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Introduction

Instead of sparking a return to the Roaring Twenties, the year 2020 saw a series of historic events such as Brexit, the Black Lives Matter movement, and the onset of a global pandemic. The World Health Organization declared the disease caused by the novel Corona virus a pandemic on 11 March 2020 ("WHO Director-General's Opening Remarks" sec. 1). As defined by the Dictionary of Epidemiology, a pandemic is "[a]n epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people" (209). In an effort to contain the spread of the virus, nations implemented safety measures such as mandatory facemasks, social isolation or lockdowns globally. The unprecedented situation of the pandemic significantly changed people's lives in the weeks and months that followed, both professionally and on a personal level. Although similar to other recent crises, such as the global economic crisis in 2008/2009, also known as Great Recession, the COVID-19 pandemic caused a distinct and unique disruption to the labour market and global economy (Verick et al. 127). As a result, governments and individuals alike have been facing unparalleled challenges, which especially affected women.

Overall, the effects of COVID-19 on national economies were drastic. Following the outbreak of the pandemic 2020, the GDP "fell by 13.9% across the EU, compared with the same quarter in 2019" (OECD and European Union 24). Unlike the global financial crisis, the COVID-19 crisis resulted "in negative economic growth in most low- and middle-income countries … far worse than that witnessed in 2009" (Verick et al. 128-29). Due to lockdowns and other containment measures that have drastically reduced economic activity, the pandemic has had a much greater global impact on economies and labour markets (Verick et al. 145). The parallels that can be drawn between the financial crisis of 2008 and the COVID-19 pandemic is their respective emergence in one of the leading global economies (the United States in the former and China in the latter), and their subsequent worldwide spread and far-reaching consequences (Strauss-Kahn sec. 1). Among these consequences were the dramatic shocks to national economies caused by the closure of entire commercial and financial sectors, and, consequently, soaring unemployment figures (Blundell et al. 292). Globally, such drastic losses to the labour market as well as the massive increase in unemployment rates were last recorded seven decades ago (Bock-Schappelwein, Famira-Mühlberger and Mayrhuber 1), in the post-war era. Many individuals found

themselves in a precarious financial situation, thus, consumer behaviour decreased and significantly disrupted the demand-side of the supply-chain ("ILO Monitor on the World of Work" 2). Moreover, in an effort to limit the spread of COVID-19, entire industries, such as tourism and leisure, were forced to close down by governmental decrees (Strauss-Kahn sec. 4). In order to minimize the losses to the economy, and to reduce unemployment figures, many local governments have introduced subsidiary schemes (Blundell et al. 297). Despite these efforts, the COVID-19 crisis has been "successively qualified as the largest since the Great Depression" (Strauss-Kahn sec. 2). Both the financial crisis and the current pandemic have reaffirmed the fact that employment and individual wealth are subject to crises (Verick et al. 130). Historic crises such as the First and Second World War, the Great Depression, or the above-discussed Great Recession, show that drastic social transitions present gendered difficulties, as women's hardship is often neglected (Enloe 88). In the case of the COVID-19 pandemic, already existing financial disparities widened and income-based inequality between the genders saw a particularly significant increase.

In recent years, the gender pay gap has been a central issue to the public discourse of gender (in)equality. The European Parliament defines the gender pay gap as "the difference in average gross hourly earnings between women and men. It is based on salaries paid directly to employees before income tax and social security contributions are deducted. Only companies of ten or more employees are taken into account in the calculations" (par. 2). Even though the percentage of income difference between men and women has decreased over the past ten years, particularly in the EU zone, it is still significant. As of the year 2020, the gender pay gap in Austria was 18.9%, which is significantly higher than the EU-average of 13% ("Einkommen"). Similar, if slightly lower, the gender pay gap in the UK in 2020 was 14.9% (White par. 12). While the most recent data from Austria is from the year 2020, an update on the gender pay gap of 2021 is available for the UK, showing a minimal improvement to 15.4% (White par. 12). One common explanation for this is that in female-dominated industries, such as healthcare, education or social services, wages are often lower (Bohrn Mena 41). Furthermore, with a rate of 49.6% compared to 11.6 % in Austria ("Erwerbstätigkeit" sec. 2), and 38% versus 13% in the UK (Irvine et al. 4), women are significantly more likely to work part-time than men. In addition to working fewer hours and for smaller wages, women also more frequently have atypical employment contracts, e.g., freelancing (Bock-Schappelwein, Famira-Mühlberger and Mayrhuber

5). In Austria, half of the women work in an atypical employment situation i.e., not fulltime (Bohrn Mena 49). However, characteristics such as industry or type of employment, age and working hours can only partially account for the gender pay disparity (“Einkommen und der Gender Pay Gap”; Smith). This indicates that structural differences between men and women on the job market have a significant impact on the size of the gender pay gap. In light of the economic situation prior to the outbreak of the coronavirus pandemic, and data on the gendered effects of previous crises, the ensuing worsening of women's economic circumstances was not unexpected.

While economic and financial crises have occasionally shaken and tested the global economy in the last decades, the COVID-19 pandemic exceeded the consequences of such crises by additionally having unparalleled impact on the healthcare sector. Although other diseases, such as measles or smallpox, have previously had an international impact, the COVID-19 pandemic’s reach has been global (Shinoda 65; Ferreruela and Mallor 1). At the time of the World Health Organisation’s (WHO) classification of COVID-19 as a pandemic, 118.000 cases were confirmed in 114 countries (“WHO Director-General's Opening Remarks” sec. 1). Similarly high numbers of infections and deaths caused by a virus in such a short period have not been recorded in Europe for a century (OECD and European Union 24). The pandemic, therefore, posed an unprecedented challenge to governments, global economies, and healthcare systems.

The 1918 influenza pandemic, often referred to as the Spanish flu, was frequently invoked during the COVID-19 pandemic to evaluate the current situation and find ways for mitigation. This can be explained by the fact that “[i]n a crisis, we often turn to history to see if there are any lessons we can pull from that time” (Bernard 04:33). Following the First World War, the Spanish flu was the world's first influenza pandemic (Shinoda 65). It is estimated that between 50 and 100 million deaths resulted from the Spanish flu in the years 1918 to 1920 (Bernard 01:08). The name “Spanish flu” gives the false impression of Spain as the country of origin of the influenza; it is known by that name because the Spanish press first reported on the illness (Bernard 05:38). Even more drastic than the geographical labelling of the early 20th century, ethnic stigmatization occurred during the COVID-19 pandemic following the outbreak of the coronavirus in Wuhan, China (“Timeline”). Especially during the first wave of the pandemic, a surge of scapegoating and xenophobia perpetuating an anti-Asian sentiment emerged. People from Asian descent, especially from China, were

increasingly experiencing racism and discrimination, a situation that culminated in several hate crimes (Human Rights Watch par. 7). The United Nations Secretary-General referred to this trend as “the virus of hate” and urged the public and governments to counteract the perpetuation of this narrative of blame, especially online (@antonioguterres). The use of social media platforms contributed to the spread of the anti-Asian rhetoric and the marking of ‘the other’ as derogatory language was used in the form of hashtags such as “WuhanVirus, Kung-Flu, Chinakidsstayhome, and ChingChong” (Hahm et al. 2). The digitalization of the 21st century has made the racialization of the COVID-19 pandemic more rapid and global, thus, more drastic than stigmatization at times of the Spanish flu.

Besides the similarity of ethnic stigmatization, the two pandemics shared several other traits including the size of the pandemic and the employment of certain public health measures as containment strategies. The 1918 influenza and the COVID-19 virus, both pneumatic diseases, are of comparable severity and magnitude (He et al. 69). Approximately one third of the world’s population is estimated to have been infected with the Spanish flu (Shinoda 70). As of September 2022, the WHO confirmed more than 600 million cases and over 6 million deaths of COVID-19 globally (“WHO Coronavirus Dashboard”), and, including the estimate of unreported cases, half the world’s population is believed to have been infected already (Van Beusekom par. 1). Public health measures for both diseases included social distancing measures such as restrictions for mass gatherings (He et al. 69). The measures during the COVID-19 pandemic were implemented not temporally consistent but varied with the current rate of infections (He et al. 69). Despite their similarities, the COVID-19 pandemic is different to the Spanish flu in its global socio-cultural impact.

The implications for people’s health caused by COVID-19 exceed the contraction of the virus. Even though the mortality rate associated with the COVID-19 pandemic is significantly lower than the death rate of the Spanish Flu (Baker et al. 6), the pandemic has indirectly influenced every area of the healthcare system as illustrated in the biennial publication *Health at a Glance: Europe 2020* by the OECD and European Union. These effects ranged from disruptions to ambulance services to delays of treatment of patients with other diseases. The document also states that despite the early introduction of measures to prevent the spread of infections, the number of COVID-19 cases were rapidly rising, leading globally to overstrained, and, at peak times of infections, close to collapsing healthcare systems. It identifies pre-

existing shortages of staff, amplified by the rapid and enormous rise in number of patients during the first wave of the pandemic, as the main reasons that left health professionals struggling to provide urgently needed treatment. Consequently, the OECD and European Union infer, many European countries mobilized medical students and retired hospital staff to assist in meeting the overwhelming demands of the pandemic (OECD and European Union 24, 43, 44, 47). These desperate efforts of managing rising patient numbers made the deficits of such vital sectors as healthcare or the caring professions visible. The pandemic highlighted whose work was necessary to uphold entire nations in a crisis that affected all areas of life. The divide between essential and non-essential workers assigned definite values to professions and social standings.

In addition to key workers in the health sector, staff in transport, retail, civil service etc., were deemed essential given that their labour was necessary to maintain the functioning of society. The idea that some institutions are so crucial to the functioning of a country, or even the world, that their collapse, due to the dire repercussions of such a failure, must be prevented at all costs first emerged in the finance-sector (Ritter and Stranger 05:02). It is commonly known as the “too-big-to-fail problem”, referring to the predicament that large companies in the financial system must not fail as to avoid a collapse of the entire system (Jackson et al. 1). Thus, governments are forced to balance out any losses for the benefit of the nation (Jackson et al. 1). In the original context, the worst-case scenario for the failure of such essential institutions is the collapse of the financial system. This would harm “the wider economy in terms of higher unemployment, lower output, and potential social unrest … and severe recession and potentially a depression” (Jackson et al. 18). The failure of any essential sector would not only disrupt the production, transport, and trade of necessary goods, but also endanger international trade chains. Transposed to the pandemic, a financial and economic collapse in the wake of the far-reaching social and economic disruptions appeared to be a possible scenario. At the same time as a potential economic collapse, the even more likely collapse of the health system would have had dramatic negative effects on public health, and, especially, on death rates. Therefore, global measures to curb the spread of the virus were drastic and included closing any public spaces that were not deemed necessary for daily survival, including educational institutions, restaurants, and entertainment facilities. The majority of the working population, except for essential workers, who, in some countries like Austria,

were even prohibited to take vacation days, was advised to switch to remote working (Bohrn Mena 27). While these measures have helped to considerably contain the spread of the virus, they also have had an unforeseeable, and ultimately unavoidable, impact on people's lives, leaving many severely struggling to adapt to these new and unique circumstances.

As people's homes were transformed into a workplace, educational space, and leisure facility, all at once, the consequences were especially felt by families. Caregivers were not only responsible for their paid work, but also had to take up an active role in the education of their children and help them navigate these drastic changes. Globally, 1.5 billion children were affected by pandemic-related school closures and, thus, the demand for at-home childcare increased drastically (Alon et al. 1). Due to social distancing and the high mortality rate for elderly and risk groups, the usual support of grandparents or friends was reduced to a minimum, leaving parents with the sole responsibility for care duties. Working mothers, especially, were drastically affected by these added responsibilities. The accumulated burdens of economic, domestic, and social labour added to already existing gender inequalities and left mothers more affected than fathers. Mothers had to bear the manifold burden of having to work from home, a space that for many already was problematic due to the amount of unpaid work women perform in the household or domestic violence, while having their children at home. Unpaid childcare significantly increased during this time and was predominantly performed by women who received little to no support, a development that has already been proven in several studies (Collins et al., Hjálmsdóttir and Bjarnadóttir; Zartler et al.) and whose long-term consequences are yet to be determined. Families with a higher income were more likely to be able to provide the necessary time and means for their children to adapt to the new situation, whereas families with lower income received inadequate support from governments and schools to continue their children's education from their homes (Blundell et al. 293). The added responsibilities and numerous changes to familial and social life have immensely affected people's overall wellbeing.

