the intersections of psychological, physical, and traumatic effects of the COVID-19 pandemic with systemic racism, discrimination, and oppression?*
3. *How did single Black mothers who are the sole wage earners for their households provide for their multigenerational families under duress?*

This dissertation used a qualitative, oral history method, which fits with the cultural histories of Africans for centuries and for African Americans since the start of slavery, to preserve the voices and stories of communities. Fourteen women recruited from targeted Facebook groups completed two semi-structured interviews at two-week intervals. Interviews were conducted on Zoom, recorded, and transcribed verbatim for analysis. From these 14 interviews, three cases were selected to for analysis to ensure representation across the sample on common themes. One composite case study was constructed to show representation, and two additional case studies show unique cases. These were each coded line-by-line for common themes, and then stories were constructed using narrative methods.

Findings from this study suggest that these women felt forced to choose between participation in the paid labor force and safe participation in the care and maintenance of family life. Careers financially supported these women and their families and provided personal fulfillment. This added to feelings of loss and isolation. A major feature pushing Black women to leave the workforce included experiences with racial discrimination regarding work schedules, limited safeguards against COVID-19 exposure, and the lack of flexibility to work from home. Though many women wanted to prioritize the needs of Black patients in these health care settings, they felt they needed to prioritize the needs of their families. Finally, participants reported their multiple family, community, and work roles become increasingly complicated during the pandemic with fewer of the supports they used to cope prior to the pandemic. Placing themselves last, in combination with the loss of common spaces and supports, meant participants needed to find strength in new places and comfort in new ways.

In conclusion, this dissertation suggests oral histories are appropriate ways to collect diverse stories from Black women's experiences. Black women navigated multiple roles and often competing priorities before the pandemic, which presented challenges that increased as community supports shut down and workplace policies reacted to global change. A pervasive narrative in all interviews was the need for quality and reliable care for children and for elderly family members. This research suggests the need for the development and implementation of policies that include job protections and allowing for paid time off during a crisis such as a pandemic. In direct practice, use of culturally specific methods and theoretical frameworks that recognize and name the intersections of multiple roles, pressures across systems levels, and competing priorities and values will support women facing impossible choices.

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Chapter 1

Introduction

Statement of Purpose

The 2019 outbreak of SARS-COV-2, informally known as the COVID-19 (COVID) virus, engulfed the globe in a pandemic that led to, arguably, the world's single biggest health crisis in modern times since the HIV/AIDS epidemic of the 1980s. In 2021, the World Health Organization (WHO) stated that COVID-19 had the highest rate of infection and death with an estimated 5.04 million deaths worldwide to date (World Health Organization, 2021). This was likely a conservative estimate as not all deaths from COVID-19 were recorded and errors in cause of death may have occurred in many cases (Centers for Disease Control, 2022).

Alarming findings from this data include the racial and economic disparities in infection rates, hospitalizations, and deaths. The pandemic's impact in the United States highlighted historical inequities by race, ethnicity, and income that are continuing to be perpetuated today. According to the American Public Media (APM) Research Lab, in the first six months of the pandemic, the breakdown of COVID-19 related deaths recorded in the U.S. reflected that Black, Latino, and Native American people accounted for a disproportionately higher impact of COVID-19 with 52% of the diagnoses and 57% of fatalities nationwide (Hardy & Logan, 2020). During this period, COVID-19 was the third leading cause of death for Black Americans behind diabetes, strokes, and pneumonia (Hardy & Logan, 2020) and disproportionately higher in communities with larger Black populations (Getachew et al., 2020). Contributing to those poorer outcomes was the far greater likelihood that Black and Latino Americans lived in poverty and resided in neighborhoods with overcrowded households, air pollution, and inadequate access to health care (Getachew et al., 2020). Historically, poor housing conditions and denser living quarters are found in communities of color to cut expenses across extended family groups and

generations, which also increased the transmission of COVID-19 (Snowden & Graaf, 2020). Further, the overlapping of three ongoing epidemics COVID-19, the drug crisis, and HIV/AIDS has contributed to excess stress and burden on communities of color (Stephens et al., 2021). These co-occurring pandemics, called a syndemic together (Stephens et al., 2021), have compounded emotional, financial, and social hardship in Black communities.

Beyond its toll on physical health the pandemic pushed the U.S. into an economic recession, which typically impacts already disadvantaged people more severely than the rest of society (Wilson, 2020). COVID-19 created complex challenges in the Black community by further widening the health and economic gap (Gould & Wilson, 2020). During the pandemic, Black workers disproportionately suffered job losses and were disproportionately among essential workers (Snowden & Graaf, 2020). Due to decades of discriminatory practices in the workplace favoring white workers, wealth accumulation for Black families has been overwhelmingly non-existent (Khanal et al., 2021; Snowden & Graaf 2020). Blacks have much less cash reserve on hand for emergency and crisis situations and fewer structural supports to address crisis situations. This includes a lack of resources to enable continued workforce engagement for Black workers, specifically the lack of childcare, eldercare, transportation, and livable wages (Khanal et al., 2021; Snowden & Graaf 2020).

In March 2020 and throughout the pandemic, as critical institutions such as schools and senior community centers went and remained offline, family members were forced to re-organize daily life to achieve basic tasks of survival. Consequently, the pandemic had catastrophic impacts for primary wage earners, primarily women in Black families, who faced the impossible choice of remaining in unsafe working conditions without structural supports or health protections or leaving the workforce without a financial safety net to provide tangible support

and care to their families and communities (Brown, 2020). The COVID-19 pandemic, like the historical and present HIV/AIDS and drug pandemics, caused particularly challenging conditions for Black women in their families and communities. One in four Black women report being caregivers for small children and/or ill and disabled family members (LePage, 2022).

We do not yet understand how African American women navigated complex choices regarding navigating roles as primary breadwinners and as primary caregiving as pandemic-shuttered services that supported family-life before the pandemic became unavailable. This dissertation uses a narrative methodology, long vital to cultural survivorship and community building in the African American community (Fulton, 2006), to build a complex, comprehensive, systems- and oppression-attentive picture of the pandemic experience for working-class African American women who left paid work to provide familial home-based caregiving during the pandemic. This dissertation may inform policy interventions around family care, paid work force participation, and the resource allocation for families living at or near the poverty line.

Chapter 2

Review of Literature

This research study examined African American social workers and nurse professionals who worked on the frontlines in health care settings during the COVID-19 pandemic who also functioned as primary caregivers to dependents, primarily small children and elderly family members. Prior to the pandemic, African American families experienced the daily effects of systemic racism. The COVID-19 pandemic shed a glaring light on systemic racism and its intersection with other systems of oppression (Banaji et al., 2021). Some of the ongoing issues that the African American community experience includes income gaps, health care disparities, limited access to fresh food, inadequate housing, poor schools, police brutality, gun violence, and the list goes on. The convergence of these issues with the COVID-19 pandemic led to increased expectations and responsibilities for African American women (Vasquez Reyes, 2020).

Dissertation Aims

The research aimed to develop a deep understanding of how Black women navigated multiple, often conflicting roles during the COVID-19 pandemic and how they coped with decisions made in the face of unprecedented challenges. This research is contextualized in the experiences of African American women navigating overlapping social determinants of health that have historically prevented them and their families from having equitable opportunities for economic, physical, and emotional health. This dissertation's literature review draws from sociology, economics, labor statistics, and qualitative research methods. I also draw on pandemic news stories addressing racial and ethnic health disparities, the experiences of frontline workers, and the aftermath of the pre-vaccine pandemic year. I use the terms "African American" and "Black" interchangeably throughout this dissertation. I pull from the literature on the social determinants of health to understand how people lived, learned, worked, played, and worshiped

across a wide range of health risks and outcomes (Barr, 2019). My conceptual framework is informed by ecological systems theory in terms of the ways systems of oppression and opportunity structure the lives of Black women and their families; histories of Black Feminist Thought (Collins, 2009); and the tradition of oral history in Black communities inform the use of a resounding method for capturing and communicating knowledge, history, and experience between generations (Mulvihill & Swaminathan, 2021).

The roles of Black women in their communities historically have been multifaceted, extensive, and load-bearing. From slavery to present day, Black women have been the keepers of Black culture and Black traditions, rendering them essential to the survival of, and continuity of, Black families of all relationship configurations and in communities (Berry, 2021). Black women are often responsible for the spiritual well-being, financial stability, educational tutelage, and emotional well-being of their families and communities (Hine, 2007). Though these roles may be experienced in unique ways based on age, era, and need (Edwards, 2000; Gross, 2015), the women who occupy these roles may share the experience of being neither sheltered nor protected by others inside and outside Black communities. In this literature review, I will explore how the social determinants of health, over time, have contributed to the experiences of Black women during the pandemic.

Social Determinants of Health

The social determinants of health include environmental, social, and behavioral factors in an individual or group's environment that shape their ability to achieve health and well-being (Singu et al., 2020). These include economic and food stability, access to health care, education, physical neighborhoods, and social contexts (Barr, 2019). The combination of these factors impacts health and mental health on a daily basis and over the course of life. In this section, I

review literature on these factors as they relate to the health and well-being of African American women.

Financial Stability: Work and Pay

African American women are amongst the most educated group in our society; however, they remain amongst the most impoverished (National Center for Education Statistics [NCES], 2021). Over the past several decades, education and employment statistics have shown that Black women achieve higher levels of education than Black men and are more likely to be employed (versus Black men being under-employed) (Goodman et al., 2021). Across socioeconomic status, African American family heads are increasingly more likely to be women than men (Goodman et al., 2021). The trend of female-headed households is shared across racial and ethnic groups; between 1990 and 2019, the share of households headed by women increased from 17% to 22.6%, and by 2019, households headed by women accounted for half of all households, with Black households having the highest share of households headed by women (52.5%, Goodman et al., 2021). Other trends that have contributed to high rates of Black women householders include the AIDS and drug epidemics in the United States and systemic injustices in police and carceral systems that disproportionately target and incapacitate Black men (Stephens et al., 2021; Gross 2015). This makes these men, from a young age, less able to pursue higher education or seek gainful employment. And this was before the COVID-19 pandemic hit. The United States Bureau of Labor Statistics reports, “African American women that are employed full-time minimum wage earners do so at a higher rate than any other racial group” (Katz, 2020). Due to systemic racism and the wage gap between African American women and their white counterparts, African American women earn 64 cents for every dollar they make compared to 79 cents earned by their white female counterparts (National Partnership for

Women and Families, 2022, October 6). Most African American women work at least two jobs to support and provide for their families to make ends meet (Frye, 2021). The wages earned by African American women are often not enough to afford homes in resourced neighborhoods. Further, wage work often means African American employees have no access to paid leave or other benefits that support work-life balance.

Structural racism in the workplace contributes to limited household income and cash reserves in Black families. Decades of discriminatory practices in the workplace favoring white families have meant wealth accumulation for Black families has been overwhelmingly non-existent (Khanal et al., 2021). As a result, Black families may have limited built savings to endure crises and financial hardships. The Black poverty rate in this country is significantly higher than the white poverty rate; one in five Black Americans live below the poverty level, which is currently set by the federal government at \$26,000 for a family of four (Stewart et al., 2022). Considering these factors, Black families are more likely to have limited, if any, cash reserve on hand for emergency and crisis situations, fewer structural supports to address crises, and catastrophic impacts for primary wage earners leaving the workforce due to disaster-related events. The COVID-19 pandemic was certainly a crisis situation.

Employment trends during the initial stages of the COVID-19 pandemic across industries indicated many frontline workers were women and men of color working low-wage jobs (Frye, 2021). In health care, to function as primary care centers for COVID-19 and all other medical conditions served by hospitals, staff from specialty physicians to nurses and social workers to sanitation and food preparation workers worked in-person shifts, often for long hours, and with little respite. African American women were a part of each of these categories, and though this

dissertation focused on college-educated, largely middle-class, health care workers, Black women across all these demographics faced unique and shared challenges (Chinn et al., 2021). Research on COVID-related employment identified three categories of employees in the COVID-19 crisis: first, many lost their jobs and faced economic insecurity; second, many were classified as essential workers and faced health insecurities; and third, some worked remotely from the safety of their homes (Aleem et al., 2023). According to The Economic Policy Institute, in June 2020, the national unemployment rate was 17.4% for Blacks, 16.9% for Hispanics, 13.3% for Asians, and 10.8% for whites (Economic Policy Institute, 2020). Since the start of the pandemic, Black workers disproportionately suffered job losses while, at the same time, they were disproportionately represented among essential workers (Wilson, 2020b). According to Casara, African American women accounted for 36% of the frontline workforce during the pandemic compared to 21% of their Caucasian counterparts (Casara et al., 2020). Working in those frontline positions put African American women at a high risk of exposure. Working in the center of high-risk exposure not only exposed these women to COVID-19 personally, but placed their families at risk through contagion at home, creating added risk for the African American community as a whole.

Black-owned businesses were overwhelmingly concentrated in industries hit hard by COVID-19-related reduced demands (Griffin et al., 2021). These industries included accommodation and food services, retail and health care, and social assistance, a category that experienced the largest losses. Black businesses account for 95% of the self-employed/sole-employed businesses in the United States (Perry et al., 2022), which amounts to devastating losses for entire communities that rely on the economic exchanges related to these businesses.

Also lost were pride and community building, investments of time and money into starting a business, and the opportunity to grow wealth and achieve stability.

Wage Work, Generational Wealth, and Systematic Discrimination

During the pandemic, many Black families had few liquid assets to cope with illness-related expenses, compensate for work days or jobs lost, or care for dependents. Often, accumulated wealth in working or middle-class Black families is tied up in real estate assets, which remain inaccessible when experiencing a sudden loss of income. Overall, white families' liquid assets are five times higher than that of Black families, with white families having, on average, \$49,529 of cash reserved compared to Black families having \$8,762, on average (Wilson, 2020). The wealth gap persists across levels of education. In fact, the gap in liquid assets is larger for Black and white college-educated families (Hanks et al., 2019). In the context of co-occurring economic challenges, housing and food insecurities and the absence of high-quality childcare are just a few problems that added stress for Black families.

Unequal Education

The majority of African American children live in school districts that are underfunded and lack resources for quality education. The funding gap between African American and Caucasian students is at least \$5,000 to \$6,000 per student (Shores et al., 2020). During the early phases of the pandemic, schools shut down to limit the spread of the COVID-19 virus. Limited school and community resources meant African American students did not have the basic necessities to be successful at home. In addition, many children lost access to proper nutrition that had previously come through school-based meal programs.

When school systems switched from in-person to virtual instruction, issues arose for parents and other caregivers in providing structure and infrastructure to support educational continuity. African Americans often lacked the infrastructure to meet virtual educational

requirements, as 34% reported no home broadband access, and 30.6% with one or more children aged 17 or under lacked high-speed internet and a computer (Joint Center, 2021). For those with access to virtual technologies, parents/caregivers needed to be home with smaller children to help navigate technology and assist children with schoolwork. Parents/caregivers also had to provide a means for children's activity and recreation during the day.

Health Care: Access Before and During the COVID-19 Pandemic

For Black communities, the COVID-19 pandemic may be considered the most recent contributor to a syndemic, indicating the three concurrent epidemics of COVID-19, the drug crisis, and the ongoing HIV/AIDS epidemic. The overlap of the three epidemics added excess stress and burden on communities of color. Striking similarities exist between the experiences and impact of the HIV/AIDS epidemic going back over four decades and the current COVID-19 in communities of color. The National Academy of Sciences reported 70% of health outcomes in communities of color are due to limited access to health care, socioeconomic factors, environmental conditions, and housing (Millett, 2020). Structural racism and discrimination against people of color overwhelmingly contributed to a higher risk of exposure, contagion, and death due to both HIV/AIDS and COVID-19. Not surprisingly, in mid-April 2020, 22% of U.S. cities with high concentrations of Black and brown residents accounted for 52% of COVID-19 diagnoses and 57% of deaths nationwide (Ray, 2020).