The increasing financial strain, the uncertainty surrounding the pandemic and the high pressure of domestic confinement has translated into a significant negative impact on people's mental health in the form of high stress levels, anxiety, and depression. Governments urged their citizens to comply with restrictions to their personal freedoms by appealing to their altruism. Seeing that self-isolation or

quarantine meant “[s]eparation from loved ones, the loss of freedom, uncertainty over disease status, and boredom” (Brooks et al. 912), those measures proved a severe emotional burden for many during the pandemic.[1] While these measures helped to stay healthy, the state of being healthy encompasses more than physical health. It is “a state of complete physical mental and social well-being not merely the absence of disease or infirmity” (Chisholm 1). The former Director-General of the WHO Brock Chisholm once stated that “without mental health there can be no true physical health” (Chisholm 3). The COVID-19 pandemic has reiterated this observation. The effects of the pandemic reach well beyond physical health. It posed a unique challenge to people’s mental health as it combined stressors of physical, social as well as mental wellbeing. For one, the duration of 10 days for COVID-related quarantine and self-isolation exceeded ‘usual’ isolation-periods warranted for other sicknesses, thus leading to “significantly higher post-traumatic stress symptoms than [experienced by] those quarantined for less than 10 days” (Brooks et al. 916). In this particular circumstance, the major stressors were boredom owing to their usual activities being omitted from people’s daily routines, the frustration about the infringement of personal liberties and inadequate supplies to sustain such a long period of confinement (Brooks et al. 916). Generally, the fear of infection as well as the uncertainty and indefiniteness of the pandemic translated into ubiquitous distress (Pfefferbaum and North 510-511). Scholars have suggested ways on how to improve the quarantine situation for the public by, amongst other things, reducing the temporal span to the necessary minimum (Brooks et al. 917). Other alleviating factors for the mental load would be governments providing the population with continuous, concrete, and non-conflicting information as well as providing adequate supplies for people in quarantine so that they need not rely on their social network (Brooks et al. 918). Apart from these methods to improve quarantine conditions and help with adjusting to the crisis in general, governments had to navigate meeting their responsibility to protect the population, not only from the virus. The confinement of the pandemic caused widespread distress amongst people, but it put certain groups at serious risk for their safety.

Infection and illness were not the only threats to physical health the pandemic posed. Globally, gender-based violence was rising rapidly as a result of the pandemic amplifying economic and social strain as well as isolation measures (United Nations

[1] These terms are not synonymous: isolation is an action taken *after* infection while quarantine is a preventive measure when an infection could have possibly happened (Brooks et al. 912).

2). Programmes to support victims of domestic abuse were disrupted or rendered inaccessible and many women were forced to go into lockdown with their abusers. This rise in domestic violence against women is often referred to as "shadow pandemic," or a “pandemic within the pandemic” (United Nations 19). For women, the effects of gendered violence was clear early on, yet research on the impacts of the pandemic on sexual and gender minorities is little (Hafi and Uvais). Therefore, comprehensive data has yet to be published to make any claims for these particular demographics. In a policy brief from April 2020 elaborating on the specific consequences for women, the United Nations have reported that prior to the pandemic one in three women had experienced domestic abuse from a spouse (17). Previous crises have shown that violence against women and children increases in situations of confinement, thus, during the COVID-19 pandemic women and girls were more likely to experience domestic abuse at the hands of a spouse or other family members (OECD 12). International organizations have issued warnings about the heightened risks to the security of women during the pandemic and the additional challenges brought on by their limited access to peer support and other resources (United Nations 17). The lack of personal contact to anyone outside the home has made interventions near impossible. Institutions that have previously been able to notice behavioural changes or visible physical harm of children and mothers, such a kindergartens and schools, were closed. It was unclear whether support facilities such as women’s shelters and emergency accommodations could remain open, and if, how affected women could reach them to receive help. As a result, several global initiatives to protect women were launched. Emergency helplines and video calls were a bypass solution, but personal contact to victims of domestic violence is vital to help them navigate such precarious situations (Grasl-Akkilic 77). Several studies (Grasl-Akkilic; Steiner; Steinert, and Ebert; “COVID-19 and Violence against Women”) have already investigated the effects of the COVID-19 pandemic on domestic violence and have published information on the availability of help. However, gathering data remains challenging due to the sensitivity, stigma, and fear associated with the topic.

In addition to the obvious disciplines of medicine and natural sciences, the novel coronavirus opened up a large field of potential research in Cultural and Social Studies. In fact, a plethora of recent studies concentrates on the effects of the COVID-19 pandemic on every aspect of women's lives across numerous nations and in a variety of professional domains. Research has been conducted to investigate the situation of

women in the occupational areas of academia (Parlak et al.) or healthcare (Lorello et al.). Geographically, findings span from large parts of Europe such as France (Hennekam and Shymko), Belgium (Assoumou), Iceland (Hjálmsdóttir and Bjarnadóttir), Ireland (Clark et al.), Italy (Del Boca et al.), Hungary (Fodor et al.) to the US (Collins et al.; Alon et al.) and Australia (Craig and Churchill). Likewise, scholars have researched the situation in Austria (Zartler et al.; Derndorfer et al.) and the UK (Reece; Almudena and Smith). Apart from academic publications, a number of non-fiction works on the topic of COVID-19 and its effects on society, specifically on women, have been published, especially in the German-speaking context (Al-Mousli; Bohrn Mena; Rußmann). These publications show that there is high demand for information and material on this subject from the general public.

This thesis reviews the existing literature on the effects of the pandemic on gender inequality and extends previous research that has critically analysed the effects on women. I aim to understand the specific experiences of mothers in Austria and the UK, specifically in England, who in addition to work, also managed home duties and childcare during the COVID-19 pandemic. Furthermore, my paper aims to give a retrospective view of the situation of the pandemic. As the pandemic is still not fully overcome, the implications of the pandemic are ongoing, thus, a definitive assessment is not possible at this point. Yet, this thesis contributes to a better understanding of the ramifications of the pandemic, by having gained more recent insights. Recent research has investigated the differences between men and women globally (Derndorfer et al.; Alon et al.; Del Boca et al.) and has come to the consensus that, overall, women have been disproportionately worse affected by the implications of the pandemic compared to men. Hence, this project does not replicate inter-gender research, but rather adds insights on intra-gender differences by comparing the experiences of the specific demographic of mothers to women without children. Combining ideas from Cultural and Social Studies, this paper contributes to a growing interest in motherhood studies and medical humanities. Additionally, my aim is to contemplate how the pandemic has deteriorated gender inequality for women both in the workplace and in the domestic sphere, and what effects this decline had on their mental wellbeing. The underlying assumption of my research is that mothers were disproportionately worse affected by the pandemic and that gender inequality for this demographic has exacerbated drastically. To prove this hypothesis, I will address the following research question:

How have women in Austria and the UK been affected by the COVID-19 pandemic in the realms of paid professional and unpaid domestic labour?

In order to answer this question, a special focus is laid on the difference of experience for mothers compared to childless women. Other guiding questions include whether women's age and their relationship status has had an impact on their experiences of workload and mental burden. I also consider whether the number of children and the children's ages affected mothers' wellbeing.

This thesis is a multifaceted study: starting from a baseline review of previous research results, I also utilize empirical and statistical methods and draw from insights of the disciplines of gender studies, sociology, and economics to illustrate the gender specific effects the pandemic has had on women, particularly mothers. I will use the findings of my own empirical research as the basis to answer my research question. In doing this, parallels between Austria and the UK will be drawn. Of course, a direct comparison between these two countries is difficult if not impossible. Hence, the comparison and contrast will consider not only the different political systems, but also local measures to adapt to the pandemic, different educational systems etc. In addition to the analysis of the individual and personal factors that have shaped women's experiences of the pandemic, I will also investigate country-level factors such as available resources and policies.

To this end, the thesis is structured as follows: In the first part, I contextualize the background of the COVID-19 pandemic, globally, and in the specific localities of Austria and the UK, focusing on three main areas: its implications on paid labour, domestic labour, and mental health. Secondly, I outline the theoretical context and define the concepts relevant to this work, followed by an explanation of my methodology. The third and main part of this thesis consists of the analysis of the empirical work and the interpretation of the results. These findings are clustered in the same three parts as the contextualization of the COVID-19 pandemic, namely, professional realm, domestic work, and mental health. Finally, in the conclusion, the main findings are summarized and the importance of scholarly contributions on this topic are reiterated. The limitations of this research are recognized, followed by an outlook on what systemic changes need to be taken to achieve gender equality and reverse the effects of the pandemic. I suggest areas for further research in order to fully understand how the pandemic has affected gender inequality. The direct impact

of the crisis on women is substantial, not only in the intermediate, but also long term. It is likely that similar global health emergencies will reoccur in the future, making it essential to gain and spread knowledge on how to curtail the challenges for women and build adequate crisis management and support systems.

The COVID-19 Pandemic

At the time of writing, the COVID-19 pandemic has already lasted for more than two years. It has influenced every facet of daily life, including, but not limited to, work, education, family, and health, for individuals all over the world. Nobody could have predicted that the pandemic would have reached global proportions in just one month after the WHO originally described it as a "public health emergency of international concern" ("Timeline"). Just one month later, on 11 March 2020, the WHO declared the situation caused by the virus SARS-CoV-2 a pandemic, due to the virus's rapid global spread ("WHO Director-General's Statement" sec. 1). In its earlier guidance document on influenza pandemics, the WHO outlines the stages of a pandemic and explains the adequate and necessary steps in responding to it. The initial three stages focus on developing strategies for pandemic-preparedness and planning actions in case of an outbreak. Stages 4 to 6 are of a more practical nature, and cover strategies on how to implement these mitigation strategies after human-to-human transmission has already occurred and infections have spread first across countries, and, eventually, globally ("Pandemic Influenza Preparedness and Response" 25-26). The WHO has published (and updated until February 2022) a timeline of their responses to the pandemic, which serves as basis for the following overview of global reactions to the COVID-19 pandemic.

On 31 December 2019, the WHO's country office in China was informed about an uncommonly high number of cases of pneumonia in the municipality Wuhan ("Timeline"). In the first weeks following this notification, the focus lay on preventing further infections as well as preparedness in case the virus spread. As early as the beginning of January 2020, the WHO published several documents for guidance on the virus, including information on preventing and controlling infections, risk communication and travel advice. Approximately a week after this publication, the global expert network on infection control convened for the first time. From the beginning of February onwards, daily media briefings were held by the Director-General Dr Tedros Adhanom Ghebreyesus. At the end of February, further information

on quarantine guidelines to contain the transmission of the virus was issued and explained. On 10 March 2020, together with the United Nations Children's Fund (UNICEF) and the International Federation of Red Cross and Red Crescent Societies (IFRC), the WHO published a guidance document for *COVID-19 Prevention and Control in Schools* ("Timeline"). The next day, 11 March 2020, the WHO Director-General spoke at a media briefing and addressed governments and individuals alike, calling for solidarity as well as cross-border cooperation ("WHO Director-General's Opening Remarks" sec. 2). The COVID-19 pandemic, caused by a coronavirus, was unprecedented. As a result, the severity of the contagiousness was further exacerbated by the lack of resources for prevention and treatment. The Director further addressed the multifaceted nature of this crisis in being more than a health emergency: "This is not just a public health crisis, it is a crisis that will touch every sector – so every sector and every individual must be involved in the fight" ("WHO Director-General's Opening Remarks" sec. 2). The disease transcended the medical realm and demanded measures across all branches, and thus transformed professional life. As addressed by the WHO Director, the protection of the public required individual's contribution. This included various implementations of stay-at-home orders, which often entailed remote working for non-essential workers. Consequently, large parts of the population in European countries have been working from home, at least temporarily, during the COVID-19 pandemic: nearly 60% in Finland, more than 50% in Luxembourg, the Netherlands, Belgium, and Denmark, and approximately 40% in Ireland, Sweden, Austria, and Italy (Bohrn Mena 24), and approximately 46% in the UK (Cameron par. 1). Alongside social distancing, other mitigating measures, such as travel restrictions, closures of public institutions, mandatory face coverings, contact tracing and, in later stages of the pandemic the establishment of testing facilities, were implemented in nations across the globe to contain the spread of the virus. In comparison to the last pandemic, the Spanish Flu, COVID-19 policy reactions were stricter, more extensive, ubiquitous, and long lasting in their limits on commercial activities (Baker et al. 1). Overall, these drastic measures, including social distancing and imposed curfews, had unparalleled effects on global economies.

The effects of the imposed restrictions severely affected all industries but hit the sectors with direct personal contact hardest. As these industries are traditionally those with high female labour force participation rates, it follows that women were most severely affected by the COVID measures (Clark et al. 1353). Most layoffs occurred in

sectors with disproportionately high female employment, such as tourism, hospitality, entertainment, and recreation (Bohrn Mena 25-26). As demonstrated by the World Tourism Organization (UNWTO), the year 2020 marked the most unsuccessful in history for tourism as the imposed travel bans and border closures resulted in an almost complete halt of travel. The number of overnight tourists worldwide decreased by 72%, this equals to about 1.1 billion tourists, which caused the number of travellers to return to levels from thirty years ago. This trend continued in 2021 when international arrivals were still 71% fewer compared to 2019. As a result, income fell more than 60% in these two years, which amounted to US$ 2.1 trillion of financial loss ("Impact Assessment" sec. 5). Apart from tourism, other industries were equally affected by the shutdown, especially sectors that demand direct customer contact such as retail or food services (Verick et al. 128). Viewed across all sectors of the economy, however, the COVID-19 pandemic's impact has varied drastically.

While certain branches experienced a dramatic reduction, at times even complete shutdown, of their work, the workload of others, namely those classified as 'system relevant', e.g., healthcare workers, increased significantly. Frontline workers such as employees in retail for necessary goods or public transport operators upheld the bare necessities of public everyday life during the pandemic; by continuing to do their jobs, they allowed the rest of the population to transition through the social distancing and lockdown phases as smoothly as possible. This has shown the significance of these jobs to society's functioning, something many people were previously unaware of. Despite their importance, these key workers were predominantly positioned on the lower half of the income divide with a predominance of women and non-white workers (Blundell et al. 302; United Nations 13). For example, in the EU, 76% of healthcare workers are female ("Essential Workers" par. 2). Likewise, internationally, a significant majority of those providing medical services to society during the pandemic, and therefore facing added health risks, were women (OECD 3). However, neither the monetary nor the temporal compensation in form of downtime matched key worker's workload, nor offset their accrued exhaustion.

During the crisis, frontline workers were subject to a variety of burdens and hazards. For example, in addition to providing medical care, healthcare providers took on the role of providing emotional care to their patients (Pfefferbaum and North 512). Psychological drain aside, female frontline workers were also at a much higher risk of contracting the virus, as their work environment was not safe from a virological and

epidemiological point of view. This risk of contracting the virus was further exacerbated in the early stages of the pandemic, as in addition to the general shortage of personal protective equipment (PPE), female staff in the health sector were not provided with appropriately fitting PPE due to prevailing andronormative standards (United Nations 11). Hence, it is not surprising that, in the first phase of the pandemic, a majority (72%) of infected healthcare personnel was female ("Essential Workers" par. 2). These data on female frontline worker's circumstances show one aspect of how the pandemic has intensified gender inequality and its associated negative effects.

Apart from an increased medical risk, the socio-economic implications for women were immense. The pandemic has meant a backlash for gender inequality in the domestic sphere and a simultaneous rise of archaic and patriarchal ideologies that have been thought overcome or at least abated in the first decades of the 21st century. This, as scholars (Hjálmsdóttir and Bjarnadóttir; Lang; Bock-Schappelwein, Huemer and Hyll; Stock et al.) agree, has renewed the discussion about gender roles and norms. One area of debate focussed on how the pandemic has reversed of some of the gains feminism has achieved over the last decades, as exemplified in the division of domestic labour. While recent trends of feminism focused on gender equality in the professional context and have dealt with matters such as closing the income and opportunity gap, equal representation on the labour market, influencing policymaking, and contributing to systemic change, the gender division within the private sphere has somewhat faded into the background (Hjálmsdóttir and Bjarnadóttir 279). The COVID-19 pandemic put these issues to the forefront of the (feminist) discussion, as, in the early stages of the pandemic, it was theorized that the crisis might act as a 'Great Equalizer' for many inequalities, including gender (Galasso 376). Sadly, this was not the case (Galasso 377; Mein 2439). Rather than a change for the better and a more equal distribution of labour, studies consistently show that women have assumed most childcare responsibilities, cut back on their working hours in favour of others, and neglected their own needs (Collins et al.; Carli; Parlak et al.; Hennekam and Shymko). Work-from-home orders and their consequent breakdown of boundaries between professional and private spheres, for example, resulted in a substantial increase of domestic work, which was predominantly borne by women (United Nations 13). The discourse about these topics during the COVID-19 pandemic have highlighted the importance of daily, unpaid labour in upholding not only families but also entire social systems.

One of the underlying cornerstones of society that has been highlighted by the pandemic was how the societal status quo was (and still is) upheld by women performing numerous unpaid tasks. Current research suggests that mothers were one of the most susceptible demographics affected by the implications of COVID-19 such as unemployment, economic loss, and division of domestic labour (Clark et al.; United Nations). Prior to the crisis, approximately 40% of working single mothers worked in sectors shut down during the lockdowns, which attests to the notion that mothers were more at risk of losing their jobs than fathers (Blundell et al. 306). In addition, mother's daily routines were impacted drastically by the pandemic-induced changes, whereas fathers' participation in domestic chores, especially childcare, remained the same or increased minimally and insignificantly (Clark et al.; Collins et al.; Zartler et al.). Numerous studies have shown that unpaid childcare, i.e., the engagement with children provided by caregivers, increased drastically during lockdown; with numbers ranging from a 25% increase in Spain to 37% in Hungary to up to twice the pre-lockdown hours in the United Kingdom (Derndorfer et al. 4). As recent data on time use in Austria from before the pandemic is missing, no definitive value for women's increasing performance of childcare during the pandemic can be given. However, Austrian mothers performed approximately two more hours of unpaid childcare daily than fathers did (Derndorfer et al. 11). Historically, and especially in the twenty-first century, a mothers' ability to (re-)enter the workforce has been largely determined by the availability of childcare, a prerequisite the pandemic has removed by forcing governments to close facilities for outsourced childcare (Blundell et al. 306). While mothers shouldered the dual burden of working from home and caring for their home-bound children, which, in many cases, necessitated cut-backs in work hours, the majority of fathers in heterosexual dual-income households continued to work full time (Collins et al. 107). Moreover, even if fathers participated in child-care or household tasks, they were more likely to complete tasks that were regarded more pleasurable and rewarding, such as playing with the children and leisure pursuits, whereas mothers performed duties that substantially added to their workload and increased their stress levels (Clark et al. 1353). Compared to fathers, mothers were more often required to multitask, which increased their perception of time and planning pressure, which in turn increased their subjective sense of daily and organisational burden as well as existential fears and feelings of exhaustion (Zartler et al. 6). It is unsurprising that women who could not work from home and did not have access to informal childcare

(single mothers in particular) were most impacted by these developments (Blundell et al. 306). The changes of the pandemic have had a unique effect on mothers, who, in addition to performing the increased demands of housework and adjusting to the new working situations, were now responsible for their children's education.

The new dynamics of working from home in addition to performing household tasks presented difficulties and had a negative impact on the mental health of many women. In general, the prevalence of mental health disorders, including anxiety and depression, has increased by 25% globally ("Covid-19 Pandemic Triggers 25% Increase"). According to recent studies, however, the implications for women's mental health were particularly severe and unique (Clark et al.; Parlak et al.). Many women experienced negative emotions in relation to the pandemic such as "higher levels of stress, guilt, increased pressure, disconnectedness, and isolation" (Clark et al. 1356). Mothers, specifically, reported difficulties adjusting to the new situation due to the loss of the social support offered by family and friends as well as the services supplied by outsourced domestic labour such as cleaning (Parlak et al. 5). The manifold responsibilities in their domestic confinement led to mothers being deprived of their alone time and personal space (Parlak et al. 13). Hence, the much-needed counterpart to women's paid work or household duties was missing (Clark et al. 1357). Studies show that parents who were able to maintain the boundaries between their personal and professional lives reported higher levels of overall satisfaction (Hjálmsdóttir and Bjarnadóttir 271). This is in accordance with recent studies, in which women reported higher rates of stress and strains on their mental health due to the pandemic in comparison to men (Clark et al. 1355). The effects of stress can be long lasting and affect not only mental health but also physical wellbeing (Hjálmsdóttir and Bjarnadóttir 270). In addition to maintaining their own mental health and having to cope with extreme obligations, mothers had to help their children navigate these times of uncertainty and cope with social distancing and the implications it entailed (Clark et al. 1356). In keeping with these ministrations, women often attempted to maintain family harmony by withholding their worry and anxiety from their children and other family members, including their male partners (Hjálmsdóttir and Bjarnadóttir 276). Furthermore, mothers frequently felt guilty for their children's forced lack of participation in social activities or for problems resulting from work-family conflict (Clark et al. 1357). Even though these circumstances were in large parts beyond mothers'

control, they assumed responsibility for helping their children cope, showing yet again that the pandemic has significantly increased the mothers' mental load.

All this illustrates that the COVID-19 pandemic is as much a health and economic crisis as it as a social one. In the sections that follow, I will provide an overview of the progression of the pandemic in Austria and the UK. Specifically, I will discuss the outbreak and spread of the virus, initial countermeasures, and in particular the immediate repercussions on women's psychological and economic well-being.

The Local Context of Austria

The first COVID-19 case in Austria was detected on 25 February 2020 and, owing to the recognized infectiousness of the virus and the discovery of the skiing area Ischgl in Tyrol, a western state of Austria, as a hotspot of the virus, local measures, and regional quarantines to curb the spread were enacted (Pollak et al. par. 3). In the weeks that followed, the Austrian government discussed new strategies to contain the virus and, from 10 March 2020 onwards, public life was progressively restricted starting with closures of tertiary educational institutions (Pollak et al. par. 5). Friday 13 March 2020 indeed lived up to its reputation of being a bad omen as it marked the announcement of the nation's first lockdown, which was due to come into effect the following Monday (Repnik et al. 15). Throughout the pandemic, Austria distinguished between a "hard lockdown" and "lockdown light". During the hard lockdowns, public life was completely halted and curfews were enacted with the exception of a few vital necessities. In the latter, retail, for example, remained open and childcare facilities were semi-operational (Derndorfer et al. 5). Starting on 16 March 2020, Austria went into its first of four nation-wide lockdowns, which lasted until mid-April (Pollak et al. par. 3). Regulations prohibiting visits to friends and family in hospitals and care facilities, as well as the closure of public places, such as restaurants, gyms, or museums, were introduced. Everyone who did not have to be physically present at their place of work, was, at first encouraged and later ordered, to switch to working from home (Derndorfer et al. 5). Until March 2020, this had not been a common practise in Austria, with only 2.6% of employees working remotely before the pandemic (Derndorfer et al. 5). Secondary schools were closed, while primary education and preschool facilities remained open, but parents were urged to stay at home with their children unless they were essential workers (Zartler et al. 6). Overall, it was only allowed to leave one's home for a select few reasons: going to work (only applicable for essential personnel), buying necessities

indispensable to life (i.e., food and medication), caring for another person, or maintaining one's mental and physical wellbeing (Derndorfer et al. 5). These lockdown periods forced people to adjust their habits and routines, thus, severely affected people's lifestyles.

Additionally, these changes greatly impacted Austria's economy. The COVID-19 pandemic, and, especially, the first wave of countermeasures resulted in a sharp rise in unemployment (a 12.3% rise in March 2020 alone) and losses to the labour market not experienced in the last seven decades (Bock-Schappelwein, Huemer and Hyll 7; Bock-Schappelwein, Famira-Mühlberger and Mayrhuber 1). The unemployment rate of spring 2020 was the highest since the 1950s, even higher than during the financial crisis ("Arbeitsmarktlage 2020" 8). Bock-Schappelwein, Huemer and Hyll state that in contrast to the financial crisis, the loss in employment caused by the pandemic was widespread and affected almost all economic sectors. They further note that certain sectors were affected more severely than others, notably accommodation and foodservice industries, which experienced the worst employment losses, falling by 41.2% in March 2020 compared to March 2019 (Bock-Schappelwein, Huemer and Hyll 3). It is interesting to note that the decline in employment numbers varied greatly regionally during the first lockdown: since winter-tourism is one of the principal sources of income in western Austria, these regions were more affected by the closure of hospitality than the eastern states ("Spezialthema 2022-01" 3). Interestingly, although the tourism industry had a relatively equal distribution of male and female employees with a male share of 44.2% (Bock-Schappelwein, Huemer and Hyll 4), in the tourism sector the number of women who lost their jobs was disproportionately higher compared to men (Bock-Schappelwein, Famira-Mühlberger and Mayrhuber 2). Additionally, employment in the personal services sector, which includes the hairdressing and wellness industries, decreased by about 10% (Bock-Schappelwein, Huemer and Hyll 3). Similar trends were recorded for the arts, entertainment, and leisure industries, which include theatres and museums, as they were collectively impacted with a 7.6% drop in employment (Bock-Schappelwein, Huemer and Hyll 3). These numbers show that female-dominated branches were severely affected by social distancing rules and experienced drastic job losses.

While the pandemic's financial effects on men were equally significant and cannot be disregarded, the consequences for women are likely to be longer lasting. Despite the pandemic hitting female-dominated sectors hardest, the majority of those

who were unemployed by the end of March 2020, were men, making up 57% of job seekers (Kremer and Wanek-Zajic 647). Several of the industries severely impacted by the reduction in employment were predominantly male industries, such as construction (87.5% male prior to the pandemic) (Bock-Schappelwein, Huemer and Hyll 4). Overall, the pandemic's unemployment affected men at slightly higher rates than women, with a decline of 5.6% for men compared to 4.15% of women (Bock-Schappelwein, Huemer and Hyll 4). Only considering Austrian nationals, the difference is not as high with a 3.6% decline for men and 3.2% for women (Bock-Schappelwein, Huemer and Hyll 4). Nevertheless, depending on the industry, men re-entered the workforce sooner than women, with 62% of men and 52% of women back in paid labour by June 2020 (Kremer and Wanek-Zajic 651). Consequently, the effects on women were longer lasting, as sectors with an above-average proportion of female employees, like hairdressers, had to remain closed for most of 2020. This, in turn, lead to medium- or long-term pension disadvantages for women (Bock-Schappelwein, Famira-Mühlberger and Mayrhuber 5). While a reduced amount of state pension due to fewer work years compared to men posed problems for female workers even prior to 2020, lay-offs, forced closures, and reduced workhours due to the pandemic further aggravated the situation (Bock-Schappelwein, Famira-Mühlberger and Mayrhuber 5). All the pandemic-related employment developments not only pose immediate impediments to women's careers, but the economic disadvantage also extends to an older age. As a result of interruptions to women's working lives (such as pregnancy, childrearing, caring for relatives, or the above examples from the pandemic), many struggle to cover their living costs when retired with the pension they receive so that the economic disadvantages of women span a lifetime.