Several environmental factors increased the risk of severe infection prior to the start of the pandemic. The water and air quality in predominantly Black and brown neighborhoods were substandard, causing a wide variety of health problems (Bullard & Wright, 1986; Henderson & Wells, 2021). Chemical pollution, noise pollution, and poor infrastructure date back decades. As a result, 9% of African American adults and 14% of African American children have asthma and

a host of other negative health conditions (Ohio State University, 2019), placing them at higher risk for long term COVID-19 complications (Terrell & James, 2020).

African American families are often uninsured or underinsured, which means that they have high out-of-pocket health care costs (Taylor, 2019). Additionally, African Americans are less likely to get needed medical care due to fear and distrust of the health care system (Moreland-Capuia, 2021). This further exacerbated obstacles in receiving *preventive* care and meeting with knowledgeable providers. Further, African American women are historically untreated/undertreated (Okoro et al., 2021; Obinna, 2020). The U.S. Department of Health and Human Services reports that Black and brown people receive the worst care on 40% of the department's care quality measures (Trawalter, 2020). According to Trawalter, racial disparities are striking in pain treatment as Black patients are less likely to be prescribed pain medication as they are *still* believed to have thicker skin and shorter nerve endings than Caucasians (Trawalter, 2020). The previous is a myth that multiple erroneous claims have supported.

Distrust/mistrust of health care systems dates back decades to three historical atrocities experienced in the African American community: Dr. Sims' surgical experimentation on enslaved women, the recently emerged story of Henrietta Lacks, and the Tuskegee Experiment (Bajaj & Stanford, 2021). African Americans, in particular African American women, have "contributed" to the field of medicine for decades, much to their own harm (Moreland-Capuia, 2021; Owens & Fett, 2019). As a result of these failures, distrust/mistrust of health care professionals is pervasive and protective. The consequences of this mistrust played out in rates of vaccination and treatment-seeking for COVID-19 infection (Bogart et al., 2021), causing further stress and strain on African American women who provided care.

During the Pandemic: African American Health, Mortality, and Access to Care

Black/African American, Hispanic/Latino, American Indian, and Alaska Native persons in the United States experienced higher rates of COVID-19-related hospitalization and death compared with non-Hispanic White populations (Gawthrop, 2023). An article on COVID-related deaths up to September 2020 reported that Black Americans COVID-related death rate sat at 97.9 per 100,000, Hispanic death rate of 64.7 per 100,00, with White deaths at 44.6 per 100,000 and Asian Americans at just 40.1 per 100,000, indicating Black Americans had the highest mortality rates (Vasquez Reyes, 2020). By the end of 2020, COVID-19 was the third leading cause of death in the Black community. Prior to and throughout the first year of the COVID-19 pandemic, Black communities experienced disproportionately high rates of preventable disease, disability, and death due to structural barriers to prevention care, access to insurance, and treatment. These disparities persisted even when accounting for other demographic and socioeconomic factors, such as socioeconomic status and geography (Wilson, 2020). African American women experienced particularly elevated risk; an analysis of COVID-19 deaths by race and sex in Georgia and Michigan found that African American women died at more than three times the rates of white men and Asian men. The only other group more likely to die from the disease was Black men (Rushovich et al., 2021).

A variety of factors likely contributed to why African American women experienced the highest risk and mortality due to COVID-19 (Cusick et al., 2021). An exploration of these is outside the scope of this dissertation. Yet, I suggest significant contributions from their dual and conflicting roles as frontline workers and primary family caregivers during the first year of the pandemic.

Housing and Food Insecurity

Economically driven family structures and housing arrangements further influenced the impact of COVID-19 on Black communities due to dense living quarters (Snowden & Graaf, 2020). This means Black women were living in overpopulated homes and managing often complex care needs prior to the start of the COVID-19 pandemic. Historically, individuals in Black communities, similar to Latinx communities, have several generations living together in one residence to consolidate finances and enable easier elder and childcare. According to the Pew Research Center, 26% of African American families live in multigenerational homes compared to 13% of their Caucasian counterparts (Hardy & Logan, 2020). These situations also made vulnerable populations more vulnerable by increasing the risk and rates of transmission of COVID-19 in these homes. For example, preexisting health conditions, such as hypertension and lung disease, in the Black community led to a high mortality rate from COVID-19 infection (Wilson, 2020).

Many poor or impoverished African Americans live in food deserts and consume diets that date back to slavery. Before the first enslaved people arrived in America in 1619, their cuisine consisted of plant-based, natural, and healthful components. Upon their introduction to America, Africans were exposed to harsh conditions on slave ships and plantations. During slavery, they were forced to “adapt and change their diet, as they encountered new nutritional, disease, and work environments” (Vance, 2012, p. 7). The adaptations made during slavery created a unique cuisine called soul food, which is still maintained today (Vance, 2012). These meals relied on affordable items, can make more than one meal, and are readily available. This diet is likely to contain foods that are fried and/or processed foods and high in fat, sodium, and sugar. The scarcity and lack of affordability of fresh produce within their neighborhoods due to limited access to grocery stores, health-conscious restaurants, and farmers’ markets leave

communities of color with little choice for healthy nutrition (Barker et al., 2012). Consumption of high-fat, salt, sugar, and processed foods contributes to chronic disease risk within the African American community (Barker et al., 2012), and leads to predisposition to chronic obesity, diabetes, and hypertension. These diseases weakened the immune system, further contributing to poor COVID-19 outcomes (Barker et al., 2012).

Since African American families often have multiple generations and family members living in the household, it is hard to put food on the table continuously. Food pantries are often utilized to fill in the gap. African American children who only get a hot meal or food from school lost this public benefit when schools closed, increasing need and growing food insecurities.

Health Care Policies in Black Communities and Red, White, and Blue States

The COVID-19 pandemic exposed many shortcomings in our public health infrastructure. The Affordable Care Act (ACA), signed into law under the Obama Administration, gave health care access to twenty million formerly uninsured people (Obama, 2016). However, a component of the ACA extends health care to low-income individuals through Medicaid. To date, not all states have elected to expand their Medicaid program. The states that elected not to participate in the expansion are mainly conservative “red” states with a high concentration of Black and Latino populations (Glied & Weiss, 2023).

The “race-neutral” policies implemented to minimize the impact of these disparities by race, ethnicity, gender, and class, such as The Heroes Act, were written to ease social and economic hardships and give people in marginalized communities access to health care. The Heroes Act prohibited employees from retaliating against workers who voiced their concerns about safety in the workplace. Provisions in the Heroes Act expanded COVID-19 testing

capacity in underserved communities. Also, the Act expanded unemployment benefits for those who lost their jobs due to COVID-19. Those who lost jobs also lost insurance, paid sick, and paid family leave. Yet, the Heroes Act and other similar policies left major gaps in supporting workers who “chose” to leave the formal labor market due to family and community pressures, fear of family contagion for those with immunocompromised loved ones (such as those living with AIDS), and other financial measures (Hardy & Logan, 2020).

Programs such as Ryan White, offered by the Department of Health and Human Services, shifted their focus to concentrate on COVID-19 relief (Ryan White HIV/AIDS Program, 2020). Workers of color were also more likely to be uninsured than any other group prior to the pandemic. This gap increased with job loss during the pandemic. By the end of 2020, many families with a decent (or better) standard of living found themselves living below the poverty line (Martin et al., 2020; Bureau of Labor Statistics [BLS], 2022).

Research Questions

Together, this literature suggests a unique combination of factors shaped (and limited) options for Black families to cope with pandemic-related shutdowns. Yet, little evidence suggests how families, particularly women, navigated competing demands of contagion risk, financial need, or family roles. Of particular interest here is developing an understanding of how Black women who functioned as primary breadwinners and householders navigated, and eventually left, “frontline” jobs in health care settings during the pandemic. This dissertation sought to answer the following questions:

- What impacts did the COVID-19 pandemic and pandemic-related shutdowns have on Black families, particularly on Black women, who were employed full-time in frontline jobs and responsible for family caregiving?

- How did Black women understand and experience the intersections of psychological, physical, and traumatic effects of the COVID-19 pandemic with systemic racism, discrimination, and oppression?
- How did single Black mothers who are the sole wage earners for their households provide for their multigenerational families under duress?

Chapter 3

Theoretical & Social Work Informed Perspectives

This dissertation uses ecological systems theory as the foundation for understanding Black women's experiences during the COVID-19 pandemic. In addition, a social determinants of health framework lays out additional factors implicated in Black women's experiences prior to the start of the pandemic that placed them in precarious positions socially, economically (work, family, and community finances), and with regard to their mental health. Finally, the perspectives of Black Feminist Thought use a critical theory frame for understanding the context and factors that shape choices and experiences of Black women.

Ecological Systems Theory

Urie Bronfenbrenner was a Russian-born American developmental psychologist who developed Ecological Systems Theory. Bronfenbrenner saw the process of human development as shaped by the interaction between an individual and their environment (Bronfenbrenner & Crouter, 1983). As such, "Bronfenbrenner's scheme is a system of concepts: the person exists in a system of relationships, roles, activities, and settings, all interconnected" (Shelton, 2019, p.10). Bronfenbrenner identified four interacting systems that shape human development over time. These include the microsystem, mesosystem, exosystem, and macrosystem. Bronfenbrenner suggested that individuals cannot be separated and understood apart from the factors in each of these systems. Finally, Bronfenbrenner understood these systems would change over time; adding the chronosphere to the model brings historical forces together with the possibility of future change (Bronfenbrenner, 1986, p. 724).

Bronfenbrenner's framework is often applied from the inside out, starting with the smallest systems, the individual and their family or social networks, and moves out through larger systems to understand their interconnectedness. This approach presumes humans have the

power and privilege of agency, to change the larger systems that shape their behavior. However, when considering African American women in the center of these systems, starting from the center does not respect the systemic and structural forces of discrimination, persecution, and profiling that have shaped their experiences and their families' experiences. This theoretical exploration will start with the macrosystem, the largest set of factors that influence how Black women experience employment, roles, community connection, family support, and psychological distress, and coping. Following is a discussion of how ecological systems shaped the pivotal roles Black women played in their communities and families during the COVID-19 pandemic.

Bronfenbrenner defined macrosystems as characteristics of a given culture or subculture (Bronfenbrenner, 1979, p. 26), with particular reference to the belief systems, bodies of knowledge, material resources, customs, lifestyles, opportunity structures, policies, hazards and life course options that are embedded in each of these broader systems (Shelton, 2019). The macrosystem encompasses the broad historical and contemporary forces that shaped disaster response to the pandemic, found Black bodies on the front lines in essential roles during the pandemic, and limited resources at all systems levels for personal, family, and community response to pandemic shutdowns.

Particularly for African American women, macro systems are historically structured to reinforce patterns of systematic discrimination which contribute to ongoing and historical trauma, damaging stigma, multiple coinciding pandemics (e.g., HIV/AIDS, Substance use), and pervasive health and mental health policy impacts across generations that bleed down into smaller systems. Examples of systematic discrimination that relate to this dissertation involve public policies governing access to health care and affordable housing. Further, years of

predatory and/or discriminatory lending have completely depressed generational wealth building (Lusardi & Mitchell, 2014). Together, these policies have limited upward mobility through diminished educational, occupational, and housing resources.

Exosystems are defined as the structures, policies, and public institutions that individuals generally do not participate in, but that structure daily life (Bronfenbrenner, 1979, p. 25). These include workplace structures, public policies and plans, policing and prison pipelines, public transportation and housing policies, funding for schools, and health care access and discrimination. This dissertation studies the decisions made by Black women in essential jobs early in the pandemic between remaining in paid jobs versus staying home to protect and care for dependents. Therefore, the workforce is an important factor to consider in the exosystem. Exosystems also include those public systems that monitor Black families, including the police, prisons, child welfare, and financial systems that take advantage of poor families. These systems require African American families, and women in particular, to protect their communities, often together, from these systems that seek explicitly, historically, or implicitly to enter into and disrupt the Black family and community life (Collin, 2005).

The mesosystem includes the relationships and connections between important people, and the contexts and places where these relationships occur and in which the person actively participates (Bronfenbrenner, 1979, p. 25). In this dissertation, mesosystems of interest include families of single and partnered women, extended biological and legal family members, and individuals that function in familial roles beyond the biological and legal ties. This framing of family was chosen to mirror patterns dating back to slavery when families related by blood were replaced with families of choice and force due to the selling of slaves and the deliberate breaking of family ties. This pattern of creating families has sustained Black communities across the

country that are separated by legal systems, death, divorce, migration, and other social factors (Franklin & James, 1997). For this dissertation, mesosystems also include community centers, churches, and other places that provided care and assistance to Black families before the pandemic, that shut down during the pandemic, and that may or may not currently be resources for the participants in the study at the present moment.

The final system of significant interest to this dissertation includes workplace relationships with co-workers, bosses, administrators, and others in medical centers that served on the front line during the COVID-19 pandemic. Bronfenbrenner (1983) defines microsystems as a pattern of activities, roles, and interpersonal relations experienced by the developing person in a given setting with particular physical and material characteristics (Bronfenbrenner and Crouter, 1983). In this study, microsystems of interest include the daily roles which African American women occupied and may have been forced to choose between in order to provide support to family groups in the mesosystem. The roles include, but are not limited to, frontline worker, family breadwinner, caretaker for ill or older adults, parent to young children, or educator to children attending school online.

The impact of these roles, and changes in these roles, on African American women's mental health is also of interest, as is the overall self-report of mental well-being leading up to the pandemic. Mental health and well-being are a core part of the microsystem (Phillips & Lauterbach, 2017). Supporting mental health for oneself and one's family involves cultural patterns passed down through generations of mesosystems through direct teaching and oral history, media images of how to be strong or vulnerable, and opinions regarding seeking mental health care. For example, African American women are often conditioned to handle grief and loss quietly and to be strong in times of adversity (Moore et al., 2022; Reetz, 2023). They are

trained from a very early age to shield their emotions for their self-preservation and protection from society, often with limited support or resources from other systems. African American women may neglect their needs to care for family and community members.

A cornerstone of mental health and well-being for many American women is their faith, both as a conduit to persevere through suffering and as a means of connecting with others (Moore et al., 2022). African American women across economic situations may hold fast to that belief, particularly during times of crisis or trauma. Further, social taboos against asking for help and distrust of therapies offered by people with power (Moore et al., 2022; Wilkins, 2019) means African American women may not pursue self-care in ways that look like “normative” self-care (Moore et al., 2022; Reetz, 2023). Responsibilities to members of Black women’s micro- and mesosystems may also mean these women lack the time or resources to care for themselves. Ongoing crises, systematic violence against African American communities, and personal trauma or loss may contribute to toxic stress or even to post-traumatic stress disorder (or its symptoms, Ravi et al., 2023). This has been made worse by the burden of extensive AIDS, drug, and COVID-19 related losses across Black communities.

Black Feminist Thought

The Feminist movement has had four distinct waves (Malinowska, 2020). For the purposes of this dissertation this researcher will focus on the second and third waves. This discussion begins with Second Wave Feminism, which emerged in the 1960s and 1970s, was a delayed response which evolved from the return of the domesticity of women following World War II (Hayes, 2022). bell hooks credited Betty Friedan as the catalyst that paved the way for contemporary feminist thought and action (hooks, 2015). Friedan’s view of oppression focused on the plight of college educated, middle and upper class, married, Caucasian women like herself

that were relegated to stay-at-home maternal and wife roles. Friedan's perspective, though novel and important among many communities, was unidimensional as she did not speak to or consider the needs of single women without children, homes, nor those of non-white or poor white women (hooks, 2015). In fact, Friedan's feminism was critiqued for being built on the backs of women of color who often took low wage jobs without benefits or security to care for the children, homes, and lives of wealthier white women as they entered the workforce (Smith, 2013). This aside, Friedan is considered a principal shaper of contemporary feminist thought (hooks, 2015).

Unlike mainstream feminist movements, the Black Feminist movement was born due to the lack of advocacy for Black women's issues and struggles. Taylor stated, "African American women's collective Black feminist consciousness evolved during the second wave of feminism" (Taylor, 1998, p. 239). African American women developed a body of theories as a resistant knowledge project that reflected Black women's political interests.

Maria W. Stewart first introduced Black Feminist Thought as she challenged African American women to reject negative images of Black womanhood in media and public discourse, pointing out race, gender, and class oppression were the fundamental causes of Black poverty (Collins, 2009). Stewart was one of the first U.S. Black feminists to champion the utility of Black women's relationships with one another in providing a community for Black women's activism and self-determination.

Black Feminist Thought provides a synthesis of a body of knowledge that is crucial to putting in understanding the experiences of Black Women with their own voices, not to be studied but as owner and subject of their own experiences. This antiracist approach to scholarship sought to recognize and eliminate gender, race, and class inequalities (Collins, 2009).

Patricia Collins has identified Black Feminist Thought as critical social theory that encompasses bodies of knowledge and sets of institutional practices relating to questions facing U.S. Black women collectively. Collins (2009) asserted that Black Feminist Thought aims to empower African American women within the context of social injustice sustained by intersecting oppressions.

One core tenet of Black Feminist Thought is that African American women's self-definition and self-valuations are linked to self-reliance and independence (Alinia, 2015). Collins suggests that African American women, whether by choice or by circumstances, embody the spirit of independence and are self-reliant (Collins, 2009). One critical dimension of self-reliance is self-sufficiency. Collins (2009) has espoused Audre Lorde, whose belief of independent self-definitions empower African American women to bring about real and needed change. Collins further explored the work of Nikki Giovanni (Giovanni, 1996) who has connected self, change, and personal empowerment. Giovanni's stance is that people are rarely powerless no matter how rigid or oppressive their conditions may be; rather, all people have the power within themselves to change their circumstances. According to Collins (2009) many African American women assist each other to personal empowerment, whereby the ultimate responsibility for self-definition and self-evaluations lies within the individual woman to discover for herself.

Oral Histories in Feminist Movement

For the purposes of this dissertation, oral histories was the chosen as a conceptual framework and as a research methodology for data collection because they have been utilized in the African American community for decades to tell and preserve authentic stories and histories in Black communities. This approach prevents the white-washing of the academy, in which the

voices of marginalized communities suffer indignities of re-interpretation to serve the purposes of the white scholar rather than the uplift the speaker (Abel, 1993; Shockley, 1978).

The origination of oral stories/histories derived from African countries where individuals known as Griots were storytellers. The role of a Griot was an honor given to a responsible individual, one chosen to take seriously this role as they contributed to and were essential to the culture and its values (Ebine, 2019). The Griot ensured tradition, culture, history, knowledge and secrets were passed from one generation to the next (Ebine, 2019). According to Fulton (2006), women become sister griot historians due to their ability to combine literary traditions with African American oral traditions in narratives that resisted and confronted the silenced, dehumanized representation of the Black woman in the master(-slave) narrative. Fulton (2006) stated in her work *Speaking Powering* that "...with Black Feminist Orality, sister griot historians cross boundaries of oral and writing traditions, folk and intellectual thought, and theory and practice" (p. 124).

Oral history is a verbal recitation of tradition and history which comes from West Africa and is based on the storyteller's personal experiences (Smart, 2019; Perks et al., 2016). Oral stories enabled slaves brought from Africa to communicate to one another, sometimes used as code. During slavery, reading and writing were forbidden for enslaved individuals since this knowledge was believed to enable slaves to organize, share information across plantations, and challenge white plantation owners. Due to this history on American soil, African American culture and legacy were preserved through the use of oral history, stories told from one generation to the next that became shared understanding and coping (Ebine, 2019). These became ongoing communal strategies for the survival of family and kinship groups with shared culture and experience. Alternative forms of creating and communicating this history are still

used today in religious and cultural contexts of African Americans (Ebine, 2019). Much of this history is preserved specifically by African American women.

The feminist movement has relied on oral stories for decades to discuss the lived experiences of women (Iacovetta et al., 2018). Oral stories are a vehicle to integrate women's voices, perspectives, and experiences into historical scholarship, challenging the reigning definitions of social, economic and political importance that masked women's lives (Sangster, 1994). The significance of oral stories in the Black community is a means of passing on family history as a form of historiography, and also resists the dominant cultures' efforts to negate Black identity (Fulton, 2006). Oral stories are woven into the fabric of African American cultures and histories as a primary source of pride and knowledge of the tribulations and successes of African Americans. Oral histories are unique in that they may include stories, old sayings, songs, proverbs, and other cultural products that have not been written down or recorded (Ebine, 2019). Through these stories, credibility is given to the stories as a way to preserve knowledge over decades of atrocities against African American people. African American communities have used oral histories to control their narratives (Turner, 1990).

In the context of the COVID-19 pandemic, oral histories provide a uniquely attuned method to capture the essence of lived and shared experiences of individuals, particularly women, in African American communities from the storytellers' perspective. Storytelling in the African American community remains a window into the intimate details of a family and their community, and allows people to experience a family's accomplishments, defeats, tragedies, lessons, and betrayals. Such storytelling creates bonds, builds trust and coalitions, and establishes open lines of communications about shared experiences, giving a true account of events past and present that have shaped and molded their lives (Scott, 2019).

Oral histories in scholarship are not widely recognized or accepted means of understanding human experience. They do not follow the definition or epistemology of conventional research methods that require significant steps to verify and validate authenticity, as a mainstream “credible” source (Kim, 2008). Yet, oral stories and histories are of vital importance as they recognize the importance of giving space to and listening to marginalized voices. Soon Kim (2008) stated, “(t)he very methodology of the oral history method re-enforces hegemonic Western ideologies about race/ethnicity, gender and class perpetuated through the connection between the cultural identity of the speaker and the notion of authenticity as ground for academic authority” (p. 1364). Traditional methods of scholarship may be rigid and out of step with marginalized populations’ experience with research (Campbell et al., 2021). Oral histories can correct and add to historical record and allows an individual’s voice to be heard who might not otherwise share their experiences (Fulton, 2006; Bent-Goodley, 2006).

A few researchers have used oral histories as a core and critical methodology in research and dissertations. Bent-Goodley (2006) utilized oral histories in her work entitled “Oral Histories of Contemporary African American Social Work Pioneers.” Bent-Goodley focused on the perspectives and analysis of events through the lens of the storyteller. Bunch-Lyons’ (1997) work, entitled “No Promised Land: Oral Histories of African American Women in Cincinnati, Ohio,” broaches oral histories as avenues to engage with migration and immigration histories. Bunch-Lyons used oral stories to create a connection between African American women’s reflections on survival in a hostile environment during and after the Great Migration. In sum, oral histories are a compelling and powerful learning tool (Chancellor et al., 2016) and constituted, in combination with narrative analytic techniques, the methodological tools for this dissertation.

Chapter 4

Methodology

Research Design

This study used an oral history approach with narrative analysis to explore how Black women sought balance between caregiving responsibilities and being front line workers in health care centers, and eventually how they left the paid labor force, during the COVID-19 pandemic. This dissertation selected an oral history methodology to focus on deep listening to stories of individuals' experiences and shine light on the contexts and circumstances that shape how they view themselves and their histories (Creswell & Poth, 2018). A methodological approach that centers oral histories is consistent with the meaningful ways that Black culture and lived experiences of African Americans have been preserved from one generation to the next (Turner & James-Gallaway, 2022). For many important events, oral histories have captured the only, or the often unheard, account of an event, phenomenon, or crisis (Turner & James-Gallaway, 2022). Though some discredit the validity of oral history as non-empirical, for centuries verbal artistry has been relied upon to create, transmit, and preserve knowledge (Kim, 2008).

Storytelling is an essential and integral part of the intergenerational connection, culture, and history of Black people (Toliver, 2021, p. xiv). Toliver (2021) has discussed the epistemological stance, Endarkened Storywork, as a methodological framework that offers a specific way of considering oral histories, centering spirituality, nurturing, affirming, and truth telling in the Black community to honor non-Eurocentric ways of thinking about, doing, and writing scholarship. Endarkened Feminist Epistemology disengages from traditional white scholarship that aligns with the "objective" to explicitly normalize white experiences, methods, and knowledge (Toliver, 2021). This dissertation embraces the approach to research, prizing the

voices of marginalized and minoritized groups who experienced systemic oppression and have endured.

Eligibility

This study recruited Black/African American-identified women who were employed as social workers and/or nurses in frontline positions during the first calendar year of the pandemic. Specifically, this researcher recruited women with ongoing, direct patient contact in health care settings during the first year of the pandemic. The researcher selected this population because of their middle-class family status to showcase the ways education and income served (or did not serve) protective roles. This researcher also chose these frontline professionals due to their daily contact with patients in a hospital setting, incurring regular risk of contracting COVID-19, and their family-based leadership and caregiver roles where contagion and medical fragility might be particularly salient. This researcher defined caretaking as in-person, hands-on activities with financial and functional dependents such as assistance with school, assistance with activities of daily living (ADLs), and with medicine and meals. Specific eligibility criteria include that:

- Participants must identify as African American
- Participants at the start as of pandemic were employed as a nurse or social worker in a hospital or health care setting
- Participants have at least a Bachelor's degree
- Participants were the primary caregiver for at least one child under the age of 10 and/or an elderly/ill adult.

Sampling and Recruitment

This researcher recruited 17 participants using purposive methods, including nomination, maximum variation, and snowball sampling. Purposive sampling is a non-probability based strategy in which researchers identify individuals, groups, or entities based on a core set of

shared experiences, identities, challenges, or other phenomena (Padgett, 2009). Purposive sampling was appropriate to this study to identify individuals who could speak to the complex and overlapping intersectionalities and experiences of Black women during the COVID-19 pandemic (Padgett, 2009). Nomination sampling requires individuals who are well-known, leaders, or community builders to identify and refer to individuals in their social and professional networks who fit study criteria. Maximum variation sampling captures heterogeneity across the sample population, which was utilized to capture diversity within stories (Padgett, 2009, p. 68). Snowball sampling is a recruitment technique in which participants identify members of their own social, professional, and familial networks who might qualify for and be interested in participating and refer them to the study coordinator for screening. This method is particularly useful to recruit isolated or hidden populations whose members are not likely to participate in formal research without referral from others in their network (Padgett, 2009, p. 68). The participants were recruited through leaders of national Black sorority networks via email distribution lists and posts to Facebook or other forms of social media communication. These sororities are social networks, organized nationally, of college educated women to support professionalization, legislative and political organizing, and social support to college students and alumni of color. Recruitment was open nationwide.

Human Subjects Research/Institutional Review Board (IRB)

In order to protect "... the rights and welfare of humans participating as subjects in the research," the United States Food and Drug Administration requires that all formal studies are approved through Institutional Review Boards (IRB).¹ This research study application was

¹ <https://www.fda.gov/about-fda/center-drug-evaluation-and-research-cder/institutional-review-boards-irbs-and-protection-human-subjects-clinical-trials>

approved by the University of Pennsylvania Institutional Review Board, including study recruitment materials, telephone screening, informed consent document, and interview guides.

Following approval, each recruited participant who met all inclusionary criteria was provided an informed consent form from this primary researcher. The informed consent form included the following items: The intention and scope of the study, any potential areas of risk, explanation of processes and procedures around confidentiality protections, and contact information for this researcher. Due to the nature of the content and risk of any post-interview emotional discomfort, additional information was proposed to be shared outlining supports that participants could access after their interviews. No participant requested such information nor expressed any indication of need at the time of their interview according to this social work clinician-researcher.

As part of confidentiality practices, all data collected was de-identified and stored in a password protected manner. This researcher invited each participant to select a pseudonym for herself and any family members or entities mentioned during the interview to be used in all dissemination of research findings. The spreadsheet file linking participants to their pseudonyms remains stored on a password-protected computer and only this researcher has access to this computer.

Data Collection Methods

Each participant completed two interviews, two weeks apart. The purpose of using multiple, sequential interviews was to build trust with participants through a relational perspective and to provide opportunities for reflection on the individual experiences of each participant. This researcher acknowledges the importance of generating a trusting environment for participants to feel safe to be vulnerable and share personal and professional experiences.

At the start of each interview, this researcher stated her name, the name of the participant, the date, and confirmation of consent for the interview and the recording, as per the informed consent document. This interviewer may conduct all interviews virtually for the convenience of the participants (in person interviews were proposed but due to geography, all requested virtual interviews). Interviews took place in a location of the participant's choosing, mostly their home. Interviews lasted approximately 45 to 90 minutes. The researcher, in collaboration with the mentorship team, developed a narrative, semi-structured interview guide for use during both interviews. Each interview focused on a different portion of the participant's story while also allowing for clarification and follow-up from previous discussions.

Data Analysis

The primary researcher utilized procedures from narrative research to engage in the data collection and analysis. Components of this process included open ended questions and deep listening, transcribing interviews, line-by-line coding of the interview transcripts, and then interpretation of the data. The primary researcher, with the guidance of a qualitative mentor and dissertation committee chair, crafted a story for participants to include: primary actors; action/inaction with turning points; personal, professional, family, community, social, and economic forces on daily life during the early stages of the pandemic; impacts of turning points for the speaker and perceived turning points for others in their families and communities. These were analyzed both within and between participants for a comprehensive picture that engages complexity.

Selecting Cases

Findings from this study are presented in two discrete cases and one composite case. This researcher selected two cases for presentation based on the participant's exploration of a rich, or holistic, story to facilitate comprehension and analysis. The two discrete cases were selected

because they captured unique complexities of the intersection of the pandemic with challenges of daily life for the participants. In the first case, this involved living with a disability and caring for an adult cousin who experienced both the same and an additional disability. The third case is unique in that the participant reported profound loss immediately preceding and unrelated to the pandemic. The second case is a composite case, integrating elements of two participants who were the most representative of other participants in this study.

A composite case study (Sandelowski, 1995) incorporates data from multiple participants with key characteristics or plot points shared across the sample. The single composite cases incorporated data from two participants representing who shared trends (including a workplace) and facilitated data anonymization. Key characteristics included (a) family constellation and caregiving responsibilities, (b) workplace challenges and decisions or policies, and (c) experiences with evaluating COVID-19 related risks for self and others. This composite case also represented an opportunity to present a more nuanced exploration of participant data.

Reflexivity Statement: My Story

When I began to see the news media coverage about COVID-SARS coming out of Wuhan, China in late November of 2019, like many others, my first thought was, “it will never reach American soil.” If SARS-CoV 2 did reach U.S. soil, we had measures in place to contain it and life would continue to be as it always has been. Well, as a Black woman living in America, I was arrogant, foolish, and privileged to think that the United States was so powerful and great that it would never harm its people. Amid all of the turmoil, cultural, civil, and racial unrest, the country’s division and anger was heating up to a point that the world had never seen before, and things were about to become much worse.

The 2020 Presidential Race dominated the news cycle. In December 2019, the news from Wuhan, China was starting to get global attention. Then, by January 30, 2020, the World Health

Organization (WHO) declared SARS-CoV 2 a global outbreak. Instead of offering solutions and putting protocols and processes in place to handle this early on, the U.S. federal government had begun to do what it did best: point the finger and blame others for their shortfall.

The moment of truth came on March 11, 2020 when the WHO declared COVID-19 a global pandemic (World Health Organization, 2020). Life and work changed seemingly overnight. One case that I recall that happened very early on shook me to my core. A woman in her mid-twenties who worked for a government agency which required her to travel extensively ended up in the ICU, gravely ill. Doctors ran all kinds of tests to find a diagnosis, but they could not. This patient was in great health prior to hospitalization. The patient was put on a ventilator and ultimately both lungs collapsed, first the right and then five days later the left. This young woman ended up dying. My co-worker and I discussed this case amongst ourselves, and we hypothesized that she could have possibly been the first COVID patient and nobody knew.