Given the economic implications for the public, especially the soaring unemployment rates, the government had to come up with a fast and effective solution to alleviate people's financial burdens. As a temporary solution to this problem, the Austrian government introduced the *Corona Kurzarbeit* scheme. The system was designed to help employers and employees overcome the period of the economic losses caused by the pandemic. Essentially, employees reduced their working hours at their regular salary, whereby the state paid between 80 and 90% of their usual net income ("FAQ: Kurzarbeit"). All businesses, regardless of size or sector, were able to use this scheme for up to six months ("FAQ: Kurzarbeit"). Both employees and businesses benefited from this policy, since the former avoided having their revenue

entirely cut off and the latter avoided going through the recruitment and training process of new staff once the situation improved (Bock-Schappelwein, Huemer and Hyll 2). This policy was in high demand, and by the end of the first lockdown “the AMS had approved short-time work applications for around 609,000 employees” (Bock-Schappelwein, Huemer and Hyll 2, my translation). Between July and September 2020, the allocation of the Kurzarbeit-budget saw an unequal distribution between men and women at the rates of 37%, equalling €715 million of the resources spent on women, and 63%, almost twice as much and equalling €1200 million, for men (“Corona und der Arbeitsmarkt“ par. 5). While the Kurzarbeit scheme achieved its goal to support the public financially and alleviate the economic strain on companies, it disregarded the unique burden for women. In general, governmental support specifically targeted towards women was minimal, leaving many struggling with the economic burden of the pandemic.

The crisis-induced changes to their employment situation did not only affect women financially. As stated before, men returned to their workplace earlier, while women, especially mothers, stayed at home in order to be able to support their children’s home-schooling (Zartler et al. 28). In Germany, for example, the lockdown has increased parents’ domestic work by two working days per week, with women three times more likely to take on childcare responsibilities compared to men (Stock et al. 8). In general did the remote working situation lead to a multifaceted burden for many women, who had to negotiate unpaid labour, especially childcare, alongside paid labour (Bock-Schappelwein, Famira-Mühlberger and Mayrhuber 1). The importance of childcare facilities, in addition to family and friends' assistance with after-school care, became very clear during the lockdown months (Zartler et al. 26). Especially the loss of grandparents’ and relatives’ support in an effort to protect them from contracting the virus, affected parents of younger children (Derndorfer et al. 4). To compensate for these losses in assistance with domestic work, women predominantly performed childcare and other, previously outsourced, domestic tasks such as cleaning, in addition to their professional duties during the lockdown period (Zartler et al. 26). It is likely that the crisis would not have affected women as severely if the Austrian society had not already been shaped by these inequalities and governed by fairly traditional gender norms prior to the outbreak of the pandemic (Derndorfer et al. 1). The last official pre-pandemic time use study is available for the years 2008/09, with more recent results expected to be published in early 2023 by Statistik Austria. In 2008/09,

women spent approximately 3 hours and 42min per day on household tasks, compared to men's 1 hour and 58 minutes ("Zeitverwendung"). One might have expected these numbers to change and to even achieve, or at least approach, gender parity in domestic work over the last 15 years, yet, the tendency of unpaid domestic labour being predominantly performed by women was upheld up to and during the pandemic. The only circumstances in which men's engagement in domestic work and childcare grew, was when the female partner was unable to work from home (Derndorfer et al. 1). This illustrates that the uptake of domestic labour by women compensated for the lack of male participation. Furthermore, this reality continues to ensure the smooth working of the system of unpaid domestic labour, which is needed to ensure the maintenance of the economy. If the hours of women's unpaid work were to be remunerated, it would amount to €108 billion, which equals 27% of the total economic output (Achleitner par. 9). Thus, women's unpaid domestic labour is a necessity for perpetuating the gendered structures of power and wealth in society.

Not only in terms of domestic labour were women indispensable. Women make up the distinct majority in eight of eleven system-relevant occupations such as "childcare (88%), retail (86%), cleaners (83%), nursing (82%) and medical assistance (80%)" (Schönherr and Zandonella 3, my translation). In the educational sector, 71% of the teaching staff is female; in full-time primary school teacher positions, women make up 90% of the personnel (Oberwimmer et al. 84). Around 80%, approximately 334,000 individuals, of the employees in the health and social care sector are women (Bohrn Mena 87). While these essential workers were shouldering immense obligations, and endured increased working hours and stress, so that the rest of society could continue their lives as normally as possible, they were, in most cases, not adequately remunerated, nor were their wages reflective of their importance for society in the first place. Compare, for example, the starting salaries of cashiers (€1.500) and nursing assistants (€1.850) (Schönherr and Zandonella 1), with those of non-essential or work-from-home personnel, like IT specialists (€2.000), or investment advisors or stock exchange traders (€2.280) ("AMS Gehaltskompass"). The income of healthcare workers, especially, did not reflect their importance for society during the health crisis, which led to the launch of a petition demanding adequate payment (Österreichischer Frauenring). A year later in June 2021, a one-time bonus of €500 for medical and care personnel, including cleaning staff, was decided on (Österreichisches Parlament, *Corona-Bonus* par. 1). This, arguably, neither reflects the importance of essential

workers during the pandemic, nor comes even close to adequately compensating for the above and beyond commitment, duty, and work shown by frontline workers.

Frontline personnel's duty remained extraordinarily demanding even after the public began to experience some ‘normality’ in the spring of 2020 and continued to be so as the pandemic progressed. After nearly two months of strict lockdown, on 14 April 2020, smaller stores as well as hardware stores and garden centres were allowed to re-open under strict safety guidelines (Derndorfer et al. 5). Following this easing of restrictions, May marked a further turn in Austria’s COVID management with the lifting of most severe restrictions and the re-opening of almost all shops and restaurants, hotels and leisure facilities – only nightlife (‘Nachtgrastro’) and large-scale events remained prohibited (Kremer and Wanek-Zajic 646). Primary and secondary educational institutions were also allowed to return to on-site teaching provided that students attended school on alternating shifts (Derndorfer et al. 5). During the summer of 2020, Austrians enjoyed a lack of restrictions, but due to travel and a general lack of caution, infections increased steadily, leading up to a second COVID-19 wave in autumn. As summarized by the Austrian newspaper *Die Presse*, the autumn of 2020 saw a re-introduction of already well-known measures, like mandatory facemasks, alongside new additions such as the “Corona traffic light”, all of which ultimately culminated in a second lockdown in November (“Lockdowns”). In mid-December 2020, right in time for Christmas, most strict restrictions were eased, and the country transitioned into a lockdown light. This phase of relaxation did not last long, and Austria entered a third hard lockdown on 26 December. This lockdown was initially intended to last until 24 January 2021 but was subsequently extended until 8 February 2021. By that time, and justified by the availability of testing facilities and increasing vaccination rates, the Austrian government resorted to regional measures based on infection rates rather than nationwide restrictions. Two months later and due to rising infections, the eastern parts of Austria, i.e., Vienna, Lower Austria, and Burgenland, decided on six days of ‘Easter rest’, comprising of the same restrictions as in previous hard lockdowns, starting on 1 April. While restrictions were lifted at the designated end-date in Burgenland, Lower Austria and Vienna successively extended the ‘Easter rest’ until the beginning of May (“Lockdowns“). This was just one of several occasions during the pandemic when political inconsistencies and abrupt policy changes characterized Austria's crisis management.

Sebastian Kurz, the then chancellor of Austria, promised a quick return to 'normality' and a 'normal' summer if people followed the regulations in the early stages of the pandemic in 2020. A full year later, and with the introduction of the so-called 3-G rule, from May onwards, his promise was fulfilled when almost all restrictions in the leisure, hospitality and cultural sector were lifted, the population no longer were under a curfew, and nightclubs and bars were allowed to re-open ("Lockdowns").[2] Again, and in an uncanny reflection of the developments a year earlier, the easing of restrictions did not last and another wave of infections hitting Austria in the autumn led to further restrictions. 22 November 2021 marked the beginning of the fourth and (so far) last nationwide lockdown in Austria, which, for vaccinated individuals, ended on 12 December in the western states and on 17 December in the east of Austria ("Lockdown ab 22.11.2021" par. 2). The lockdown for unvaccinated individuals lasted longer and eased at the end of January 2022. At that time, a mandatory vaccination rule, stating that everyone over the age of 14 had to get their first, second and third immunisation within set intervals, or risk fines up to €3.600, was decided on in parliament and became law on 5 February (Österreichisches Parlament, *Bundesgesetz* §§1, 4, 7). Due to frictions within political parties, civilian protests, and other adverse factors, the law was suspended, first for a period of three months until the end of May, then for another three months, until the end of August 2022 (Bundeskanzleramt Österreich par. 1). Still heavily debated, the mandatory vaccination rule was finally withdrawn in July 2022, with health minister Rauch claiming that the public health situation under which it was introduced had changed drastically, and therefore, rendered the mandate superfluous (Österreichisches Parlament, *Nationalrat* par. 1). The discrepancy surrounding the vaccination rule was not the only political disagreement and policy U-turn Austria experienced during the COVID-19 pandemic.

In the last two years, and now, in the third year of the pandemic, several changes in the Austrian political leadership have occurred. Since the outbreak of the pandemic, Austria has had three Federal Minister of Social Affairs, Health, Care and Consumer Protection, starting with Rudolf Anschober, Wolfgang Mückstein, and now Johannes Rauch as well as three Chancellors, Sebastian Kurz, Alexander Schallenberg and incumbent Karl Nehammer. In times of uncertainty and crisis like this, people need stability. This stability can be provided by leaders through a sense of

[2] "3-G" is an abbreviation for the German terms to be vaccinated, tested or cured.

belonging, security and transparency in decision-making (Boudreau par. 4). In Austria, as demonstrated by the numerous political changes and various scandals (causa Kurz, plagiarism scandals of ministers, etc.) happening alongside the ongoing health crisis, this was not the case. Similar to the political instability Austria, the UK had entered the pandemic on shifting political grounds following the Brexit referendum and other political and social upheavals.

The Local Context of the UK

Both locales of analysis were confronted with political instability in addition to the health emergency. For the United Kingdom, the year 2020 started with a major political event, when on January 31 the UK left the European Union, four years after the Brexit referendum. This was followed by a transition period in which it was uncertain whether an agreement allowing for a continuation of the economic relationship between the EU and UK would be reached (Harari 4). Contested areas, which, without settlement with the EU, bore great uncertainty, were potential changes in currency value, trade barriers, and possible border disruption (Harari 5). Eventually, a last-minute deal to curtail further economic detriment was agreed upon on December 30 2020, right before the end of the transition period on January 1 2021 (European Commission pars. 1-3). On the same day as Brexit was finalized, on 31 January 2020, the first cases of COVID-19 infections in the UK were confirmed (Department of Health and Social Care, *CMO Confirms Cases* par. 1). A mere month later, the breakout of the COVID-19 pandemic made the already unstable situation even more volatile and left both businesses and the public no time to adjust to the UK's new geopolitical situation. On 26 February, the Health Secretary Hancock announced the "four part plan" to "contain, delay, research, mitigate" the spread of the virus (DHSC, *Covid-19* pars. 9-10). At first, the UK followed a strategy designed to achieve herd immunity through infection that was characterized by a reluctance towards lockdown measures and contact tracing and the continued downplaying of the virus's threat level. Once this strategy and its associated risks and consequences became intolerable, the UK, following the example of several other European countries including Austria, went into its first lockdown on 23 March 2020, and restricted all contacts not deemed essential ("Covid-19 Policy Tracker" 3). This included the shutdown of a wide variety of economic sectors, such as education, hospitality, and retail, but excluded amenities that are indispensable to life such as supermarkets or pharmacies, analogous to the restrictions and exceptions seen in many other countries (Blundell et al. 298). This severely affected the UK's economy,

as stated in the House of Commons Library's brief authored by Harari and Keep. GDP data for 2020 show a 9.7% decline in economic activity, the highest fall since the beginning of consistent records in 1948. According to less exact estimates of GDP from earlier years, the 2020 decrease was the same as in the post- World War I recession of 1921 (Harari and Keep 13). Certain sectors were especially affected by the pandemic, for example the accommodation and foodservice industry, which recorded the highest decline (Harari and Keep 23). The economic output in this sector during the first lockdown in April 2020 was 91% lower than two months prior before the onset of the pandemic. Similarly badly hit was the arts and entertainment sector, which in May 2020 recorded a decline of 51% in the economic output compared to February 2020 (Harari and Keep 13, 23). As discussed in the previous section, this trend was also observed in Austria, showing the parallel in the sectoral effects of the pandemic on cross-country levels.