I recall patients flooding the hospital I worked in, in droves. People begin showing up in the hospital ED with a range of symptoms. The less severe symptoms that I saw were body aches and pains, sore throat, diarrhea, headache, conjunctivitis, loss of taste or smell, and skin rash. Some came in with more severe symptoms which were difficulty breathing or shortness of breath, chest pain/pressure and high fevers. The individuals whose symptoms were severe ended up on the Medicine Intensive Care Units, placed on a ventilator generally in a prone position. Individuals that were exposed to the sick had to quarantine for 14 days and those in the hospital with COVID could not have visitors at all. Patients would typically have high anxiety and I could see the fear in their eyes. The thought of death combined with the fear of dying alone caused anxiety for both the patient and their families. I saw families completely devastated, angry, and in shock over losing their loved one. The loss was particularly harrowing because

families did not get the opportunity to be with their loved one when they took their last breath. Some families tragically lost several family members at once.

There was no real guidance from any of the federal agencies on how to handle what we encountered. Unnecessary exposure to COVID-19 was a great concern as we continued to enter patient's rooms to deliver the same standard of care as before. I thought that was incredibly stupid since these were definitely not normal times we were experiencing and surely those in positions of power understood that things could not continue to be business as usual with so many lives at stake. Work became chaotic when my coworkers and I would leave to go home at the end of our shift and return the next morning to completely changed rules, signs, and ways of doing our job. When I began to see an increase in patients coming to the hospital sick with COVID, I thought of my family and the best way to protect them. I became anxious, fearful, and angry as my thoughts began to drift toward "what ifs." Being on the frontlines of COVID care made me think long and hard about my family.

One of the units that I worked on housed COVID patients and even though I did not go in those rooms there were other floors that were assigned to me whose rooms I had to go in. I came up with a routine for when I got home to limit my family's exposure to COVID. I could not mentally handle it if they got sick with COVID as a result of exposure from me. I was the only one that was knowingly and regularly exposed to the virus. By this time my husband and daughter were at home as the initial stages of the shutdown had begun to take effect. The only good thing about any of this for me at that time was they did not have any further exposure outside of me and I was taking great measures to keep them from getting sick.

As time passed, I began to get angry because hospital administration continued to make us go into patients' rooms. Employees began to get sick with COVID due to unknown exposure.

What I mean by that is, one of my co-workers went into a patient's room to talk with her as is customary to get information to assist with patient needs and discharge planning. The patient tested negative for COVID at that time; however, a day later she fell ill and tested positive for COVID. They had to go back and inform all the employees who had been in the patient's room that they had been exposed. By then, the employees who were notified had gone home and unknowingly exposed friends, family, and anyone else they encountered. Adding insult to injury, to take COVID related time off, employees had to identify which patient s/he contracted the virus from, including asymptomatic patients. If a worker could not identify the point of contagion, then s/he was required to use personal time for their 14 days of quarantine. Several employees were exposed to COVID and a young Latina employee who contracted COVID in the community subsequently died.

As the impact of COVID-19 expanded, the hospital put up a tent outside of the emergency department to test patients prior to entering the doors. Other precautionary measures included signs and tape markers six feet apart for social distancing. Patients were required to wear masks and it was mandatory for all employees to wear masks at all times. The entrances were closed off and there were only two entrances for patients and one for employees to enter the hospital. Patients could not have any visitors.

Then, as if dealing with COVID was not enough, my heart hurt watching a white Minneapolis police officer enjoy taking the life of an unarmed black man named George Floyd. As a Black woman, I was traumatized by this while dealing with the trauma that I saw at my place of employment because of all the death that I was witnessing firsthand. I could not escape either situation and I became angry, anxious, disgusted, and fearful for the lives of people that looked like me. I realized that, but by the grace of God, that could have been my husband, my

cousin, my uncle, or myself. I saw Black people fighting wars on two fronts, fighting for our lives. The wars were against the police, because they were gunning us down in the streets for no reason, and against COVID, disproportionately killing members of my community. The culmination of decades of systemic racism, drugs, HIV epidemic, health disparities, police brutality, and now COVID, has struck yet another blow to the mental health of individuals in Black America.

I was taught that Black women are nurturers, to not show weakness and mask our hurt. I was taught that our faith will carry us, and I am a firm believer in that, so my thoughts were, “How do I help families overcome and/or cope with their fears when I was fearful, myself?” One thing I can say about this virus is that it does not discriminate and does not care who you are. It ravaged the bodies of young and old; those that did not die had life changing and lingering health effects.

Outside the hospital, life ground to a screeching halt! States shut down, local governments imposed curfews, dining in restaurants was not an option, and bars were closed. Wearing a mask became mandatory in public. All schools in the state of North Carolina, including colleges and universities, closed to in person learning and went virtual. As industries closed, individuals living in working class and poor communities lost jobs at alarming rates. Those individuals who could work from home did, those who could not and were essential employees, like me, had to choose a paycheck or safety.

As the months went on more co-workers, friends, and family members got very sick. Some lived and others did not. I began to see nurses and doctors crying daily because of the death all around them. I remember being told by the nurse who had to Facetime a patient's granddaughter, the woman was very close to her granddaughter, so that the patient could tell her

she loved her one last time while she could. The nurse was traumatized after having to witness these loved ones saying their goodbyes for the very last time. At home I saw news stories about New York and California using refrigerated trucks as morgues because there was no more space to put the bodies. In my mind, that was a scene from a war zone in another country, something I could not fathom witnessing in the United States of America.

Several people that I knew personally, including one of my coworkers who had just given birth six months prior to the arrival of COVID on U.S. soil, contracted COVID-19. She was the breadwinner in the family as her husband had lost his job shortly after she had given birth and unfortunately could not find a job anywhere. My coworker had three other small school aged children at home who required assistance with online learning. I remember days that she would come to work in tears fearing that she would expose her family to the virus. The fear of her family dying because of exposure was overwhelming and she contemplated quitting to minimize that; however, if she quit, she knew she would struggle to pay the bills and feed her family. Before she could decide what to do and despite being extremely careful, she contracted the virus in late May of 2020 and everyone in her household became sick, including her baby. Due to the unnecessary hurdles and hoops she had to jump through at work to prove she contracted the virus there, she resigned from her position without knowing how she would pay bills or would feed her family. She told me she had enough and none of it was worth her family dying over. She verbalized that she was not willing to put her family in further risk and she had given enough not to be appreciated, valued, or respected in the workplace. Her story, and so many others like hers, inspired this dissertation.

In the following months, I witnessed several situations where essential workers felt forced into “choosing” between providing for their families or having a job. As I reflected on

their decisions, I realized these were not choices. Another friend of mine, single and responsible for the care of an elderly sick mother at home, found herself in a similar situation. She resigned from her position because she was the sole available caregiver for her mother and did not want to expose her mother to the virus. She, too, resigned without a plan to pay her bills. The weight of caring for her mother was crushing enough with everything else placed upon her shoulders, but, as she so eloquently verbalized to me, “which is worse, my mother dying from a virus she was exposed to by me or dying because I am drowning from the debt caused by the very same?”

As lockdown became the new normal, the world became still and quiet for a while. It was as if GOD said, “ENOUGH! Be still!” and punished us for hate, divisiveness, greed, and unnecessary chaos. It was a rest, reset, and recharge period for the world. It gave me the opportunity to focus on the important things in my life. At least, that was my perspective and how I coped with the onslaught of change. My belief was that GOD had to get our attention with something this major because the human race would not listen otherwise. A global life changing event was the only way to wake everyone up so we could pay attention, then maybe, just maybe, some of us would hear HIM.

As for me, seeing so much death, sickness, separation of families, the devastating mental health effects this pandemic caused forced me to look around at things that used to bother me and realize they had no need to affect me. Things that I used to worry about, I don't anymore. I have resolved to live life with purpose in all things because they can all be taken away at a moment's notice.

Chapter 5

Findings

Introduction

For this dissertation, this researcher conducted a series of two interviews with 17 African American identified women who made the choice to leave the paid labor force within the first few months of the COVID-19 pandemic. All women were caring for young children, elderly parents, or disabled loved ones, or a combination of all three. Three composite cases are presented below. These cases explore common and extraordinary themes and plot lines presented by a selected group of these women. When discussed in the interview, these themes interact with the Black Lives Matter movement sparked by the murder of George Floyd.

For each case, an extensive composite case study is followed by a brief analysis of the primary themes of the case. The first case of TS explores the experiences of a differently abled advocate against ableism and her challenges and joys caring for an adult cousin with autism through the pandemic and a pregnancy. The second case of Tammy discusses experiences of a single mother who experienced workplace discrimination and relied on a multigenerational family home to raise her children. The third case of Lynn discusses the experiences of a young mother who entered the pandemic in a state of profound grief over the unexpected death of her husband in the weeks before the start of the pandemic. Each experienced racist practices in the workplace, profound concerns about their own and the safety of their loved ones, a mix of losses, and identity shifts.

TS

Plot Overview

TS was born deaf and has never been able to hear sounds. She developed the ability to communicate through sign language, taking speech classes, and lip reading. When asked if she needed any assistance such as an interpreter, TS confidently refused and noted that would be able to read my lips and then respond back verbally. TS further expressed that she does not experience her deafness as a disability. “I’m proud to be deaf. There’s nothing wrong.” TS described her experience as a Black, deaf individual as an identity that has made her stronger, wiser, and better equipped to handle our world. “Being born deaf is not a disability for me; it may be for others, but I do not view it that way.” She viewed her hearing impairment as a blessing (rather than a disability) because it elevated her skills, self-reliance, and self-sufficiency to the point where her deaf experiences and identity became a springboard for launching her into the roles she occupies today, the ways she supports herself, her family, her tribe.

Her enduring identity as a disability activist pushed her advocacy for the deaf and hard of hearing, particularly in communities of color. She reported that they are often misunderstood and mistreated because of their disability. TS maintained a strong belief and commitment of support, especially among those in the deaf and hard-of-hearing community. She understood the extra challenges they face with communication, being understood, difficulty navigating systems, and just living. “We are about empowering you guys and providing the resources. But with the system, it still need to be fixed; it’s a lot of things that need to be fixed.” She gave back to this community: hosted events, supported discussion panels, educated, acted as a resource, participated in community events, encouraged others, and lived by example.

TS worked as an in-person, community-based medical social worker throughout the pandemic, supporting those who were made more vulnerable during the lockdowns and societal shifts. TS’s job became incredibly dangerous during the beginning of the pandemic, which was a

leading factor for TS and her immediate family moving across the country. TS also became a first-time mother during COVID-19, which connected her to new parts of her community.

Communities

TS identified with multiple communities. During these interviews, her identities as an African American woman, a deaf woman, a new mother, and a caretaker were the most discussed. Primarily, the overlap of the African American and deaf communities has been her prominent place of social activism, self-identification, and focus. “I want to be the voice for deaf and hard of hearing who have low self-esteem, who don’t understand how important it is to seek the help they need.” She prioritized her efforts in this majority black community, but TS reported supporting deaf individuals and families regardless of race. TS emphasized that, often, deaf individuals she works with also feel as though they are isolated, “on an island” when engaging with individuals that can hear. TS’s goal was to create a space for Black, deaf individuals to feel belonging, as she directly works to dismantle structures of oppression. She assisted her community in navigating systemic barriers such as difficulties with opening and keeping minority-owned businesses. “I can opt to show other Black deaf women who feel they couldn’t accomplish their own business because there are not many Black deaf women like me who are successful who have their own business.”

Regarding the deaf community specifically, TS familiarized hearing and deaf individuals with each other, bridged gaps, and created a “heard” dialogue by both sides through social networking and daily interactions. TS believed these bridges were critical to deaf people, showing they were *able*.

We just human being just like you are, we just can't hear. That's it. Some people view as we are slow or we handicapped or we stupid, we not mature, and that's not true. We can do anything except hear. There's nothing wrong with us.

These connections permitted education and group familiarization to enhance understanding and reduce barriers.

Through TS's lived and professional experiences, she learned the skill of moving through and navigating systemically oppressive systems. By being part of this community, TS connected with her clients as she helped them through these challenges. "I was able to vent with my client who feel the same way, who feel isolated, who feel lonely, frustrated." Communication barriers for the community included being unable to read lips, especially over the computer, access to speech classes, sign language interpreters, or sign language fluency. The elimination and, at minimum, the reduction of these barriers is vital to the survival of that community, with TS being one of the voices leading the charge to affect the change needed.

Within the Black deaf community, these intersectionalities were distinct. This group managed stigma and discrimination based on ableist and racist discourse and structures. TS described the challenges of a smaller subset of the deaf and Black communities. Their needs were more significant, and their resources were more difficult to access than other members of the deaf community. Within this space of resource deficits, she worked from a strengths-based perspective to address the systemic challenges in advancement. "I felt I just had too many jobs all at once. I did. I guess that's what it's like being a Black woman. We just work hard. It's in our DNA."

Work

At the beginning of COVID-19, TS worked professionally as a social worker in an inner-city mental health facility. Her job was in-person and involved working within the community. Due to pandemic protocols, the work environment became increasingly chaotic and dangerous. While “(Supervisors) had the privilege to work from home, but (the workers) still had to be out in the community busting our ass to go. It was just crazy. And I’m like, ‘What are you doing? We need y’all’s support too.’” TS understood that the work policies prized money over safety. The company showed this lack of concern through behaviors such as “writing people up if they call out of work...even with doctor’s notes...that’s when I knew the company didn’t really care about me. They just care about collecting the money.” TS felt that the company was placing measures to protect the company’s bottom line, not the workers. TS felt her employers and managers did not value or respect her.

TS’s lived experience as a Black individual has taught her that capitalism uses “Black bod[ies]...to generate revenue.” In a society that does not place the same importance on the Black community as the white community, TS commented, “if you’re poor [and Black], they’re going to kill you off the map faster.”

TS and her family lived in the inner city, where resources were scarce. Poverty and crime were high. TS’s neighborhood was a low-income area, and people struggled to make ends meet. TS saw people in her community struggle during the COVID-19 pandemic and shutdown. Most people in the neighborhood worked in positions requiring daily and consistent contact with the public. The nature of their work increased vulnerability and risk of them contracting the virus. The constant exposure to the virus angered TS as she knew it would put Black people at high risk of getting it. TS was also outraged at the lack of education or support from the government. She knew that, once again, the people who worked in the service, health

care, and transportation industries were Black and the very ones who would pay the heaviest price during the pandemic. TS saw entire families suffer because individuals had to work to put food on the table and keep a roof over their heads. Safety was of the utmost concern for everyone, but most had no choice.

The ultimate decision for TS, her husband, and their unborn child was to move. Moving across the country was a test of her faith, as she put it, and she was ready to step out on her faith and create a new life, chapter, and new beginning for her family. TS quit her job in Philadelphia, and she and her husband were offered jobs in California. “I’m not going to question God. I’m not going to question my ancestors. If he want us here, then we’re going to go here then.” For TS, she needed to step boldly as a survivor and a Black woman to support her family better.

Family

TS provided housing and care to her adult cousin, who had diagnoses of autism and deafness, before and during COVID-19. She felt that she, alone, understood his challenges and needs. Due to TS’s intersectionalities, she empathized with her cousin’s communication struggles. His ability and comfort communicating needs, compounded by mask mandates, which prevented lip-reading, further isolated him. She reported that he did not understand the mask mandate and felt uncomfortable wearing it. People of all communities would often speak cruelly to him. Autistic people would say things like “Can’t you hear me or I’m talking to you?” and become frustrated when he did not respond because they were not speaking loud enough for him to hear, as if he was intentionally ignoring them.

So, wearing a mask was a struggle. And some hearing people would be rude, like, “You can’t hear what I said?” Or they would have an attitude. If a hearing person wanted to

communicate, they scream my name. Of course, we didn't hear you, but some of them might view that we being rude or we ignored them. No, we couldn't hear.