As the closing of entire sectors meant a drastic shift in people's employment and, thus, income situation, the British government had to find a solution for financial support. For employers the furlough scheme was created so they "could get a government grant to cover the majority of wages for employees not working due to coronavirus restrictions" (House of Commons, *Examining the End* par. 4). The solutions for individual citizens, such as the job retention scheme or employment insurance covering the majority of lost income, were different depending on whether people were furloughed or let go (Blundell et al. 297). Despite the severity of the recession, the unemployment figures did not mirror the dramatic negative impact on the economy. While it is likely that even higher unemployment rates have been prevented by governmental support such as the Coronavirus Job Retention Scheme, which furloughed employees rather than letting them go, unemployment rates still increased from 4.0% to 5.2% by the end of 2020, with a total of 1.8 million unemployed (Harari and Keep 26). In 2021, unemployment figures slightly recovered and decreased to 1.4 million, excluding people furloughed, equalling an unemployment rate of 4.2% (Harari and Keep 26). During the first lockdown between April and May 2020, over 8 million employees were on furlough, a number reaching its peak at the beginning of May with 8.9 million, which is roughly one-third of all UK employees (Harari and Keep 26). Overall, the scheme's effectiveness varied: While it proved successful in lowering layoffs during the pandemic and helped to reduce forecast unemployment figures, it was not able to protect all jobs, which could be seen in the still considerable

unemployment rates. Nonetheless, furlough measures offered valuable assistance and hope to individuals navigating these uncertain and unprecedented times.

Alongside the practical help of the government's furlough scheme, moral support for the population was provided by the Crown. On 5 April 2020, Her Majesty Queen Elizabeth II spoke to the British people and the Commonwealth, thanking and reassuring them, sending a message of hope that "better days will return: we will be with our friends again; we will be with our families again; we will meet again" (The Royal Household par. 10). This message of reassurance and unity on a personal level was not mirrored in the day-to-day politics of dealing with the pandemic. Within the UK, regional differences in the timing of the introduction or lifting of restrictions were the norm. In the following, I will focus on the measures in England, given the relevance for the sample of the empirical part of this thesis. The summary of COVID-19 measures in the UK in the research brief by researchers Baker, Kirk-Wade, Brown and Barber for the *House of Commons* informs the following outline. The lockdown imposed in March 2020 gradually softened from 13 May onwards and was fully lifted in June 2020 (Baker et al. 17). During the summer months, restrictions were minimal, except when, at the end of June, the UK's first local lockdown in Leicester was enacted. This marked a turn in the UK's COVID management from national to local restrictions (Baker et al. 21). Re-imposing safety regulations in autumn, on 14 October 2020, the three-tier system was introduced in England (Baker et al. 22). Each tier reflected the current regional situation in terms of transmission and number of confirmed COVID-19 cases, using an ascending scale of one (medium alert) to three (very high alert), which carried a set default of social restrictions and other preventative measures adjusted according to the respective alert level (DHSC, *Full List*). The second national lockdown started on 5 November 2020 and lasted until 2 December when the tiered system, slightly modified with a fourth level, was re-introduced (Baker et al. 13). The newly added "Tier 4: Stay at Home", as the name suggests, enacted stay-at-home orders for the public reducing social life to a minimum by switching to remote working wherever possible, closing leisure and close contact services, and introducing stricter contact rules (Prime Minister's Office, *Prime Minister Announces Tier 4*). On the same day, the Health and Social Care Secretary announced that "the UK is the first country in the world to have a clinically approved coronavirus vaccine [available] for supply", referring to the Pfizer/BioNTech vaccine (DHSC, *Update* par. 10). Most of the country was classified within tier four by 30 December 2020, and shortly after, on 6 January 2021, England

went into a third and last national lockdown that lasted until March (“Covid-19 Policy Tracker” 21; Aspinall). Between March and July 2021, the country was slowly easing out of the last lockdown, and in July 2021 almost all restrictions were lifted (Aspinall). Despite increasing deaths and record-breaking numbers of infections during the summer of 2021, a development that continued well into autumn and winter, the UK followed through with their abandonment of most COVID-19 measures and abstained from restricting public life once more (Aspinall). Despite regularly recording new highest numbers of infections and COVID-19 related deaths, this situation continued into 2022. Indeed, the UK Prime Minister Boris Johnson, affirmed on 21 December 2021, the day after new COVID-19 infections exceeded 100.000 cases daily for the first time since the beginning of the pandemic, that no new limitations would be implemented in England (Aspinall). Public measures were to remain minimal, and only comprised of mandatory face coverings on public transport and in shops as well as PCR tests for arrivals to the UK (Aspinall). The strategy for the year 2022 was to learn how to live alongside COVID-19. Consequently, all restrictions were abolished in late January 2022, and it was announced that all further preventative and mitigating measures were considered a last resort (DHSC, *Health and Social Care*). For Boris Johnson, this essentially put an end to the discussion of COVID-19 measures.

His government's rather lax response to the pandemic was reflected by the Prime Minister's actions. After weeks of discussions about and excuses for alleged gatherings and social events happening in 10 Downing Street during various lockdowns, Boris Johnson was forced to apologize to the Queen and express regret for hosting two parties the day before Prince Philip’s funeral in April 2021, which, adhering to the measures in force at that time, was held socially distanced (“Partygate” par. 15). Months later, on 7 July 2022, Prime Minister Johnson announced his resignation due to, amongst other things, the backlash he received regarding his repeated disregard of COVID restrictions, especially his participation and even organization of social gatherings in lockdown (Amos). Johnson and other political staff that attended these events were investigated and fined for breaking the lockdown rules in place at that time (“Partygate” par. 15). On 6 September, the Conservative Liz Truss assumed the office of Prime Minister of the United Kingdom as the third female in this position (Prime Minister's Office*, Liz Truss's Statement*). In her former position as Minister for Women and Equalities she committed to women’s economic empowerment in a meeting of the Women and Equalities Committee in Spring 2020

(House of Commons, *Unequal Impact* 3). One of the goals outlined was the support for women to start businesses, specifically in male-dominated branches such as the tech-industry, as she attributed the UK's gender pay gap to "occupational segregation" (House of Commons, *Unequal Impact* 3, 12, 13). Another government policy presented in the Queen's Speech of December 2019 addressed parts of the planned Employment Bill. Planned measures included improved support for working families and additional financial allocation to help expand childcare (Prime Minister's Office, and HM the Queen 43). Moreover, in order to prevent discrimination against mothers and pregnant women, the Bill was shaped to extend redundancy protections as well as granting leave for neonatal care (Prime Minister's Office, and HM the Queen 44). As of September 2022, it remains to be seen whether this Bill will be passed and whether it will bring the expected changes. While Truss briefly mentioned support for families in her acceptance speech ("[w]e need to reduce the burden on families and help people get on in life"), her three main goals for the premiership revolve around Britain's economy, the energy crisis and supporting the NHS (Prime Minister's Office*, Liz Truss's Statement* par. 12). Addressing and resolving issues of gender inequality, once again, is no priority – despite the examples of the party base electing a female Prime Minister, and the internationally acclaimed leadership of the late Queen Elizabeth II.

Gender Inequality

Having established the context of the COVID-19 pandemic and the general consequences for the public, this section will address gender inequalities in general and further elaborate on how perceptions of inequalities are often inaccurate. For the discussion of the specific consequences of the pandemic on women, it is essential to conceptualize and define the term gender. Like Butler (2004), I oppose biological determinist approaches to gender. Following Simone de Beauvoir (1949), Butler challenges the essentialist view on gender, meaning that nature determines a person's gender, but she rather views expressions of gender as social practices. Consequently, she rejects the binary distinction of male and female, as they are not encoded in nature.

Within this thesis, I will make use of a deconstructive definition of gender: "Gender is the mechanism by which notions of masculine and feminine are produced and naturalized, but gender might very well be the apparatus by which such terms are deconstructed and denaturalized" (Butler 42). Therefore, in the following, the term gender refers to the cultural and social product of gender. In contrast to biological sex,

gender is to be understood as performative and not naturally given. It exists as a repetitive performance of our daily actions that are shaped by socio-ideological norms. In this sense, Butler's definition of gender as a socially constructed and repeated performance serves as underlying basis of my research. In my study, no distinction between sex and gender was made as all people who self-identify as female were invited to participate. Hence, in this thesis, the term 'woman' encompasses all people who identify with this label, not only cis-women with female reproductive organs.

Inequalities

Times of crisis, and the rising levels of inequality they entail, can be incisive moments in shaping public opinion and raising awareness for overlooked matters. This, however, often is only temporary (Gimpelson and Treisman 29). For many, the COVID-19 pandemic acted as a magnifying glass for existing inequalities in society. While "[i]nequalities existed along many dimensions before the pandemic hit, across the population and between different groups – by gender, ethnicity, age and geography" (Blundell et al. 293), the crisis has widened previous social disparities. Groups who were already disadvantaged prior to the pandemic were hit the hardest by the drastic changes it brought along (European Institute for Gender Equality 9). Especially, "workers who are from an ethnic minority group, women, young and older workers, low paid workers, and disabled workers have been most negatively impacted economically by the coronavirus outbreak" (Francis-Devine et al. 11). Moreover, certain job sectors were more exposed to contracting the virus than others, such as healthcare workers or educational personnel. Although the pandemic has affected every individual, beyond national borders and across all class divisions, the consequences were felt and coped with differently. While in the beginning it seemed as if the COVID-19 crisis had the potential to incite permanent change in the systemic and structural roots for social inequalities, people's misperception and the normalisation of inequalities limited this development. Indeed, the pandemic has created a temporary awareness for unequal social arrangements and the hardship of others, yet public opinion on welfare and redistribution remained largely unchanged (de Vries et al. 2). As Ragnarsdottir et al. explain, crisis-induced increases in inequality should have important political outcomes such as inciting a revolution among the population starting by reshaping their attitudes and beliefs, however, in reality, this is predominantly not the case (756). The COVID-19 pandemic sadly proved to be no exception to this observation.

While both Austria and the UK have seen an initial spark of social solidarity and frontline worker's appreciation at the beginning of the crisis, this perception of unity eventually faded. Studies in Austria have shown that during the first wave of the pandemic the majority of the population not only perceived a strengthened sense of solidarity but also actively contributed to overcoming the crisis and "protect[ing] the weak" (Kittel par. 1, my translation). Similar developments were observed in the UK when, initially, there was a noticeable increase in solidarity, "ranging from the creation of formal and informal support groups to widespread public expressions of support for the NHS and other key workers" (de Vries et al. 6). However, as the pandemic progressed, this trend declined, and the sentiment of de-solidarization spread (Kittel par. 1). One explanation for this is an increasing 'pandemic fatigue' – the mental exhaustion of constantly being confronted with the topic and the drastic adjustments to one's daily routine (Kieslich et al. par. 6). Another explanation can be inferred from the concepts of social affinity and similarity preferences. Social affinity describes the phenomenon that people tend to be more concerned about the situation of those with whom they share similarities, meaning that the empathy for one's own group is greater than for any group perceived as 'other' (Bridgman et al. 3). Consequently, support for equitable cases like redistribution depends on subjective perceptions of similarities with others (Bridgman et al. 2). This explains why attitudes towards redistribution and welfare have not changed lastingly, as, in general, people tend to distance themselves from inequalities. They view inequalities as the "experience of others, a marker of victimhood and lack of agency" (Irwin 213). Hence, people are more likely to acquiesce to inequality as they feel they are not affected by the situation and the subsequent lack of personal distress does not create a pressing urgency for action. This proves problematic as individuals' perceptions of inequality, and not the objective situation, "drive behavior and preferences for redistribution" (Hauser and Norton 21). The relation between people's subjective perception and the objective levels of inequality in a society is complex and multifaceted. Various factors influence people's perceptions of crises and may limit or intensify responses.

In the context of the COVID-19 pandemic, social comparisons serve as an explanation to people's misconception of inequalities. Scholars differentiate between three types of social comparisons: comparisons to the past, to the situation of other people, and to an expected future (Ragnarsdottir et al. 760). The second form of social comparison, the comparison to other people's lives, proved especially problematic

during the pandemic for two reasons: On the one hand, social comparison can create the so-called perceived relative impact, the feeling of being more privileged or advantaged in certain circumstances than others (Ragnarsdottir et al. 760). For example, the overall sentiment during the pandemic was that its effects harmed others similarly or even more than oneself. Although everyone felt the ramifications of the COVID-19 pandemic, such as temporary confinement in one's home, social distancing, etc., certain groups were in an even more disadvantaged position and had to bear greater losses. While this kind of awareness for the hardship of others is necessary for change, it also puts people's own struggles into perspective, making them believe to be situated in a middling-position in society (Ragnarsdottir et al. 758). Hence, for many, the illusion that one's own challenges were not severe was created. On the other hand, people greatly underestimate the severity of inequalities, as they remain unaware of them. Several scholars (Irwin; Hauser and Norton; Gimpelson and Treismann) have proven that social comparison gives people an inaccurate sense of a situation. The reason for this is that comparisons are primarily drawn with people in close proximity to oneself, such as friends, family, co-workers, or neighbours, who are likely to have the same or a similar socio-economic status. "People 'read' the world from their own, situated, position, and extrapolate out from their own experience" (Irwin 214), which is why social comparison usually happens within an isolated reference group. Consequently, this gives a false sense of equality in a society. This applies to everyone, no matter their social standing and position on the income divide (Mijs 12). People largely remain unaware of the objective scale of socio-economic differences such as income, educational opportunities, etc. for they are not tangible in their everyday lives.

The outcomes of social comparison are not only problematic as they limit subjective involvement in contributions against social disparities, but also as they create isolated and one-sided views, which often bias people into forming meritocratic beliefs. Middle- to upper-class groups, especially, find that everyone's lives are similar to their own (Irwin 224). Consequently, they do not experience the need for equality. The belief in a fair and equal world relieves individuals from the accountability to address social inequalities and serves as a way of justifying their own privilege (Mijs 11). The drastic changes of the pandemic have caused serious deteriorations of living standards both for people who had previously never claimed financial benefits and longer-term welfare

recipients. Yet, radical notions of who is ‘deserving’ of governmental support and who is ‘undeserving’ formed during that time (de Vries et al. 3), perpetuating the ongoing myth of meritocracy (Mijs 8). Generally, attributes that are “commonly associated with ‘deservingness’ include illness, unemployment, and the presence of children in the household” (Bridgman et al. 2). During the pandemic, new benefit claimants were deemed blameless of their situation and were, thus, seen as more deserving of governmental support (de Vries et al. 6). Yet, those who have previously claimed support, and therefore were even more affected by the challenges of the pandemic, were blamed for the negative impacts on their already struggling position (de Vries et al. 3). These meritocratic beliefs naturalize inequalities as “the ideas that become dominant in society are ideologies which legitimate the interests of dominant groups”, implying that people in disadvantaged positions are “a personal failing” (Bottero 58). Therefore, meritocracy justifies an unequal status quo by providing an explanation for why people belong in their current positions within society. Moreover, the shift of accountability and control from the political and social structures onto the individual also implies that demands for systemic change are rare and are not likely to be initiated by governments. Hence, the ideology of meritocracy is upheld, making it much more challenging to overcome and refute these structures.

The traditional Marxist sense of ideology addresses class rule and economic supremacy. An ideology, according to Marx, is a system of beliefs and “the way men live out their roles in class-society, the values, ideas and images which tie them to their social functions and so prevent them from a true knowledge of society as a whole” (Eagleton 15). In short, ideologies are the practices and discourses that perpetuate the privilege and power of the dominant class in a society and distorts the subordinate group’s understanding of the situation. Gramsci adds to this idea to develop the concept of hegemony. Hegemony, then, is a process of subtle domination and taught consent to the moral and intellectual leadership of the ruling class (Grelle 16). It creates a collaborative system in which the dominant as well as the subordinate class perpetuate the existing power relations. At first glance, this could be read as a normalisation of inequalities. The difference between hegemony and the normalisation of inequalities is the awareness of the subordinate group’s

acquiescence. While it is true that hegemony and the normalisation of inequalities both are forms of symbolic legitimations which are institutionalized through cultural practices, i.e., the media or educational and religious institutions, the normalisation of inequalities is an uneven process. For those in the position of power, the institutionalisation of their privilege becomes unmarked; [3] for those in the subordinate groups, it leads to a more critical awareness of inequality. People at the bottom of social hierarchies have a unique perspective on power structures, as they inevitably must navigate environments in which they are 'other' than the social norm.

In Austria and the UK today, men are still the cultural and social norm, as illustrated in the example of PPE designed for male bodies in chapter 2. The configuration of cars, speech recognition software, musical instruments, and suggested dosages of prescription drugs are some further examples of male as the unmarked gender (Criado-Perez ch. 8). This shows that social structures enable the normalisation of male social advantages, which perpetuates male privilege and gender inequalities. While "one in five men in the UK don't believe that gender inequality is still a reality in society today" (Ross par. 1), women are aware of and negotiate normative maleness in their everyday lives. Apart from gender, other features such as race, class, and sexual orientation, shape individuals' experiences of privilege and oppression, which creates a situation where those who identify within these categories are aware of their (dis)advantages, while those outside are not. In academic discourse, this is addressed by the notion of intersectionality.

Intersectionality

The concept of intersectionality, coined by Kimberlé Crenshaw in 1991, refers to the interconnectedness of social categories of oppressions in a person's life. The idea originiated from the realisation that discourses of feminism and anti-racism failed to acknowledge the experiences of black women (Davis 68). Subsequently, intersectionality came to be understood as "the notion that subjectivity is constituted by mutually reinforcing vectors of race, gender, class, and sexuality" (Nash 2). Identities are constructed and shaped by the overlapping of multiple layers of

[3] The concept of (un)markedness derives from Linguistics and refers to the difference between a standard and non-standard version of a word or concept (Brekhus 35). Hence, the unmarked gender, the societal norm, is male, while the female is regarded as deviating from the norm, thus, marked.

difference. However, this conceptualization of “multiple oppression” does not acknowledge that the belonging to a social category can mean a disadvantage in one situation, while it can also include privilege in other contexts. It also perpetuates a dichotomy of victim and oppressor, which leads to a situation where individuals choose the categories they wish to identify with wisely in order to establish victimhood or at least renounce the role of an oppressor. The concept of intersectionality has been reformulated to address these shortcomings and focus on the reciprocity of institutions of power that secure and perpetuate privilege and oppression based on different categories that shape identities. To summarize, it gives an understanding of how the intersection of identity markers such as race, gender, class, ableism, etc. are maintained within cultural discourses, social practices, and institutions to uphold hierarchical power structures (Davis 68). This notion is vital to the context of the COVID-19 pandemic not only because the distinction of ‘risk groups’ has foregrounded the vulnerability of contagion and likely poorer outcomes of the disease for certain groups, but also as the social consequences for intersectional subjects were disproportionately disruptive. Nevertheless, much of the public discourse has focused on universal trends without further nuancing the several levels influencing people’s experiences (Maestripieri 1). If any, information on the effects of the pandemic in relation to pre-existing marginalisation is self-contained and hardly touches upon the intersection of gender and other categories of oppression such as race, ableism, and sexuality.

In this thesis, I extend existing intersectional categories and argue that motherhood is a social category separate to gender that constructs women’s identity at the interplay of privilege and oppression. Motherhood entails its very own form of oppression different to other categories such as “age, race, income, education, or position, [as] becoming a mother mean[s] a decrease in autonomy, economic security, health, and happiness” (Kawash 970). O’Reilly goes even further and states that mothering “requires the repression or denial of the mother’s own selfhood” (*Feminist Mothering* 10). Even though, the deconstruction of gender essentialism and recognition of female agency, including motherhood, were central concerns of previous feminist theories, motherhood has not been present in academic feminist discourse up until the 2000s, which was “a political rejection of maternalist politics construed as a conservative backlash to feminism” (Kawash 972). While in current feminist thought, the deconstruction and even rejection of essentialism has become mainstream or, in

post-feminist theories, even redundant to address, within the social category of motherhood, these essentialist systems of belief still prevail. Gender essentialism for mothers continues as the ideology of “new momism”, a concept proposed by Douglas and Michaels that naturalizes the role of the mother as the ultimate goal for women and “redefines all women, first and foremost, through their relationships to children” (Douglas and Michaels 27). It upholds patriarchal power and the gendered dichotomy of the “naturalized opposition between public and private spheres” (O’Reilly, *Twenty-First-Century Motherhood* 367). The notion of the ‘perfect mother’ is essentially an unattainable ideological construct that is deeply rooted in sexist and patriarchal thought that undervalues mothers’ labour and consolidates gender inequality in both the private and the professional realm.

As a way of deconstructing this ideology, a focus on the potentials of mothering creates a shift from the institutionalized form of motherhood to maternal agency and empowerment. Adrienne Rich’s work *Of Woman Born* “is recognized as the first and arguably the most important book on motherhood” in the context of feminist empowerment and maternal agency (O’Reilly, “Maternal Theory” 20). It is, therefore, vital to mention her ideas in this discussion of motherhood contextualized within the framework of COVID-19. Rich suggests two different meanings for the concept of being a mother: While *motherhood* is a culturally constructed patriarchal ideology imposed on women, *mothering* is the women’s lived experience and the actual relationship with their children (13). In recognizing and acknowledging that being a mother is not inherently or naturally oppressive, while the patriarchal concept of motherhood is, Rich has provided feminists with the impetus to create mothering as an experience of empowerment (O’Reilly, “Maternal Theory” 20). Despite these efforts of shifting the focus from the ideological identity of the mother towards the actual practises and experiences of mothering, the patriarchal concept of a ‘good mother’ persists.

Many of the traditional myths about motherhood are still prevalent in contemporary discourse. 15 years ago, O’Reilly (*Feminist Mothering* 10) articulated eight ideologies revolving around motherhood:

> 1) children can only be properly cared for by the biological mother; (2) this mothering must be provided 24/7; (3) the mother must always put children's needs before her own; (4) mothers must turn to the experts for instruction; (5) the mother must be fully satisfied, fulfilled, completed, and composed in motherhood; (6) mothers must lavish excessive amounts of time, energy, and money in the rearing of their children; (7) the mother has full responsibility, but no power from which to mother; (8) motherwork, and childrearing more specifically, are regarded as personal, private undertakings with no political import.

Today, mothers are still expected to meet these, almost dogmatic, standards, a problematic situation, which is even further aggravated in difficult times such as the pandemic. Villalobos describes the struggles of US mothers after the 9/11 terror attacks but infers these arguments to "numerous less dramatic but highly salient forms of 'everyday' insecurity plaguing many people today, such as fears of bankruptcy, downsizing, divorce, or medical catastrophes" (59). The COVID-19 pandemic falls under the category of the latter 'medical catastrophes', and thus, has had a unique impact on mothers, concerning not only their workload and the negotiation of paid and unpaid labour, but also the impacts on their psyche as primary caregivers for another human being. During times of uncertainty and grief, mothers tend to have a more intense and protective relation to their children "as an antidote to the world's ills" (Villalobos 62). The availability of information on catastrophes, tragic losses, and global dangers due to ever-ongoing technological advancement and globalization of the twenty-first century, intensify the already existing fears of mothers. Within the context of 9/11, Villalobos names two oppositional parenting strategies. On the one hand, mothers try to shield the child from negative influences of the outer world including upsetting information and experiences; on the other hand, an alternative to this protective parenting method is to "intentionally expos[e] children to these for the sake of their emotional growth and edification" (Villalobos 62). Studies (Hjálmsdóttir and Bjarnadóttir; Clark et al.) show that mother's prevalent strategy during the pandemic was the attempt to keep the children shielded and protected from the intense and drastic changes and create as much 'normality' for them as possible.

Whether these theoretical claims and previous findings, alongside additional hypotheses, also hold true for Austria and the UK was tested in the empirical part of this thesis.

Methodology

This thesis draws from the results of quantitative empirical research. Based on the plethora of existing research, I chose to contrast the specific demographics of mothers to women without children for the empirical part of my thesis given the lack of research of, let alone the comparison of findings, within those two groups in the Austrian and Anglophone context. The survey was designed to elicit the subjective perspective of women in Austria and in the UK. A separate survey comprising of identical questions was created in the respective language of each country. The sets of questions were developed based on state-of-the-art academic expertise and methodological literature on the development of empirical research. The questionnaires were created to gather data on five main areas: socio-demographic information, child-specific questions, domestic labour, mental health, and support during the crisis. Further, a comparison between the circumstances before and after the outbreak of COVID-19 was retrieved. Prior to the actual questions, participants were made aware of the purpose of this project, the use of their data, and were guaranteed confidentiality and anonymity. Furthermore, participants were informed that they were able to withdraw from the study at any time and without further justification by sending me an email.

In the first section of the questionnaire, I asked general questions about the women's socio-demographic background, including gender, age, and ethnicity. For the latter, the official categories listed on the Austrian and UK government webpages were chosen. As these options, especially the ones offered by the Austrian government, were quite restricted, the option "other" enabled participants to add their own categories. For each of these questions, information was thoroughly researched. Either official governmental sources were consulted for the specific choices of categories, or other state approved services such as the *Austrian Public Employment Service* or the UK's *Office for National Statistics* were used as resources. Both questionnaires were designed identically in terms of content, with the exception of residential areas and job sectors. While the job sectors listed on the official governmental webpage were used (Office for National Statistics) for the UK, the Austrian Public Employment Service offered a more nuanced categorisation ("AMS Berufslexikon") in the Austrian context. Subsequently, participants were asked to reflect on the impact the COVID-19 had on

their lives.[4] Different temporal spans were highlighted in terms of layout as several questions differentiated between *before* and *during* the pandemic. These reflections consisted of two overall categories: questions about mental health on the one hand, and questions concerning unpaid labour such as childcare responsibilities and household duties on the other. Even though, domestic violence has re-appeared and intensified as a topic in public discourse during the pandemic, participants were not asked any questions about experiences of psychological, physical, and sexual abuse within their homes, as the quantitative research approach did not seem suitable for the subject matter. The questions relating to participants' mental health were based on commonly used inventories to ensure reliable and valid results. The following tools were used as guidelines and selected questions were adopted in this research.