Her time away from him at work challenged her ability to ensure his safety. COVID-19's lockdowns limited TS's cousin's schedule and other community safety support. Before the pandemic, her cousin attended a daycare center that shut down at the beginning of COVID-19 and, upon its reopening, the center no longer felt safe to TS's cousin. Since individuals with Autism often struggle with change, this massive transition period was incredibly difficult for everyone involved (Spain et al., 2021). "He felt like he was in jail, to be honest, because he was not used to that. He had to adapt to the new environment, staying at home."

TS left her career to uphold her family and community during the height of the pandemic, as her family struggled through with minimal support. TS felt that "this could have been prevented instead of them waiting, waiting, waiting. I felt like they knew about it. I felt like that was their way of taking us out. I felt like the government were trying to control the population."

Grief and Loss

TS's grief and loss came to a very crucial point when she recognized that her stress level was high from caring for family members and others. Coping with the deaths of family members, and all of the uncertainty and unknowns of the pandemic increased her stress tremendously. Then, a loved one died. Her grief and ongoing fear pushed her to recognize that she needed to prioritize herself and her unborn child. "It was hard, it was a challenge, trauma. It was too close to home for someone who I knew died in front of my eyes. And I'm still healing now. It's hard to grieve because some people grieve different than others."

Two of TS's close relatives died during the pandemic, which weighed heavily on her. She viewed grieving as a process that required meaning-making, so she tried acknowledging her

feelings to make sense of these losses. TS “put on a brave face” yet felt deep anger that her family and community did not have the care they needed to survive the pandemic. She knew this resulted from disparities [AWL4] in health care for Black people. “Some people feel oppressed when it comes to the hospital, don’t really trust the doctors.” During the pandemic, the disparities were exposed globally for all to see, yet with no change.

Pregnancy

Several months into the pandemic, TS became pregnant. She wondered how to continue caring for her cousin and maintain a demanding and dangerous job while caring for a newborn. She also worried that should she become infected with COVID-19, her baby would suffer and possibly develop life-long complications or die before birth. Her husband told her, “Do not go back to work. I do not want you to expose our unborn child to this virus; stay out, and I will take care of everything.” TS reported excitement and fear during her pregnancy about the challenge of becoming a parent. TS turned to her community for support “going to support group, just reading, listening to women’s testimony, that gave me high hopes. Or my husband being very, very supportive, listening to me, family, just trying to find that balance.”

TS knew she needed to focus on her health, disability, and unborn child, and she felt that to do that, she would need to put some distance between herself and her family. Eventually, this also meant that TS and her immediate family would be moving away from Philadelphia altogether. She talked with other family members and educated them on how to care for her cousin. TS thought it was best to teach “more than one family member” so that they could rotate and “no one would get burnt out and frustrated.” Bringing in multiple family members would also create “a stronger support system” for her cousin as he would benefit more with “three people instead of one.” Once TS solidified his support system with extensive education on caring

for him and his routine, TS spoke to her cousin about what she was doing and why. TS ensured her cousin that his opinion and wishes were worked into the plan so that he had autonomy and understanding of what was happening around him. She slowly began implementing the change and promised him she would still be there in a limited capacity to help him whenever needed.

COVID-19

TS experienced the start of the pandemic as a confusing and terrifying time. “It was confusing and upsetting; people were dying left and right. So, we thought, ‘it’s the end of the world,’ to be honest with you.” With both experience and education about the disparities in health care for African Americans and an understanding of the structural barriers to equity, TS believed COVID-19 to be another attempt by the government to eradicate the African American population and strip their ability to sustain themselves without government assistance. Her lived experiences of COVID-19-related loss across all parts of her world further solidified what she already knew. “Well, the system is not built for Black identity people of color, clearly. It is built for the white people, clearly.” Witnessing the incredible loss of life firsthand, the overwhelming amount of sickness, and the overall impact and trauma created by COVID-19 devastated her communities. Fear of extermination and the safety of her unborn child are the significant reasons she refused to get vaccinated. “I felt like the government knew about (COVID-19), but then they waited. I felt that’s just my personal opinion; they try to control the population, they feel like too many people are living on this earth. The government believed Black Americans were expendable.”

TS’s distrust of the system was due to systemic racism and decades of multiple events where Black people were experimented on. “That’s why, it breaks my heart, and I’m sad about it, that we still have to fight for equality. It’s sad and heartbreaking.” These experimentations

ended in severe illness or injury, physical harm, emotional trauma, and sometimes death (Saunders, 2020). “I felt like my aunt could have still been alive to this day. It’s a lot of frustration because my close aunt died from COVID-19. And the more and more I learned about COVID-19, I feel like it could have been prevented earlier.” She feels there is a movement to terminate/extinguish as many Black lives as possible, and she will not give them the opportunity and access to take her out. TS’s perspective of COVID-19 is that it is real and created with a purpose and goals, population control, and experimentation. “Yes, because they want to kill us off. They want to kill us. Yes. I feel like we were affected the most.” In her experience, the population they (the government) target has historically been Black people, and our community suffered the most during COVID-19. “We are Black every day, 365 days.”

Vaccine

She doubted the vaccine’s safety, saying, “So I don’t trust the system; I don’t trust the vaccine because I felt like it still need more time to research.” Once the vaccine was available, work mandates to get vaccinated “felt like they were taking people’s rights away. It’s my body. Who in the hell are you to tell me what to do in my body? So, you telling me the government has control of my body? No!”

However, her fear was not just for herself but also for the child she was carrying. “I’m not vaccinated. They were saying at that time, if you’re not vaccinated, you would be easy to get COVID-19, or it may affect the baby or something.” TS did not want to inadvertently give her unborn child something that would ultimately hurt, disable, or subsequently kill him. “But my intuition always told me, don’t get vaccinated. I have a healthy baby boy. He’s just fine. But still, for me to prevent that, I choose not to work. I was not feeling good. It was just too much.”

Masks

Mask mandates during the pandemic limited TS communication abilities while adding to the fear of the pandemic. Given that “they said some masks were not as protective as other masks,” TS said how “overwhelming” it was.

However, the primary hardship TS faced with the mask mandates was the limitation on communication. Masks stopped the deaf community from being able to read lips. Masks made it so that people were not “willing” to communicate. It made people in the deaf community feel they were not, as TS put it,

allowed to communicate, or they felt isolated from family members who don’t sign. It was a lot of isolation where they didn’t feel included. Our family member doesn’t sign to communicate and that’s what break my heart too. So it’s a lot of frustration without communication. Big communication barrier. That has really affected our community. TS found that these limitations caused depression and anxiety. “I would say it was a lot of social anxiety. I would say that. I would use that. Social anxiety. Just want to stay home and not want to go out.”

When TS interacted with the hearing community, she found that people did not “know” and did not “listen to her when she told them she was deaf.” Dealing with the ignorance and arrogance of others made things more isolating for her, including name-calling and being ostracized. COVID-19 closed doors that previously allowed TS to interact with the community, making both her community and her individual experience limited and parse. TS wished that more hearing community members understood that

it’s okay to write back and forth. If you don’t want to do it, it’s okay to learn sign. It’s okay to learn something new if you not familiar. It’s okay. I feel like I’m learning

something every day, and that's okay. You're never too old to learn anything, and it's not too late to learn sign language.

The Murder of George Floyd

Among the events that TS witnessed, the death of George Floyd was the most overwhelming for her. The murder and the horrific treatment of other Black people without cause outraged TS.

Floyd's killing shook her as

It could happen to any of my family members. It could happen to me. It could happen to my husband. It could happen to baby boy. It could happen because the color of our skin. They view us as a threat, and I feel like a lot of these cops shouldn't be cops. [...] I feel like cops use their uniform as they're in control. They control people.

She felt it was open season to kill as many Black people as possible, given the national headline increase over the summer and fall of 2020.

They wanted us to get riled up, get angry. But we're getting tired of getting riled up and angry. It's starting to burn out. Now, it's starting to seem like a pattern, like they enjoyed it. It's really hard to explain it. It's a lot. It's triggering, trauma.

TS saw how it took the murder of an innocent, unarmed Black man at the hands of the police for the majority to see what Black people have been screaming for decades. "We are Black every day, 365 days." "Blue lives is not a human right. I got tired of them keep comparing us as a material." TS asked the questions and pondered, "Why?" Why do Black people continue to suffer, and others keep turning their heads, pretending they do not see it? Why do we suffer the trauma and atrocities because of the color of our skin? "We are tired. We're burned out. You couldn't see. It's not just only me. It's everybody else who are Black is affected by this situation." Analysis of TS

TS's sense of self and positionality inside of a larger community narrative are striking throughout her interview. She was hyper aware of, but not defined by being deaf. She was also not defined by the intersectionality between race and disability within the deaf community. She spoke passionately about the ways in which this intersectionality further complicated her family and community's challenges with COVID-19. She highlighted a number of discriminative COVID-19 practices that lead to health disparities, including the impacts of mask mandates on the deaf community and micro/macro aggressions in her workplace related to race.

TS's life experiences as a differently abled African American woman contributed greatly to both her deep commitment to advocacy for marginalized groups as well as her significant distrust of systematically oppressive systems. Taking in and caring for an older cousin relative who had a hearing impairment and intellectual disability during the pandemic was very challenging but something TS described herself as committed to and ready to take on. This reflected her deep devotion to her family and the sacrifices she was willing to make to support both her immediate and extended family members. The lack of system support she experienced for her disabled cousin, as well as the loss of two close family members from COVID-19, reinforced her stark criticism regarding the ways in which the government navigated COVID-19 policies and practices for minority people. TS described a number of ways in which she saw the government intentionally use COVID-19 as a tool of genocide on poor black bodies and perpetuate further negative impacts on health determinants of marginalized groups. Further, TS saw the vaccine as a form of eugenics, with marginalized communities being the test subjects, with results that would negatively impact generations to come.

Individual discrimination and feeling personally devalued was also a theme that ran through her story. She noted the frustrations when her white counterparts were afforded

opportunities to work from home, while she was not allowed the same accommodations at the start of COVID-19. She also observed the transition of her organizational leadership from centering the client and staff needs, to appearing to center revenue for the agency.

TS experienced a number of separations and losses during COVID-19. Prior to COVID-19 TS found a sense of identity, connection, and community through her employment and advocacy with and for deaf individuals. The forced separation from community advocacy activities was very challenging and often isolating. Additionally, the evolving incongruence in her alignment of her agency's values left her feeling frustrated and disempowered. These feelings led her and her husband to make the decision for her to quit her job and sacrifice the income for the sake of safety. TS also felt disempowered when actively working to bridge the chasm of supports for her disabled cousin. Despite the many losses, however, TS's pregnancy during COVID-19 mitigated many of the separations and losses that she was experiencing.

Although she quit her job due to a lack of safety accommodations around her pregnancy, she found ways to prioritize her own needs and the needs of her unborn child. TS felt newly empowered and supported by her faith, to reprioritize and center her own needs inside of her career and her familial relationships, which was evidenced by the decision to move across the country for new opportunities, resulting in an intentional distancing from her family.

In addition to personal reflections, TS discussed the confluence of COVID-19 and racism in the United States. She noted and was observably pained by the coalescing event of the murder of George Floyd. She saw her family through the lens of vulnerability to a police state that saw Black men, which could include her husband and son, as potential threats. This had a significant impact on her mental health.

TAMMY

Plot Overview

Tammy is an African American female, a single mother of two small children. Tammy comes from a close-knit extended family and loves spending time with family and friends. Tammy and her family live in a metropolitan community. Tammy has a Master's Degree in Social Work and an extensive work history as a Social Work Care Manager at a major medical center for a decade. Tammy worked closely with a small, specialized team in a multidisciplinary setting.

Work

Tammy enjoyed her work. She loved supporting her patients and working with her team. Tammy was very organized in her interactions, communication, and movements with her co-workers and the management team.

Her work in the hospital added another layer of stress as hospital leadership did not have a plan or guidelines to deal with this virus. The change in management styles and culture because of the pandemic altered Tammy's expectations and reactions to her place of work. Tammy realized that, although she was an excellent employee, she often did the work of others for one reason or another and did not receive the credit or promotion that she was due. This pattern increased as the pandemic continued, leaving Tammy increasingly feeling as a "perceived threat to her co-workers and the leadership team." She noticed an increase in microaggressions throughout the pandemic, "very subtle ways, nothing blatant, but I feel like it's because I'm Black." Tammy became more and more aware of how her management comments were taken and skewed by colleagues. She grew more concerned about "being labeled an angry black woman."

If Tammy talked with her manager about her concerns regarding her employment during COVID-19, management often deflected and would dissuade by discussing the "importance of

being strong and hanging in there for the patients and the team.” Tammy began to feel like leadership and management wanted her and her colleagues to take care of the patients, but asked “who was taking care of the caregiver and making sure they were okay?” She felt her colleagues did not care about her mental health and well-being, which made her angry. She began to question everyone in leadership and decision-making roles. “But what bothered me was you’re still expected to do all the things in the midst of a pandemic. We are supposed to empathize and sympathize with others, but we didn’t get the same treatment.” Time and time again, she heard the same toxic positivity message, which became detrimental to her health and state of being.

We’re at the hospital; you’re helping everyone else, but you’re not helping the people that’s helping people. And for me, my thought process with this was I’m looking around and I’m seeing in doctors and nurses, and no disrespect to anybody else or any other race, if we are doing that on the job as a Black woman, we have society to deal with as a Black woman, we have our family to deal with. What are we really experiencing? What are we not talking about? How is this making us feel? I know how I feel. And people say when everybody else catches a cold, we catch pneumonia. That’s the truth.

Tammy was frustrated and, in some cases, angered by the lack of leadership and common sense utilized when making decisions that put employees, patients, and their families at risk. As far as Tammy was concerned, all management cared about was their bottom line and making money. “I just felt like profit was at the top. That was the main goal and not patient care because the people that were needed were the nurses and the doctors.” She went on to say,

I learned that in grad school. They’re going to be policymakers or people making decisions, and they have absolutely no idea what we do, never done it. So you make decisions based on what, numbers? Money, because the federal government gave you

COVID-19 money. But at the end of the day, we're supposed to be caring for the patients.

In her mind, she was at war with an opponent (the administration) she could not see and did not know how to fight. She felt their lack of prioritizing workers' safety was irresponsible. Tammy disagreed with the decision leadership made regarding case managers continuing to go into patients' rooms, even though there was no way to keep employees from getting sick. She felt that as situations changed, so should the hospitals' way of doing things, and hospital leadership felt that case managers needed to continue to go into patient's rooms to ensure patients' well-being.

Adding to the lack of support from her management, toward the beginning of the pandemic, Tammy discovered she was pregnant. Pregnancy combined excitement and fear as a woman in her thirties with medical conditions. She immediately sought help from her doctor in taking the steps to require Tammy to leave due to unsafe conditions during her pregnancy.

While working in person, she tried to shorten her workday as much as possible, "but then you have to go back to work hoping and praying that you don't contract something to bring home." It was mentally taxing to her to carry that burden, which weighed heavily on her consciousness. Tammy took issue with going into patients' rooms and not being provided with the proper protective equipment to do her job. Tammy also felt that because hospital leadership did not have to go into the patients' rooms and physically do the job themselves, they did not care about their staff unnecessarily putting themselves at risk for patient care. She felt they were out of touch and did not listen to their staff when told of the patients' and their families' conditions. Tammy explained her work environment and position to her doctor, and he evaluated her and completed her paperwork for medical release to work from home; Tammy turned it in to leadership for review and her request was denied. Instead, her elderly white female colleague

was approved for accommodation and became able to work from home due to chronic illness. Tammy's risk level increased as Tammy stayed in the office to continue the in-person tasks. "They're not in the daily dirt and grind. They're not seeing people dying." Tammy was infuriated because not only was she denied, but she was also asked to do some of her colleagues' work as well. "It made me see more that lack of support overall in a health care system and how they expect you to do more, but there's no compensation." Leadership expected her to be a team player; however, Tammy received less respect and different treatment compared to her white colleagues.