1. The Burnout Assessment Tool

While the *Maslach Burnout Inventory* (MBI) has become a widely used standard measure for burnout-centred empirical research, for this project the *Burnout Assessment Tool* (BAT) was more appropriate. The MBI has certain shortcomings, such as "extreme formulation of some of its items" and a rather poor practical applicability, to which the BAT offers an alternative that is "psychometrically sound and practically useful for the assessment of burnout" (Schaufeli et al., *Development* 3). The respondents were presented with 15 statements, selected from the BAT-12, about their physical and mental wellbeing and were asked to position themselves on a 5-point Likert scale ranging from "never" to "always". Each answer corresponded to an appointed value between 1 and 5. The necessary instructions for the analysis of data and the evaluation of results were provided by the *User Manual – Burnout Assessment Tool (BAT)* (Schaufeli et al.). Comparative data from Flemish employees are used as statistical norm to classify and interpret the scores of this study within four levels of burnout, that is, low, medium, high, and very high. In addition to an interpretation of the results according to statistical norms, an evaluation based on clinical cut-off values is possible. For this kind of interpretation, the results are categorized in three colours analogous to a traffic light: green (meaning the score does not indicate a risk of burnout), orange (there is a risk for burnout) or red (very high risk of burnout). Both types of analysis and interpretation were applied in this study.

[4] When referring to the period "during the pandemic", specifically the time span between March 2020 and up until May 2022, when the participants filled out the questionnaires, is meant. By no means does the choice of tense to communicate these findings imply that the pandemic is over.

2. The Beck Depression Inventory

In the research of depression, the *Beck Depression Inventory* (BDI) is globally used as it has been translated into many languages (Sauer et al. 530). Its high reliability and its validity were attested in several studies (Schmitt et al. 51), and therefore, it proved suitable for this research. The respective section in the questionnaire is based on the German and English versions of the BDI, but has been modified slightly in keeping with the format needs of the questionnaire. A selection of items of the simplified BDI scale was used with slight adaptations with regards to point attribution. Different to the original BDI, which employs a 6-point Likert scale ranging from 0 - 5, a 5-point Likert scale ranging from 1 - 5, “never” to “always”, was used. The maximum possible points were 75, denoting severe depressive symptoms. The severity of depression is distinguished in the categories no depression (≤13% of the total score), minimal depression (14% - 21%), mild depression (22% - 30%), moderate depression (31 - 44%) and severe depression (≥ 45%) (Wintjen and Petermann 244). The statistical norms and percentages of the BDI-II were modified so that the results from this questionnaire could be classified within the five categories

3. The Authentic Happiness Inventory

Contrary to the BAT and BDI, which focus on negative impacts on and developments in mental health, the *Authentic Happiness Inventory* (AHI) measures positive changes and overall happiness levels. This method is frequently used in positive psychological interventions and its validity has been attested by several studies (Proyer et al. 77). A selection of five questions was used for this study. Participants had to choose from five statements, which were assigned values from 1 - 5, 5 being the highest in terms of happiness within each question. In this study, 25 was the maximum number of points to reach, denoting the highest possible state of happiness.

4. PERMA Scale

Similar to the AHI, the *PERMA Scale* (an acronym for positive emotion, engagement, relationships, meaning and accomplishment) is a measure for wellbeing (Butler and Kern 1). It was developed with the intention of adding a positively articulated counterpart to existing research that has dominantly focused on negative psychological and emotional states (Butler and Kern 9). From this questionnaire, three main subparts of the scale were selected with a total of 12 items. Participants were asked to position themselves on a 10-point Likert scale (either never-always, not at all-always or not at all-completely) for questions about their mental wellbeing. There are five categories for

the evaluation and interpretation of the scores, very high functioning (a score of ≥9 or 0 - 1 for negative emotions), high functioning (8 - 8.9 or 1.1 - 3 for negative emotion), normal functioning (6.5 - 7.9 or 3 - 5 for negative emotions), sub-optimal functioning (5 - 6.4 or 5.1 - 6.5 for negative emotions) and lastly, languishing (<5 or >6.5 for negative emotions).

While the questionnaire overall employs a quantitative design, in many instances the possibility to add their own categories was given to the respondents through the option “other”, which happened in an open question format. Moreover, a last and optional question was added to elicit a narrative account of the participants about any experience, positive or negative, during the pandemic. For the evaluation of the data, the software IBM SPSS Statistics 28.0 and the add-on Process macro for SPSS was used.

Analysis and Interpretation of Results

In the following sections, the questionnaires’ results are presented within the categories composition of sample, professional realm, domestic labour and mental health. Direct numerical comparisons between Austria and the UK are indicated, which are followed by a discussion of the potential causes and consequences for these trends.

Composition of Sample

Between 22 April and 16 May 2022, a total number of 320 women, equally distributed between Austria (N = 155) and the UK (N = 165), started the questionnaire. Ultimately, 131 women in Austria and 112 women in the UK finished the questionnaire, which means they reached and filled out the designated final page. Some participants did not complete the full questionnaire and just provided answers to some of the questions; nevertheless, these data were incorporated in the analysis. Hence, the number of respondents varied throughout the questionnaire. Although for some questions participation was lower, the sample is still sufficiently large so that it does not negatively affect the reliability of the results. In the following description and interpretation of the results, the respective total number of respondents (N) is indicated for each question as well as the mean value (M). Women of all ages, professions and ethnicities were invited to participate in this study. The sample is self-controlled and relied on a convenience procedure. Women in my personal networks were directly approached to fill out the questionnaires. The call to answer the questionnaire was accompanied by

the appeal to forward the survey to friends, family, and colleagues. Hence, the sampling strategy is a limited version of the standard snowball technique, which exclusively relies on respondents' help to recruit participants. Moreover, the sample consists of individuals who responded to a call to participate that was posted in various Facebook groups of the University of Vienna, namely English Studies and Translation. In Austria, a quarter of respondents (25.7%, N = 148) had a BA or an equivalent tertiary educational degree. The most-represented highest level of education of participants was "Matura/Hochschulreife" (equivalent to A-levels) (34.5%). 19.6% had a Master's degree or an equivalent thereof. Similarly, 26.8% of women in the UK (N = 153) had an undergraduate degree or equivalent tertiary educational degree. The highest education with the greatest representation (32%) was a postgraduate degree and 21.6% had completed their A-Levels or equivalent. It therefore can be seen that the majority of participants in both countries were from an elevated socio-economic background, which indicates a highly educated sample. It, therefore, must be acknowledged that the findings of my study are not representative for less privileged contexts. However, individual responses to the COVID-19 crisis carry a degree of universality.

The Austrian participants' (N = 124) ages ranged from 18 to 74 years. Half of them (50.9%) were between 18 and 37 years old (M = 38). The mode of all ages, with a percentage of 5.6%, was 22, followed by 24, 27, 28 and 30 (4.8% each). Similarly, the UK sample (N = 128) spanned from the minimum age of 16 to the maximum age of 70. Half of the participants (50.8%) were aged 18 to 41 (M = 40). In contrast to Austria, the mode value for women's age (5.5%) was 42 and 44, followed by 41 and 43 (4.7% each). The difference in mode age can be explained by my primary contacts in each country. While my immediate network in Austria are women close in age to myself, the participants from the UK were drawn from the personal networks of my family, thus, close in their age range. In general, both countries' samples reflect a similar composition concerning women's ages.

Regarding the ethnic background of the participants, the samples were rather homogeneous. The ethnic group most represented in the Austrian sample (N = 155) was Austrian (90.3%), followed by the significantly lower percentages of German (3.8%), Croatian (3.2%), Slovak (1.9%) and Hungarian (1.3%). A small number of women used the option "other" to add their ethnic identity: Russian (1.3%), French and Bosnian (0.6% each). A similar result was obtained in the UK sample (N = 165), in

which 86.1% reported to be White, followed by 3.6% who identified as Asian or Asian British, 3% as Black/Black British/Black Caribbean and 2.4% as Mixed. In the UK, respondents used the option "other" to describe their ethnic identity as well, namely identifying as Middle Eastern (1.8%) and South American (0.6%). Apart from the ethnic diversity, certain geographical regions within each country were not reachable through these methods, yet the sample still encompasses a broad variety of urban and rural settings. The majority of women in Austria (N = 153) were from the capital Vienna (51.6%), followed by Lower Austria (39.9%), Salzburg (3.9%), Tyrol (1.3%), Upper Austria (2%), Burgenland and Styria (0.7% each). No women from Vorarlberg and Carinthia participated. Therefore, the sample is especially representative for the Eastern Austrian regions, specifically the Lower-Austria area, which fully surrounds Vienna. A significant majority of participants from the UK (N = 165) were from England (97%), while only 1.2% were from Scotland and 1.8% from Wales. No women from Northern Ireland participated. The distribution of participants in England spanned over six of the nine geographical regions: North West, West Midlands, East of England, London, South East and South West. The majority of women were from South East England (61.2%), specifically Reading and Greater London (14.5%). Initially, this thesis aimed to investigate the experiences of women from all over the UK; in the end, the results obtained are representative for women in England. This sample is fairly homogenous concerning ethnic background. Information about able-bodiedness and sexual orientation were not collected deliberately.[5]

As this paper seeks to answer the research question "How have women in Austria and the UK been affected by the COVID-19 pandemic in the realms of paid professional and unpaid domestic labour?" with a special focus on the differences between mothers and childless women, respondents were asked whether they have children or not. Participation for this question was the lowest (UK: N = 91, Austria: N = 96), yet a significant number of responses was yielded, so that these results are reliable. In Austria, slightly more women (58.3%) were childless compared to those who had children (41.7%). In contrast, in the UK more women (52.7%) had children than not (47.3%). Linking back to the participants' ages, the mean age and mode reflect the results for the distinction between mothers and non-mothers. In the UK, the ages

[5] For information on the experiences of physical ability during the pandemic, see Naronnig; Udl; and International Disability Alliance/European Disability Forum. Insights on sexuality in relation to COVID-19 during have been published in Zacher; Köhler et al.; and Phillips.

most represented were the early forties explaining the slight majority for mothers. Comparatively, in Austria the mode ages varied between mid- to late twenties. These numbers correspond to Eurostat data, which shows that, in recent years, women have had children at a later age. The last EU data collected for the UK is from the year 2017, with an average age of 28.9 for mothers at the time of first childbirth. Meanwhile in Austria, in 2021, the average age at which a woman had her first child is 29.7 ("Women in the EU" par. 1). Official government statistics on women's childbearing in England and Wales closer examined data spanning the past 70 years concerning women's ages and the number of children they are having (Sharfman par. 9). Within the demographics of women born in the 1990s, the generation most recently having turned, or soon turning, 30, the statistic finds that "this is the first cohort where half remain childless by their 30th birthday" (Sharfman par. 5). The age of thirty is much discussed in public discourse as a point of reference for women's 'biological clock'. This is a result of the above discussed patriarchal gender ideologies which make women without children seem to be deviating from their supposedly 'naturally' ingrained maternal instinct. This, of course, is not true, and as these statistics show, women are increasingly dismantling these ideologies.

One explanation as to why women choose to have children later in life is the increased likelihood of being no longer in training (i.e., pursuing a first educational path) and having a regular and stable income. The resulting financial stability enables them to provide better for a child, than would be possible at the beginning of women's careers in their twenties. Moreover, "evidence indicates that having children early in their professional career puts women forever behind their male colleagues" (Pridmore-Brown 26), which is another economic explanation for the tendency of older mothers in the UK sample. However, it is also possible that women's ages and their likelihood of being mothers are not related and these explanations are synchronistic. As Pridmore-Brown explains (25):

> having a child is no longer a matter of fate or of the natural order of things; it is not a matter of economic necessity as in agrarian times, and it is certainly not a social badge signaling full adulthood. Rather, the decision to mother is considered in privileged places … to be optimally a matter of thought, of judicious timing under uncertainty.

The reasons for having or not having children are diverse: financial resources, educational or professional success, or considerations about global events such as the climate crisis or the COVID-19 pandemic. Equally, personal reasons such as illness,

the lack of a partner, no desire for having children, or the awareness of still having sufficient time to have children later in life (particularly for younger women), may influence the decision to postpone or decline motherhood. Hence, a woman's decision over whether and when to have children is no longer as influenced or even mandated by society as it once was.