Tammy had no choice but to fight her management for the ability to work from home to care for herself, her existing family, and her unborn child. Tammy voiced her opinion about this to her manager, who expressed it was the best she could do to support Tammy. Tammy felt undervalued and unheard. "I didn't feel supported whatsoever!" As a single mother, Tammy did not have the option of quitting her job. "But what they use, for all of us, black, white, green, whatever color we are, they use it. Because at the end of the day, your job is your livelihood." Eventually, Tammy was able to get permission to work from home temporarily. It was a process that took almost six months.

Family

As a self-described "germaphobe," cleanliness was very important to her in protecting her family. This was how she felt she could keep her family as safe as possible. Tammy feared getting her family sick, so she took precautions the best she could to protect them. While working from home was physically safer, it created new challenges for Tammy. She worked much longer hours, sometimes until 7 or 8 p.m. The work schedule meant that she rarely saw her children and increasingly had to rely on her mother for help with childcare, house chores, and

cooking. “When I was home for those months, they were home with my mom.” This deeply bothered Tammy because she did not know how long this would continue.

Tammy knew herself and her self-worth before the pandemic. She was raised in a close-knit family and was taught to continually work to support herself, be strong, dig deep, show no emotion, and persevere when life gets complicated. She learned “failure is not an option.”

It’s that same concept we always get all the time, which is you a strong Black woman, so you supposed to do everything. But I think some of us have a hard time asking for help. Her work ethic and endurance resulted from her upbringing and what she saw her mother and the women in her family do. Tammy looked inward, for the most part, to push herself through for her family. To her, it was fight or flight, and Tammy knew that, like most significant things in her life, she did not have an option to flee. She had to fight. She did not know how long she would have to sustain this work schedule and balance it with her home and family responsibilities. Mentally, she did not have an outlet since she considered herself a private person and learned not to expose weakness. “And even when I was mad about stuff, maybe I internalized it, but I kept my mouth closed because I’m like, I know my battles. I know what I’m going to do, what I’m not going to do.”

Before the pandemic, Tammy would take her daughter to daycare each morning, and her mother would pick them up most of the time. “My mom was here with my youngest. We took my oldest out of daycare, so my mom was here with my youngest and my oldest.” Tammy made sure to spend as much time as possible with her daughters. During the pandemic, when the shutdown occurred, the daycare closed, creating a considerable loss in the community because both children were home. The daycare provided a needed social and learning environment for her daughter. Tammy’s daughter suffered from the difficult transition out of daycare, as she was

used to being around other children her age, socializing, and learning through play. Tammy noticed signs of anxiety in her older daughter when the daycare closed down. She realized it came from being constantly shut up and isolated in the house. Tammy's daughter was like her, a social butterfly, and her inability to congregate, play, and interact with her playmates at daycare was hard.

Tammy's mother began caring for her daughters at home so that Tammy could work, even from home. When Tammy took a break, she spent time with her children only for a few minutes. "I would take a break, maybe to eat, to see my baby, my oldest, my mom. My mom would cook, and after about 30 minutes, I go back upstairs." Her mother would ensure the children's needs were cared for when Tammy worked. Tammy viewed this work as what she was supposed to do.

You supposed to be strong. You supposed to tuck this somewhere and keep going. That's what you supposed to do. Take care of the kids. When they get COVID-19, you get COVID-19. You coughing up blood. You supposed to take care of the kids and whoever else is in the house. It's that same concept we always get all the time which is you a strong Black woman, so you supposed to do everything. And then you have to change that narrative, which means setting boundaries. You're a single parent, and you have no choice. You got to take care of your kids. But I think some of us have a hard time asking for help.

During the pandemic, Tammy's community struggled. Community centers, daycares, and churches all closed or went online. Tammy's social isolation during COVID-19 affected "every aspect" of her life. Tammy could not go out with family or friends, and she found this hard because she enjoyed going out to different restaurants with her friends for the dining experience.

Sometimes, this would be in other cities; it did not matter to them where the restaurant was, giving them a reason to travel to different places. “We just like quality food, and I like new places.” These different dining experiences were part of Tammy’s self-care. She understood the importance of self-care and mental health breaks. It took the pandemic shutdown for Tammy to fully understand and appreciate just how precious and unique being able to experience these different social and travel experiences were to her. Before the pandemic, she and her friends could go wherever without much thought other than planning for their excursion. “So I feel like self-care was just overlooked, and we just sucked it up because that’s what we’re used to doing.” Overall, Tammy saw that the main reason was the “lack of caregiver support” many in her community had to deal with. “People felt like they didn’t have the support. A lot of us don’t have that.”

COVID-19

When COVID-19 first hit, Tammy was scared. She was worried about herself and her family because she worked at the hospital and was exposed to COVID-19 virus daily. As “a germaphobe,” so she was not a stranger to cleanliness. However, COVID-19 was an alien enemy that no one had seen before, and Tammy was fearful because of the lack of knowledge.

You couldn’t see it; it attacked and took entire families out. I remember that Madonna made a comment and she said that COVID-19 was the great equalizer. Meaning that whatever color you were- It didn’t discriminate at all. But then you began to see in our communities... And it was bad. But the Hispanic community, it was horrible because they are in homes, it’s two families in one house. And it decimated whole families. And I just remember thinking the reasons why, the cultural reasons why, and being that we have

multi-generational homes, meaning that we got grandmama, granddaddy, Uncle Ray-Ray and whoever else living in the house.

The information came from the Center for Disease Control (CDC), and the federal government needed clarification. Tammy erred on caution and took measures to protect herself and her family.

The social change for Tammy was the most difficult for her to navigate because her free time centered on time spent with friends and family before COVID-19. She had to plan and coordinate going to the grocery store and doing what her family needed. Tammy put a routine in place when coming home from work. She followed it daily to protect her family.

I would come home, take off all of my clothes, and just head upstairs with them. I didn't hug nobody. I'll talk, but I don't physically touch the kids. I just go upstairs, throw the clothes in the laundry room, and actually in the washing machine, then go take a shower. "They're not seeing people contracting COVID-19. They're not seeing what we see. They haven't built a rapport with the family. They don't do what we do." At the beginning of the week, she "received surgical masks, one to use daily." She felt that she should have gotten more than one to use per day, and this put her at a greater risk of contracting the virus. She felt the thin surgical masks provided for her and other employees did not protect her. The policy also instructed Tammy to share her face shield with another employee. "My colleagues were probably right about this. Two of my colleagues said they sent us an email that said, "When you get there, share your shield with others." I was like, "No."

Tammy worked closely with her Black and Hispanic community and patients throughout the pandemic. Navigating the medical system was crucial to the community's survival during the pandemic. "Let me say this, a lot of people in our community were dying because of the health

issues. We know that health issues or health disparities stem from other- access.” Tammy worked to support her communities by building trust within their medical teams in her role in the hospital and her personal life.

We don’t trust, and I get it, they don’t trust the health care system. And I know exactly why. And I’m going to be honest with you, unless you find a good primary care doctor, you have to find, just like we’d like to find good hairdresser, you have to find a good doctor. Someone who’s going to listen to you because when they don’t, I move on. I move to the next doctor. Everybody can style your hair, but everybody can’t grow your hair. And in between all of that styling and growing, if you find somebody that can style it and grow it, you better stick with that person because everybody can’t do. Your doctor, the same way.

Still, the death toll and the statistics within the Hispanic and Black communities rose.

They said the statistics show more of us were dying from it. But then when they made reports about it, all I saw were Caucasian people. To me, that’s just me, the faces I saw were Caucasian people, not black and Hispanic. It was more so them than the minorities that were dying.

Like always, Caucasian people’s lives mattered more. They received the sympathy, and the Minorities faded into the statistics.

George Floyd’s Murder

During the COVID-19 pandemic, this was still very much the case; however, Tammy felt politically and racially divisive rhetoric was on full view, especially the televised killing of George Floyd. Tammy was not surprised by what happened to George Floyd. Instead, she was dismayed by the horror of it all. “When that happened... I didn’t watch it. I can’t see it anymore.

That's trauma. That's imprinted in our brains." She discussed Derek Chauvin's sheer delight and smirk as he was slowly cut off the air to George Floyd's airway.

I saw the look on Derek Chauvin's face was like I'm just squashing a bug. And it made him feel like... a God. You could see the joy, the sheer- To kill someone, to kill another man. That right there is diabolical. That's beyond redemption.

Tammy felt the connection of George Floyd's murder to "everyone I knew who was a black male: cousins, friends, boyfriend. But then I also started to think about the black woman. We're not exempt because we're female."

She had to explain the difficult task of explaining Floyd's death to her oldest daughter and having "the talk" with her at the tender age of 4. Her youngest daughter was just a baby. Tammy was angry about all of it but had to gather the strength and composure to calmly talk with her and answer questions that she may have. However, since the world could see it this time, she thought it impossible to cover up like so many times before.

We got two, we're black and we're female. So you got two and you hate to say stripes, but that's how society looks at it. I tell my daughter all the time, you have five strikes against you before you even walk out that door in the morning, you're black, you're female, you're intelligent, you're beautiful, and you can think and speak for yourself.

Society does not like that.

She felt like the African American community was in crisis mode again, with several crises occurring all at once, and the COVID-19 pandemic was yet another nail in the coffin that may break the African American community, particularly the African American woman.

Analysis

Tammy is an African American mother of two young children and during COVID-19 she became pregnant with her third child. She is a professional Social Worker. She found herself confronted with the uncertainty of COVID-19 and the unreasonable expectations of her employer. These expectations conflicted with her role as a single parent and sole wage earner, which was further complicated by racial discrimination in her attempts to seek solutions that would help her protect herself and her family as well as her employment.

Tammy was concerned for the financial stability of her family, as a single parent of two small children and one unborn child. Being the sole wage earner of the family presented a complication that made Tammy's personal circumstances and work experiences become increasingly stressful. She was confronted with the difficult decision of choosing between her family's safety/well-being and her employment. Her concerns regarding employment were exacerbated by what she believed to be evidence of her employer's devaluing of her person and concerns. Tammy believed that her employers "expect[ed] you to do more...[without increased] compensation" and "at the end of the day, your job is your livelihood" so there was no reason to consider your concerns or worries. As the sole wage earner, Tammy expressed feeling the pressure of the responsibility of being the provider for her family and acknowledged her limitations.

Tammy's work experiences during the COVID-19 pandemic were unfortunately riddled with the historical memories of her experiences of marginalization and discrimination despite her 10-plus years of work experience with this hospital. Tammy reported a history of being repeatedly overlooked for promotions and other career advancements, despite her qualifications and years on the job. Therefore, it came as no surprise that Tammy would experience racial discrimination and microaggressions from her employers and co-workers during this period of a

global pandemic. Since she excelled in her job duties, Tammy was often drafted to engage important/influential hospital guests/personnel as the representative of her department. Consequently, Tammy felt frustration and anger when her employers denied her request for telework accommodations to protect herself and her unborn child, and then questioned her integrity and loyalty. Tammy expressed that this experience “made me even see more the lack of support overall in a health care system and how they expect you to do more,” expecting her to be a team player, while disrespecting, devaluing, and discriminating against her based on the color of her skin. These experiences were overwhelmingly compound by her fears around exposing her family to COVID-19 and the potential consequences thereafter. The work environment was constantly challenging for Tammy during COVID-19 and yet resigning from her job was not an available option as a single parent.

Outside of her employment, Tammy experienced a number of losses due to COVID-19. Prior to COVID-19 Tammy’s method of rejuvenation and relaxation was hanging out with a select group of girlfriends who loved fine dining and wine tastings. Their outings were local as well as across the country. For her the experiences were everything and made her feel like she could enjoy and live her life in a way that felt most gratifying to her. Tammy found peace in each new experience which gave her new perspectives and she was able to use the lessons of those experiences in other areas of her life. This made her a well-rounded individual and shaped her life in so many different ways. When COVID-19 abruptly stopped travel and interrupted face-to-face contact with others outside of one’s immediate system, Tammy struggled to wrap her mind around the loss of this coping strategy and worried that there would be a direct impact on her mental health. This was a real loss for her and she did not know what to do as she was unable to identify alternative coping strategies.

Prior to COVID-19, Tammy was confident in the ways that she was managing her many roles- as mother, sole provider, and helping professional. However, the challenges of working inside of a COVID-19-stressed health care environment along with the stressors of being pregnant and parenting required Tammy to expand her village or proximal support. In comparison to other families of color, Tammy's story is unique in that her mother was able to move into her home to help provide childcare for Tammy's children. This multigenerational living arrangement is consistent with many communities of color, especially when experiencing an untenable taxing on financial, physical, and emotional resources. Tammy's mother moving in was a financial sacrifice for her mother, requiring significant vulnerability by Tammy, while also being an invaluable support. Relying on the help of her mother to get through the rough times with her children was something Tammy did not want to have happen and yet without the help Tammy was certain she would be not able to manage all of her responsibilities, especially during COVID-19. Tammy explained that there was no one else to assist the family with additional funds and she was reluctant to ask for help outside of her family. Tammy felt that the government-issued stimulus checks were not enough to sustain the family long term. The weight of being the sole wage earner of the family was consistently weightier when putting herself in harm's way due to COVID-19.

Tammy's greatest anxieties were being pregnant during COVID-19 and having to find ways to educate her older children on very complicated concepts regarding reasons why things were being done in a certain manner or why they were being done at all. Tammy's oldest child was very outgoing like her and was very distressed by not being able to engage with her peers. Tammy watched her two oldest children try to understand and make sense of what was happening all around them. Tammy noted an increase in her anxiety due the anxieties of her

children, her inability to engage with preferred coping strategies, and the stressors from work. Subsequently, Tammy worried about transferring her anxiety and stress to her youngest child. Given everything that Tammy was experiencing emotionally and mentally her anxiety was not what she wanted her youngest child to feel in utero.

While health and safety were significant factors that came up generally around COVID-19 exposure, this also intersected with other themes during Tammy’s interview. Tammy expressed her deep concern for the safety of the “helpers,” inquiring “who was taking care of the caregiver and making sure they were okay.” She shared that often her concerns about her personal safety went unnoticed and unaddressed. Upon learning of her pregnancy, Tammy’s concern for her safety grew exponentially more significant as the uncertainty of the survivability and long-term effects of COVID-19 was an unknown factor. Despite her request for special consideration due to her pregnancy, as hospital personnel, the “hero” was expected to sacrifice for those in danger. The dismissal of Tammy’s health and safety was subsequently confirmed following her attempts to obtain special accommodations to work from home during her pregnancy, following her doctor’s evaluation and recommendations, her request was scrutinized and initially rejected. It took Tammy additional attempts, over a six-month period, before her request was finally approved, in addition to learning that her Caucasian counterpart did not experience the same level of scrutiny and was approved for accommodations with ease and far less invasive perusal.

LYNN

Plot Overview

Lynn is an African American female, widowed with two small children. In a multigenerational house, Lynn lived with her children, elderly parents, and younger sister. Three

months before the start of COVID-19, Lynn's husband suffered a stroke and passed away. The death of her husband left Lynn as the sole breadwinner in her home.

Work

Lynn had a Bachelor of Science Degree in Nursing and worked in a medium-sized hospital in the town where she lived. She worked as a nurse for over five years in the Emergency Department. Lynn's role as sole financial provider of the household, especially after the start of COVID-19, was extremely challenging.

I provide all the household income, so I work a lot trying to provide. And during the COVID-19 pandemic, I had to always leave my family behind, go to work, then come back late. And so, it was really stressful for me trying to work hard to feed the family. Lynn explained that she constantly found herself worrying about her children and the care that they received when she was working. During this time, she also struggled with the traumatic loss of her husband. Despite the emotional turmoil and constant worry, Lynn felt she had no other options but to try to maintain her employment. "I had no other choice but to work: state, nothing would help, and bills had to be paid." She felt compelled to be grateful that she was not laid off like others. Lynn worked to put all of her personal challenges aside as much as possible to provide quality patient care and simultaneously follow all of the hospital's COVID-19 protocols.

Lynn's experience in the hospital was similar to that of many frontline workers. She described her fears for her patients. "People came in, but very few came out, so they were scared." She knew firsthand the fear, death, and illness from the virus that she saw daily. Lynn saw how the virus could spread and decimate entire families from one person contracting the virus. As the pandemic went on, the constant death weighed on Lynn and became harder and harder to bear witness to. She found it impossible not to see herself in the lives and struggles of

her patients. “Seeing a person being brought to the hospital, a few minutes later, she’s dead. A few minutes later, he’s dead. I could just think of what the family would be going through. I would think of what if this person was a breadwinner. How are they going to survive? How are they going to continue?”

Lynn was also constantly worried about being exposed to and possibly dying of COVID-19 while working in the emergency room. This fear was significantly compounded by the fear of taking COVID-19 back home to her family, making her family sick and someone dying because of it. Lynn was in an impossible situation as the only way that she could feed and support her family was by risking daily exposure to a deadly virus. She would get home from work and “keep my distance until after I’ve showered, taken my clothes off, freshened up, and then into clean clothes” before she felt able to greet or “even hug” her family.

Racism at Work

One of the main reasons that Lynn continued to push through her fears to continue working was for her marginalized patients. “It’s almost like you have to be there in order to help those coming in so that they feel or if they see a friendly face or somebody that looks like them and they’re comfortable with attempting to get care there.” Lynn discussed the importance of seeing yourself in your care team and the increased ability of the hospital to care for the patient thoroughly.

I can agree with that because there have been times when I’ve been the only Black face or maybe one of three or four Black faces, and because I was there, it allowed others to be okay and sometimes get the treatment that they needed because they come from the same community as me.

Giving back to her community gave Lynn additional strength to continue. She dealt with “some racist stuff” before and during her work at the hospital. “So I felt like sometimes we don’t get what we feel we should get. Like when I was applying for this job, I was really qualified for it, but because of racism, I couldn’t get that job.” Lynn had to use other networking support to be seen as the asset and leader that she was. Moreover, she felt

like I am standing in for so many Black women because where I work, we have a lot of white people. So I feel like I am lucky being a Black woman there. And I’m standing for a whole lot of Black women. Because a lot of Black women do come there and they seek help, and when they find me there, they’ll feel that, they feel that comfort. So I felt like that’s where I’m supposed to be.

Quitting the Workplace

Realizing what she saw and went through because she had no choice but to work and what she experienced with her family at home almost pushed her over the edge. She had no idea how she would navigate all of these competing priorities successfully. Lynn felt there was no one to depend on, and everything was on her shoulders. She had to be strong and carry this alone. “I had to cope, I had to try, the whole responsibility was on me.” She did not want her mother to think she could not handle what God had placed upon her shoulders. Lynn leaned heavily on her faith, what her mother taught her, and her determination not to let her family down. Eventually, Lynn had to quit her job at the hospital. “But when I left the job, I know it affected my finances, it affected my career, but I was at some level of peace. So, if I was working, making a lot of money, and then something happens at home, who is there to enjoy that finance with me? What am I supposed to do with the finance? Am I supposed to now enjoy it on my own?” She made this decision after her daughter became ill. She realized that “if I lose her, I

don't know what I'll really be working for, so that was my decision." This terrifying decision affected everyone in her family home. Still, Lynn "had to put it on hold and look after my family."

Family

Her son, aged 7, went to school before the pandemic and was schooled at home through the public schools during the pandemic. "He got used to it and was doing really well." Her daughter, however, was home-schooled. The daughter "didn't adapt" to public schooling as quickly. Her daughter, aged 5, suffered from sickle cell. Lynn felt that her daughter "was too little. I was scared." While Lynn worked full-time, home-schooling her daughter was a challenge. "I often had to take some off and then try to homeschool her. Then, sometimes, my sister would take days over and try to homeschool my daughter."

Lynn's sister, aged 26, worked as a bartender part-time. After the death of Lynn's husband, her sister

was really there for me. Because I don't think all of this could have been possible without her. Sometimes, she had to stay off and off work just to look after my kids and look after our parents. Sometimes, I'd have to beg her to stay back and not go to work that day. And sometimes I'll ask her, "Okay, while coming back from work, you could pick up some stuff. Groceries and stuff for our parents, bring them back." Or sometimes I would just ask her to stay back while I go and do the shopping myself."

The two sisters worked tirelessly to care for the rest of the family. Their dynamic was crucial in keeping the family together through the pandemic rules, such as limitations at the grocery store where families "couldn't go in and get as much as I wanted," which meant more trips and logistics.

Lynn's parents were "old," and both her mother and father had health issues; however, Lynn's father has mobility issues and "cannot walk," and her mother "takes care" of him. Lynn's mother had her hands full in caring for her father as he required much time and support. This only added to Lynn's worries when both sisters had to work, and her parents supervised the children. Lynn often worried about the capacity of her parents to provide adequate supervision and care for the children. While Lynn knew her mother would not intentionally cause any harm or danger to her grandchildren, she remained in a constant state of worry. "All I'm doing is thinking about my kids. Are they fine? Are they okay? Have they had something to eat? I hope there's no problem at home, so I could barely concentrate."

Death of Her Husband

Lynn remembered going to the hospital every day, crippled with fear to see her husband, as she was so afraid of losing him. With the increased stress of becoming her family's sole breadwinner and primary caretaker, Lynn placed her needs on the sidelines. Lynn did not have a chance to grieve as she had to remain strong to do what was necessary to care for her, her young children, her elderly parents, and her young sibling. "We knew that everything was on our shoulders, so we had to keep the family going. We had to sustain the family. We couldn't just keep grieving on the loss." Eventually, Lynn pursued counseling to deal with the loss of her husband and the stress of working during the pandemic. Lynn understood that she was in her own personal hell and never processed her loss and ongoing grief. Lynn's feelings of confusion, hurt, heartbreak, anger, fear, and devastation were real, and they numbed her.

After the death of her husband, Lynn faced the impossible decision of what to tell her children. Lynn told her son what had happened. "It really affected my son." But, he was "very strong. He responded quickly, and he knew that he was the man of the house." Lynn and the rest

of the adults in the house made the heartbreaking decision not to tell her daughter. She knew her daughter was “a daddy’s girl,” and she was “so young” she would not understand what happened to him. Lynn told her daughter, “Her dad was away on a trip and would not return for a while.” This was not how Lynn wanted to handle this, but she knew at this time “it was the best thing” for her daughter. For a “long time” after his death, her daughter “used to wake up at night, midnight, telling me that she had nightmares, that she wants to see daddy.” Eventually, Lynn told her daughter about her dad’s death. It “broke” Lynn’s heart to see her daughter “destroyed.” Lynn sought out “counseling for her.”

Finances

Prior to his passing Lynn and her husband did some financial planning, which meant that after his death Lynn had a small financial cushion to fall back on. “He had to make sure that he had left support for the family. So that’s what we have been trying to manage with the income I am making to survive.” Even with the financial support, life was hard and at times felt impossible. Once Lynn quit her job she felt more of a sense of “loss” because she had both time to grieve for her husband’s death and deal with the “sense of guilt” from quitting her job. She was also trying to navigate the increasing financial instability. During this time Lynn also reflected on sacrifices she had to make. She expressed, “[I] had to sacrifice a lot of needs, a lot of wants, things I love doing just to make sure I could catch up for the rest of the people.”

Daughter’s Illness

During the pandemic, her daughter became ill. While it could have been Sickle Cell’s flare-up, the “doctors weren’t sure what caused it.” Lynn felt completely helpless. She stated,

When my child, my daughter, started falling sick during the COVID-19 while taking her to the hospital, that same song played on the radio, and it brought memories that I was so scared that something was going to happen, that there was something linked to this song.

She initially thought it was a sign from God that HE was trying to send her a message. She was unsure if it was a sign from her husband “to let her know he was watching” over their daughter or if it was a sign from God that Lynn’s daughter was being called home. Thankfully, Lynn’s daughter got better. This health scare was the final reason for quitting her job.

Community and Faith

Lynn is very tied to her community. She attended church weekly, something that she got great strength from. Lynn placed “complete trust” in God and is “very grateful” for the good given to her. Like many, her church changed to a virtual format during the pandemic.

You could walk into a church. There was 200 members, and you walk in, and you find 50. Now, you’re moving again. Next Sunday, you find 20 and 10, so the church had to shut down, and we started attending programs live, broadcasted live on Facebook.

The change was difficult for her as it minimized her community interaction.

She eventually found a new source of in-person community during the pandemic through a support group. The group, comprised of Black women, provided Lynn with an outlet for her grief. It also allowed her to connect with other women dealing with loss and “enduring...impossible situations.” The support group gave her the community and support she missed. “That’s kind of like what we do as Black women. We come together, solve the problem, and try to do the best we can to make what we have work because we don’t have any choice. And time and time again, we find ourselves having to do that.” By working together as a group, Lynn and the women could “conquer these issues. And sometimes we make some contributions

amongst ourselves to help. When one of us is sick and/or one of us is going through some really difficult stuff, so we contribute, and we help ourselves.” Through sharing her story and hearing others, Lynn felt that she “got the energy to stand strong” to help “support other women.” Lynn received the “motivation I needed,” the knowledge “that this is not the end,” and the hope “that I have a better future ahead of me.”

Analysis

Lynn is a widowed mother of two small children who was also caring for her aging parents. The multigenerational household included Lynn’s younger sister who was only able to contribute minimally to the financial support but bridging the gap in many other substantive ways. Three months before the pandemic Lynn experienced profound traumatic loss with the sudden passing of her husband from a stroke. This unexpected tragedy left Lynn heartbroken and struggling to pick up the pieces of her life and her children’s lives without her life partner. Like many matriarchs in communities of color, Lynn put on a brave face and hid her grief for the sake of her family. She suffered in silence significantly and shed many silent tears. Her primary task was often digging deep and trying to find the strength to live each day without her partner. This was met with excruciating pain to the point that Lynn often felt numb. She felt the weight of the responsibility of her own role and stepping into the role and responsibilities held by her late husband. Lynn’s feelings of unprocessed grief, confusion, hurt, anger, fear, and devastation were overwhelmingly isolating as she felt unable to trust or burden anyone with her pain. Lynn’s increasing household responsibilities, development of Post-Traumatic Stress Disorder (PTSD), and persistent isolation were all compounded by the onset of COVID-19.

Lynn’s identity as a caregiver was seen in and outside of work. She enjoyed the role of caregiver from the position of wife, mother, daughter, sibling, and nurse. During this time in her

life, her job seemed to become her struggle of wearing the many hats of a Black woman. The spiritual, emotional, and mental weight of it all is an enormous burden often dismissed by those who cannot conceptualize it. After the loss of her husband and the start of COVID-19, all of these roles were stressed and often seemed conflictual. Her role as mother was now also sole parent and sole provider. Lynn was working to facilitate healing and to establish a new familial homeostasis inside of the very uncharted traumatic experience of COVID-19. The role conflict presented in ways such as her constant worry about the children eating and concerned with their safety, due to her parents being elderly and barely able to care for themselves, let alone small children. She often felt guilty, and the anxiety-provoking work environment Lynn labored in daily presented a huge challenge for her to balance as she made every effort to be fully present for her gravely ill patients while at work. The move to virtual schooling as well as Lynn's longer hours at work due to COVID-19 stressors on the health care system meant that Lynn's aging parents had to step in and provide a great deal of supervision in the home. In many ways Lynn was grateful for the village support, which is common in marginalized communities. Lynn's mother was the healthier and more mobile of Lynn's parents and she took on the vast majority of caring for all of the needs of her husband and Lynn's children. Lynn's mother is a very proud woman which often made it challenging for her to express her own overwhelm and limitations, which is also consistent for matriarchs of color. Lynn and her mother also had to rely on Lynn's younger sister to provide extra support, which often meant that her sister was having to choose between picking up shifts at work and helping Lynn care for the children and their parents. Lynn's reliance on others, like her mother, often challenged her natural desire and inclination to be the support for others, especially in a multigenerational household. As Lynn's interviews

evolved, it became clear that collectively being interdependent upon one another added both a sense of security and level of stress.

As noted earlier, Lynn's work hours increased significantly during the early months of COVID-19. Her financial situation left her feeling forced to continue working in order to provide for the family. This was not Lynn's only motivation. Lynn felt compelled to show up each day for patients of color. Like many caregivers of color, Lynn described a deeply rooted desire to provide culturally sensitive and supportive care to patients of color. She recognized the significance of patients seeing someone on their care team that looks like them. She wanted these patients to not only take comfort in seeing her face but also in having the experience of being genuinely seen and understood. Surprisingly Lynn did not see this as her burden and instead viewed it as a privilege. She described herself as "lucky" to be able to show up for her patients in this way. It is also notable, however, that overtime, going to the hospital became difficult. Inside of her gratitude she struggled with the weightiness of being a witness to all of the suffering related to COVID-19. This ultimately became emotionally untenable. This was compounded by her PTSD symptoms connected to the hospital setting. Additionally she found herself regularly empathizing with and worrying about her patients' families, fearing that they too would struggle to survive after the loss of a loved one. A further complication was the high-risk work environment of the ER that not only put her at risk but also the risk of her immune-compromised parents and small children at home. COVID-19 not only added the risk to the physical health of her and her loved ones but also changed her interactions with them. Physical connection, which she knew that her children desperately needed, now became complicated and calculated in order to keep the family safe.

The impacts of COVID-19 on Lynn's caregiving experiences at work and at home led her to quit her job. Like many participants, Lynn had to weigh the financial needs of the household with the emotional and safety needs of her family members. The stress associated with multigenerational families in a single household, and the pandemic created a complicated emotional and spiritual trauma that Lynn's family was not immediately prepared to address. Lynn wrestled with the risks of the choice to continue working and the risks of quitting. Ultimately, like so many marginalized families, she felt compelled to value connection over financial gain.

It was evident that Lynn relied heavily on her personal faith in God and her community of faith for support and direction. Because of this, the move to virtual church services and programs was a major loss for Lynn. She no longer had her church family to engage with and lean on for support. This contributed to Lynn's sense of isolation and limited her coping strategies. However, she was able to re-establish new support through a local in-person support group for African American women. The connection and sense of belonging was renewing and provided the sense of community that is often so important for individuals and families of color.

Chapter 6

Discussion, Implications, and Conclusions

This dissertation sought to understand the ways in which social workers and nurses experienced and navigated “frontline” jobs in health care settings during the COVID-19 pandemic. Particular interest was given to how Black women functioned as the primary breadwinners of their households. Additionally, this study hoped to learn more about the impact of the aforementioned on social workers’ and nurses’ formal and informal labor force participation. Participants shared their experiences as frontline workers in health care settings while caring for their families, patients, and navigating racism. Each participant engaged in two interviews to build rapport with this researcher and to explore the full extent of their experiences across COVID.

Primary Takeaways

There are several significant points of consideration that surfaced in this research. The most significant were the ways in which COVID contributed to the already complex struggles of Black women as they work to navigate familial roles, work pressures, and racial tensions in their macro and micro experiences. For many participants their lives were already riddled with complications related to social determinants of health prior to the start of COVID, which were then exacerbated by shifting circumstances, and responsibilities both internal to their family systems and external in their professional environments.

All participants in this study were deeply invested in their roles of helper or caregiver both in their family systems and through their career choices. The majority of the participants identified as the head of the household and the sole breadwinner. These roles became significantly more complicated and burdensome at the onset of COVID. The families of

participants often started as single generational households and transitioned to multigenerational households as a form of communal support.

Reconnecting to the Tribal Model

This research reflects the need for the participants to find their tribe again as a necessity of support and ultimately survival. COVID forced a shifting in family structures in order to close the gap of care as well as physical and emotional safety. Because the participants already bore the weight of the responsibilities for meeting all the needs of their families before COVID, the added stressors of COVID forced them to find a way to expand the support network and share the burden. COVID directly complicated the natural functioning of the single-parent family structure. While participants were not unaccustomed to the village experience, they felt disempowered and forced to make this shift in the family dynamic. It is also important to note the weightiness of being the sole provider and having to navigate the added responsibility of taking on generational care in the home. The participants needed the help of others to care for the children at home, which also added additional financial responsibility on themselves. The choice was often difficult and taxing on these Black women.

Situating Data Within Theory: Pervasiveness of the Exo- and Chronosystems

As noted in the theory section, Bronfenbrenner's approach to ecological systems reflects a micro to macro systems progression of observation, assessment, and evaluation, which ultimately reflects the interconnectedness of each system. However, for the Black woman of this study, it became evident that each system was impacted by the challenges related to operating inside of exo and chronospheres riddled with systemic racism and generational marginalization. Further, the intersection of the themes of family, work, and discrimination highlighted the ways in which

systemic challenges permeate throughout each level and every aspect of the life of the Black woman in this study.

This research counters the presupposition that each individual is imbued with power, privilege, and agency to engage with and impact their ecological systems. As reflected in the themes, the participants in this study often felt even more disempowered and marginalized within the pandemic. While they were being asked to provide almost miraculous care without resources, they were also being expected to assimilate and accommodate a discriminatory system without questioning or challenging that system. When asking to work from home or to have more protective safety measures in the workplace, they could see the blatant inequities with white counterparts. While the participants desired to shift the stressors of their own ecosystems, such as taking measures to protect their own microsystems, they were met with systemic discrimination, that often reflect the historic discriminations.

Relatedly, it appeared that the woman experienced what may be likened to “code switching” where they developed varying identities that deviated from the most genuine representation of self which was only safe to present within their families of origin. Code switching within the African American familial and professional community for acceptance, a better life, and career advancement can have both positive and negative consequences for the individual and the larger community experience.

When people show up within their families and/or within their communities they typically present their genuine selves unless there is some trauma or dysfunction that alters their authenticity. When people show up in majority spaces or communities they present differently often because they do not feel comfortable or they feel inadequate as their authentic selves.

One major example of a challenge was safety. For many women in the study, they felt torn between choosing physical safety for their families and emotional safety by giving into the expectations of the racist systems at their workplace. Authenticity to who they were as heads-of-household and primary caregivers at home would be reflected through advocacy for themselves, families, and in many cases their unborn children- and not allowing their employers to prioritize the needs of their white colleagues, and counterparts. Authenticity to who they were as professionals and “team members” would require them to assimilate without advocacy. When they attempted to reconcile these identities, several found that the only viable option was to quit and take an enormous financial risk. The woman felt devalued, unheard, unprotected and disrespected when engaging in personal and familial advocacy. At times they even felt like their managers were intimating that they should “suck it up,” “deal with it,” and “be a good team player.” Both Tammy and Shawn reflected on the feelings that management prioritized the team over the safety of their unborn babies. The participants could not present themselves in a genuine and authentic way, and protect their own micro system, while also maintaining employment in a completely stressed discriminatory macro system.

Researcher Positionality

As a Black woman working on the “frontlines” in a hospital setting in COVID-19, I experienced many challenges and tragedies. As I read the stories of helping professionals and their personal and professional experiences during COVID, I became keenly aware of the lack of voice given to the experiences of Black female nurses and social workers showing up every day to support their patients as well as other hospital staff. I related to the silencing and the implied insignificance of our experiences. This research was designed to elevate the untold and unheard stories.

During the interviews I identified with many of the thoughts, feelings, pressures, and trauma that the participants discussed in relation to the COVID-19 pandemic. The experience was anxiety provoking due to the extreme stress and weightiness of everything that we all shared in one way or another. Fear of losing loved ones to this highly contagious and unknown deadly virus was a daily concern especially after seeing entire families decimated by it. In many ways the research took me back to the frustrating and isolating experiences such as a routine of sanitizing at the front door before being able to engage or connect with my family in any way, or the extreme precautions taken at work to prevent infection transmission among staff. I connected deeply with the participants around their greatest fears of causing harm or even death to family members. I could relate to many aspects of the participants' stories while also recognizing the importance of maintaining objectivity in the research. At times it was challenging to maintain the necessary distance from the participants and their narratives. I addressed the potential for bias in several ways. I met with the research chair of this dissertation weekly to discuss each step of the research process and discuss ways in which I was identifying or over-identifying with the participants. I utilized secondary coders to explore themes and consulted with other peer researchers throughout the analysis process and development of the findings.

The utilization of oral storytelling is historical in preserving and translating the generational experiences of Black culture. Historically this is a traditional method that is utilized to understand and preserve Black history. While my identity as a Black woman and "frontline" worker framed my view of this research, it also offered participants relatability that allowed them to quickly connect, build rapport, and feel free to open up and speak their whole truth. They

were able to connect with me as a comrade in the struggle. This depth of vulnerability significantly enhanced this research study.

Strengths

Participants were frontline workers who worked in health care settings in high contagion areas such as the Emergency Department, Intensive Care, Infectious Disease, and Respiratory/Pulmonary units with direct patient contact. Many faced trauma and extreme loss during the early phases of the pandemic in their places of work, in addition to high risk of contagion, making the sample particularly well suited to address the research questions.

The unique experiences of Black nurse and social work professionals have been historically overlooked, with limited attention to the intersectionality of gender and race for health care professionals. This study gives firsthand accounts of actual events in the lives of these participants which increases the trustworthiness and credibility (Elo et al., 2014) of this study. It also identifies the common areas of constant struggle in the participants' communities and offers new perspectives to provide some insight into a diverse population that may typically lack trust in research or researchers. To that end, the knowledge gleaned from this study will help in understanding the issues that professional Black women face and in determining how to best treat them when they seek help.

Future Research Directions

The findings of this study included the multiple roles that formal labor force participation plays in the lives of professional Black women, including as family wage earners, as sources of accomplishment, as advocates for their communities, and as mechanisms to achieve personal fulfillment. Additional research may consider examining the long-term intellectual, emotional, and professional consequences of pausing or sacrificing a career to become a full-time caregiver for multigenerational families. Further research may also focus on barriers and facilitators to

workforce re-entry. Of specific interest to this researcher is the impact of leaving the paid work force not only for professional Black women, but the family members they care for and live with. Additional research may also work to contextualize and update dominant sociocultural narratives around “the strong Black woman.”

Limitations

Participants who responded to the national call lived primarily on the east coast. Snowball sampling strategies limited those who lived on the east coast to recommend other participants in their geographic regions. Due to the limited number of social media groups dedicated to Black caregivers and the COVID-19 pandemic, recruitment focused on identifying Black social workers and nurses who were providing care rather than caregivers who were trained as social workers or nurses.

Participants ranged in age from the early twenties to early forties. The participants’ ages may have limited diversity in experience, the breadth and depth of generational experiences, professional experience, and views on family dynamics, family roles, and caregiving.

This researcher conducted all interviews online using the Zoom platform. This may have impacted rapport building.

Clinical/practice Implications

This study may inform tailored interventions for professional Black women, or other minoritized groups, who must make impossible choices during times of national and international crisis. Such work must start in a space that is grounded in the social practices and norms of the group with flexible creativity and reservation of assumptions. Further, these interventions must use methods that resonate with the sociohistorical experiences of the group under study, ideally in partnership with that group.

This study used Oral History, which has a long and distinguished place in African and African American cultures around the world. Narrative and family-focused interventions that center cultural norms around collectivist family groups are critical to successful work with women like those represented in this study. Understanding their obstacles, holding safe and supportive spaces to allow free flowing discussion of trauma, inequities, lack of professional support, and lack of personal underpinning will all be key components in helping Black women navigate widespread crises in addition to challenges presented by structural inequalities. Continuing the use of oral histories as a vehicle to bring forth direct relevant content to inform and influence practice and policy in a relatable, familiar, and historical way will continue to add trustworthiness to the clinical endeavor in a fluid manner. Finally, understanding what it means for Black women to find sources of strength, internally and in relationships, requires additional study.

These findings might be different for the non-professional groups as they often have fewer degrees of flexibility in their labor force participation, are underemployed, or are part of informal labor markets without benefits. Non-professionals' ability to find different work options and opportunities may be unstructured and easily changed in the absence of contracts, legal protections, or advocates.

This work may inform the creation of continuing education classes and a seminar/lecture series, discussing the outcomes and important lessons learned from the lived experiences of professional Black women during the pandemic. Creating dialogue through continuing education classes to educate social workers and other mental health professionals of diverse Black demographic backgrounds may include content on the social determinants of health at the intersection of a global health crisis and the needs of marginalized populations. Training may

include the use of narrative or oral history methods in the clinical space, grounded in the tenets of Black Feminist Thought. Other ideas include addressing how much the plight and issues of Black women both professional and non-professional, as well as bringing awareness to and shine a spotlight on what is needed to help Black women succeed and thrive mentally, physically, emotionally, and spiritually during periods of major crisis and pandemics.

Social work practice implications would include the critical importance of narrative and oral histories as a means of preserving the African American experience in the United States. African American women are not monolithic, and with the use of oral stories and narratives a voice will be given to the stereotypes and challenges African American women face. In their own words this study seeks to get a better understanding of how those stereotypes emerged and all of the ways they do and do not fit. The need to be strong does not equate to angry; the need to be providers, community organizers, and the piece that holds their communities and families together does not translate to African American women being all the same. African American women are as diverse as the world in which they live. To that end, the challenges that come from that multiplicity and the infinite ways that African women enact those roles must be embraced.

Appendix

Appendix A: Email/Flier for Participant Recruitment

Appendix B: Consent for Interview

Appendix C: Participant Face Sheet

Appendix D: Interview Guide

Appendix A: Email/Flier for Participant Recruitment

I AM ONLY ONE PERSON: Black Women as Caregivers Maintaining the Wellbeing of Their Families and Communities during the COVID-19 Pandemic

- Have you worked in a hospital/health care setting as a social worker or nurse?
- Have you ever quit your job to be a caregiver to a small child or adult family member?
- You may be eligible to participate in a study exploring health care professionals involuntarily quitting their jobs to become caregivers during the pandemic.

You may be eligible to participate if:

- You are a social worker and have earned your MSW degree
- You are a nurse with a BSN degree
- You were a social worker or nurse for at least one year in a hospital/health care setting
- You worked during the early stages of the pandemic and quit your job to become a full time caregiver to dependent children or elderly loved ones
- You identify as African American and female

Participation involves:

- Completing two, 60-minute Zoom interviews at times of your convenience

Benefits and risks

- Findings from this study may improve opportunities for women of color with resources and recommendations for changes in policy to better assist with their needs.
- This study will have no direct benefit to you
- This study has minimal risk for you

**** Participants will receive a \$25 Amazon gift card upon completion of both interviews ****

To learn more and to schedule your interview: Please contact Jacqueline Coleman-Carmon at carmonja@upenn.edu or (252) 917-1036.

Thank you!

NOTE: This research study is a part of a DSW doctoral dissertation. Participants will not be identified in any reports of findings.

Appendix B: Consent for Interview

Protocol Title: I AM ONLY ONE PERSON: Black Women as Caregivers Maintaining the Wellbeing of Their Families and Communities during the COVID Pandemic

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Research Study Summary for Potential Subjects

You are being invited to participate in a research study. Your participation is voluntary, and you should only participate if you completely understand what the study requires and what the risks of participation are. You should ask the study team any questions you have related to participating before agreeing to join the study. If you have any questions about your rights as a human research participant at any time before, during or after participation, please contact the University of Pennsylvania Institutional Review Board (IRB) at (215) 898-2614 for assistance.

This research study is being conducted to learn about the experiences of African American women who are social workers and nurses and who worked in a hospital/health care setting at the start of the pandemic. Specifically, this study is interested in interviews with women who left their jobs to be caregivers for dependent children and/or elderly family members. We are seeking to understand your views and experiences to further help the exploration of the effects of systemic racism, aid with making policy, understand how the pandemic impacted the African American community.

If you agree to join the study, you will be asked to participate in two Zoom interviews lasting 45-60 minutes each.

Appendix C: Participant Face Sheet

PARTICIPANT FACESHEET

Name/Pseudonym:

Email address:

Phone number:

City:

State:

Age:

Gender:

Profession:

Appendix D: Interview Guide

FIRST INTERVIEW

Introduction: Thank you for agreeing to be interviewed. The purpose of this study is to understand the experiences of Black women as caregivers during the COVID pandemic. In addition, this study will explore the ways in which social workers and nurses navigate complex systems, and how social workers can meet the needs of Black women both professionally and personally. Interviews will be conducted in a semi-structured format, which allows you to explore this topic openly, and in a conversational manner. Your participation will include two interviews of 45- 60 minutes each, approximately one to two weeks apart. You may end either interview earlier at your request. The second interview will provide an opportunity for me to ask any follow-up or clarifying questions and provide an opportunity to ensure that I accurately understand your perspective.

As explained in your consent form, your participation will always be voluntary, and you can end your participation in this study at any time. Your personal identification information will remain confidential, and I will ask you to choose a pseudonym as an identifier for your data and reference in the dissertation analysis. However, it is important to note that, like you, I am a mandated reporter, and I am required by law to disclose any information regarding harm to yourself or others.

The consent form that you reviewed and signed includes how the information you provide will be collected, transcribed, maintained, and stored to protect your privacy and confidentiality. I am available to answer questions at any point during or after the interview process. Do you have any questions for me at this time?

Let's start with your pseudonym: _____

The focus of this first interview will be on your experiences and your relationship with family and community. Are you ready to get started?

1. Tell me the story of how you experienced the early days of the COVID-19 pandemic?
2. At the start of the pandemic and the shutdown, you worked in a health care setting. Tell me about the experience of working on the front lines.
3. What challenges or fears did you face because of this work? What challenges or fears did your family face? Did you talk about these challenges or fears with your family? Colleagues? Others?
4. What changes did you experience in your community because of the pandemic shutdown? (if the participants asks for clarification: Tell me about school and child care centers, essential services like supermarkets and clinics, church and other spiritual groups.
 - a. How did these changes impact you?

b. How did they impact your family life?

Closing of the first interview

Thank you very much for participating in this interview. I am looking forward to our second interview in about two weeks. In the second interview I will ask you to reflect on the overall experiences that the pandemic had on your professional and personal life. Do you have any questions for me at this time? Could we set up a time for your next interview?

If you have any questions or concerns between now and the second interview, please feel free to reach out to me at the contact information on your consent form.

SECOND INTERVIEW

Thank you for meeting with me again to complete your participation in this study. As a reminder, your participation is still voluntary, and you can end your participation in this study at any time. Your personal identification information will remain confidential. However, as I mentioned the last time we spoke, I am a mandated reporter, and I am required by law to disclose any information regarding harm to yourself or others.

Do you have any questions for me at this time?

1. During the first interview, you shared important information about the decisions you made to cope with the early stages of the pandemic, including being on the front lines in a health care setting and leaving the paid work force to care for family members. Would you like to share any additional thoughts or memories about this period of time?

This study is particularly interested in how professional Black women in health care settings at the start of the pandemic needed to leave the paid workforce to care for dependent children and elderly loved ones in their families and communities.

2. Please tell me about this decision. When did you realize you had to make the decision to leave your job?

c. What factors did you consider when you decided to leave your job?

d. What concerns did you have about your family?

e. What concerns did you have about your career? How did you weigh these with your concerns for your family?

3. What supports did you have in place to assist you with these changes at work and at home?

Now I'd like to turn to the impact of the pandemic on your current experiences:

1. In what ways did the pandemic shutdown impact your family's long-term well-being?

a. In what ways was your mental health impacted?

b. Over the last three years, have you seen long term impacts of the shut down on your mental health? On the mental health of your family members? On physical health?

2. Have you returned to the work force? (If yes, continue with prompts below)

a. How does your current position compare to your position at the start of the pandemic?

b. What challenges have you faced re-entering the workforce?

3. Are there ways in which you believe the pandemic impacted African American/Black communities differently than predominantly white communities?

4. What supports do you believe African American communities, and specifically African American women needed during the pandemic?

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