Following the questions on the participants' general demographics, those who had reported to be mothers were then redirected to another page where they were asked to give information about their children. This question helped gain insights into whether the number of children and their age influences mother's wellbeing and domestic workload. Participants were asked to give their child's or children's ages, with ten available answer-slots, depending on their number of children. In Austria (N = 79), the maximum number of children in this sample were four, while in the UK (N = 78) the maximum was six children. However, the percentage of mothers with five or six children was not significant. On average, women in both countries had two children. In Austria, data on women's fertility rates for 2021 shows that a woman has an average of 1.48 children (Mohr). While there is a slight increase in the number of children women have, compared to previous years (1.44 in 2020) (Mohr) in Austria, a negative trend is observable in the UK (Sharfman par. 6). Official government statistics on women's childbearing in England and Wales show that "[t]wo child families remain the most common family size (37%), however this is a decrease in the proportion of those having two children compared with their mothers' generation born in 1949 (44%)" (Sharfman par. 2). The results of the questionnaire support this. In the UK, 26.9% of mothers had just one child. The age indicated for "Child 1" ranged between 2 and 49 years. 47.4% of mothers in the UK had a second child, whose mean age was 16 years. In the UK sample, 21.9% of mothers had a third child (M = 18) and 3.8% a fourth (M = 24). The Austrian results are very similar with 77% of mothers listing their first child's age (M = 17), half of these children (48.1%) were aged 13 or younger. For Austria, 56.2% of the mothers reported to have a second child. The mean age of the second children was 16, while 50.9% were 11 years or younger. Similarly, 20.8% of Austrian mothers had a third child (M = 11) half of them aged six years or younger. The answer option for a fourth child was chosen by 5.2% of mothers (M = 13). A fifth (1.3%) and sixth (2.6%) child was reported by a small number of women, all of which were residents of the UK.

Professional Realm

Participants were asked to state their employment status. In Austria (N = 149), the majority of women (71.8%) had a regular income while only 2% were unemployed. A smaller percentage stated that they were homemakers (3.4%) or retired (9.4%), and some (13.4%) were still in training, meaning they were pursuing (further) education fulltime. Similarly, in the UK (N = 153) most women in the sample (79.1%) were employed, while 6.5% were unemployed. The number for homemakers (3.9%) was very similar to the Austrian sample, and the percentages for women retired and still in training were slightly lower (5.2% each).

Apart from their employment situation, women were asked to position themselves on an income scale ranging from “I do not have a personal income” to “4000 or more” euros or pounds. In the questionnaire, the term ‘income’ was specified as total income after tax and social security deductions, which means that it was left open to the participant’s unique situation, and could include child maintenance payments, unemployment payments, pension etc. Most women (42.2%) in the Austrian sample (N = 147) indicated that they have a monthly net income between €1500-2500. Almost a quarter of the women (21.1% each) chose the income categories €1500-2000 and €2000-2500. While the majority was situated in the middle of the income scale, only 2% of the women chose the highest option, €4000 or more monthly. This small number, as well as the 6.1% of women who did not have their own income, can be explained by the larger number of women who were still in training, were homemakers or unemployed. The Austrian government provides financial support for people who earn nothing or less than €977.94 (or €733.46 each if they are in a relationship). Only considering the specific income limit for the eligibility for financial support, 23.1% of respondents of this study were eligible for financial support (“Mindestsicherung” par. 1). However, even after subtracting this proportion of women from the eligibility rate for financial aid, approximately 10% is still a significant number that must be taken seriously and into account in future policy-making decision. While this seems like a substantial number of women, it must be reiterated that 13.4% were still pursuing an education in some form, thus, they were not working to an extent that their pay would accurately reflect a holistic view of women’s financial situation.

In general, these results mirror the so-called glass ceiling. It refers to the phenomenon that women are underrepresented in leadership positions as they hardly

reach the top of the employment hierarchy. The BCG Gender Diversity Index of 2020 showed that compared to other European countries, “Austria rank[ed] second to last out of 27 countries with 8.9 per cent” (Stock et al. 12, my translation). At that time, Austria had three female CEOs in the 50 largest companies listed on the stock exchange (Stock et al. 12). The number of female supervisory board members increased from 23.8% in 2019 to 26.1% in 2020, and the proportion of female board members rose from 7.6% to 8.9% over the same period (Stock et al. 7). Most recent data from 2021 shows that the share of female supervisory board members has increased to 29% and the number of female board members to 9.4% over the course of one year (Haider and Dorninger 3). Despite these positive developments, “[t]hree quarters of all executive floors remain exclusively male … [and] [t]he number of female CEOs remains unchanged with three women at the top” (Haider and Dorninger 3, my translation). Furthermore, in 2021, 22 of the 50 companies did not meet the legal quota of women on the supervisory board (Haider and Dorninger 8), which was legally stipulated in the Equal Opportunities Act of 2018 and sets the minimum share of women at 30% (Stock et al. 10).[6] Consequently, the number of all-male supervisory boards is slowly decreasing and the number of boards headed by a woman has risen from eight (2019) to ten in 2020 (Stock et al. 10), and from ten to eleven in 2021 (Haider and Dorninger 3). When looking at individual income, however, it becomes apparent that wealth is still male-dominated as no woman was amongst the 25 top earners who make more than €1.85 million (Haider and Dorninger 10). The three females in Austrian top management positions are ranked among the 80 best earners with an income of €1.1 million (Haider and Dorninger 10). While progress is made, at this pace it will take another 36 years to achieve gender equality in Austria’s 50 leading companies (Haider and Dorninger 7). As no data on the UK’s BCG Gender Index is available, I will now briefly discuss the Gender Diversity Index by *European Women on Boards* (EWOB) for Austria as well in order to facilitate a direct comparison between the two countries. The Gender Diversity Index indicates a company’s score between 0-1, with 1 denoting a 50% parity of women in leadership positions (EWOB 6). Austria scores in the lowest quarter of the ranking of 19 European countries in fifth to last place with 0.45 points (EWOB 83). This result is 0.14 points below the average for Europe and 0.27 points behind Norway, who took first place in the GDI ranking with 0.72 points (EWOB 32,

[6] This policy applies to larger companies i.e., those with more than one thousand employees, or those listed on the stock exchange (Stock, Haider and Schetelig 10).

83). Compared to other countries studied, Austria has the lowest percentage of women in executive positions and performs poorly on almost all other metrics (EWOB 83). Both the BCG Gender Diversity Index and the GDI produced comparable results in their surveys, demonstrating that Austria's poor performance in these evaluations is not arbitrary. Regardless of the metrics used, one result is clear: despite minimal progress, Austria still has a long way to go to create gender equality in the professional realm.

The income situation for the participants in the UK (N = 147) was similar. More than a quarter of the women (34%) had a monthly net income between £1500 and up to £2500. Most (18.4%) earned between £1500-2000. The number of women who were in training, were homemakers or were unemployed are likely to be encompassed in the 10.9% who did not have their own income. The higher the income categories, considerably fewer women have chosen these options. For example, only 8.2% of the participants earned £4000 or more per month. Comparable to the Austrian *Mindestsicherung*, the UK government supports low-income citizens financially with its *Universal Credit* scheme. However, this system has no clearly defined lower limit for income to be eligible for financial support as it is calculated on a person's individual circumstances, taking into account relationship status, number of children or health conditions. One specific requirement is to "have £16,000 or less in money, savings and investments", which was not elicited in this questionnaire, so no claims can be made about the participants' eligibility for Universal Credit ("Universal Credit" sec. 2). In April 2021, the national minimum wage was established at £8.91 per hour (Irvine et al. 24). This does not cover the living wage of £11.05 in London nor of £9.90 outside the capital (Cominetti par. 1). Calculating a monthly income based on the national minimum wage, based on a 40-hours fulltime job, amounts to approximately £1500. While two thirds of the participants indicated to earn £1500 or above per month, 40.1% indicated to earn less, namely less than and up to £1500, meaning their pay did not match the national minimum wage.

While the difference of one or two pounds per hour might not seem drastic, even small differences add up over the course of months and years, and therefore this perception of it being 'just a little less' distorts the real life impact this low income has on women. Smaller wages implicate a struggle to get by financially for these women, since it directly translates into less money available for covering regular expenses, such as rent or mortgage payments, or daily supplies such as groceries. Additionally,

a low income presents challenges in terms of savings: setting aside money for unanticipated expenses is difficult, starting a savings account to eventually supplement the smaller state pension that results from women's lower earnings during their working years is, oftentimes, unaffordable.

Although the empirical results for the UK show more women in top paying (£4000 and above) positions (6.2% more than in Austria), two things need to be mentioned. Firstly, there is a substantial currency value gap. The current exchange rate, as of 8 September 2022, is at approximately 0.87 (European Central Bank). Thus, earning €1500 in Austria equals only about £1300 in the UK, which relativizes the slightly higher income. Secondly, the cost of living in Austria is 18% cheaper than living in the UK, as calculated per 8 September 2022 ("Cost of Living Comparison"). Consequently, women in the UK have less available spending money, as well as less means for savings and building a financial reserve.

Despite the fact that more women in the UK than Austria placed themselves in the highest income category, 8.2% is not a significant enough percentage to indicate advancement in gender equality in leadership positions. The results of my survey mirror official analyses of the UK's performance concerning equality in leadership positions. As of June 2021, directors of FTSE100 (The Financial Times Stock Exchange 100 Index) UK businesses had 37.7% of female representation (Irvine et al. 5). Moreover, following Sweden (25%), and tied with Finland, the third-highest number of women in executive positions is found in the UK (24%); so is the third largest number of women on committees (43%) (EWOB 39). Looking at the overall ranking, the UK's top five businesses are represented in the top 20 businesses of all countries considered in the analysis (EWOB 40). In regards of the Gender Diversity Index, the United Kingdom comes in third out of the 19 European nations considered in the analysis with a score of 0.67, which is 0.05 points lower than top ranking Norway (EWOB 39). These results are considerably better than those of Austria are. Despite these positive results, however, there remains room for improvement. According to data from 2011, it will take more than 70 years to achieve gender equality in the boardrooms of the 100 largest corporations in the UK if change proceeds at the current rate (Department for Business Innovation and Skills 3). This shows that while the UK is slightly more advanced in its way towards workplace gender equality, there is still more work to be done.

It is vital to the discussion of women's lower income to consider female-dominated occupations, which, as mentioned before, are concentrated in lower paying sectors. To elicit the different areas of employments in Austria, the categories from the Austrian unemployment service were given as answer options, while in the UK the sectors available on the Office for National Statistics site were listed. In Austria (N = 107), the sectors in which most of the women were employed were

- Social services, Health, Beauty (32.7%);
- Office sector, Marketing, Finance, Law, Security (23.2%); and
- Science, Education, Research and Development (19.6%).

The majority of women in the UK (N = 165) worked in the sectors

- Public administration, Education and Health (55.9%);
- Transport and Communication (10.3%); and
- Banking and Finance (6%).

Due to the official national sources that were consulted as guidelines in the conception of the questionnaires, the grouping of several jobs differs between countries. Therefore, the numbers for the respective sector may appear higher or lower in one country. Overall, the dominant female employment sectors were very similar in Austria and the UK. When asked about the type of their employment, most women in Austria (N = 107) reported to be employees (77.6%) and significantly less reported to be self-employed (11.2%). Very similar results for the UK (N = 116) were obtained, where 69% of women were employees and 16.4% were self-employed. Regarding working hours, there was a main difference between Austria (N = 107) and the UK (N = 116). While most women (52.3%) worked part-time and only 41.1% worked fulltime in Austria, in the UK the results are reversed with the majority of women (58.6%) working fulltime and significantly less (34.5%) in part-time positions. Still, even though there was a propensity of women working part-time in Austria, the average income was higher than for women working full-time in the UK. This cannot be ascribed to the gender pay gap however, as in both countries the gap is very similar (Austria: 18.9%, UK: 15.4%) ("Einkommen"; White par. 12). A more likely explanation can be found in the fact that the Pound Sterling is stronger than the Euro, but costs of living in Austria are considerably lower than in the UK.

In Austria, it made a significant difference for women's income situation whether the women had children or not. In this sample, women with children earned less than

women without children (B = -1.423, p < 0.001). In contrast, in the UK being a mother did not negatively impact women's income to an extent that a trend was observable in the results (B = -1.53, p = 0.158). Ostensibly, this does not support the claim that mothers experienced more disadvantages in the professional realm, at least for women in the UK. However, it is necessary to take a closer look at policies regarding parental leave in both countries in order to fully appreciate the findings. While mothers in Austria get paid Maternity Leave for up to 2 years ("Elternkarenz" par. 1), women in the UK only get up to 39 weeks of paid maternity leave, half of the possible time in Austria (NHS par. 3). During that time, women's income in Austria is reduced to 80% of their previous salary and 90% in the UK ("Karenzgeld" par. 11; "Maternity Allowance" par. 1). Consequently, mothers in Austria experience longer and slightly higher income losses than mothers in the UK do. Moreover, when considering different incomes for women with children to that of women without children the different childcare systems in the two countries need to be taken into consideration. Both in Austria and the UK, free childcare options are available to parents. In Austria, half-day kindergarten attendance (20 hours per week) was introduced free of charge in the year 2009/2010 and for children aged five and up, attendance is mandatory ("Kindergärten" par. 1). When children graduate to primary and secondary education, their schooling continues to be state-funded. Still, for the school year 2020/21 families spent an average of €2.132 on their children's school attendance (Schönherr et al. 2). This includes additional expenses related to childcare, such as school meals or afternoon childcare (Schönherr et al. 2). In comparison, in England children aged three to four are eligible for free childcare for 15 hours per week for 38 weeks annually (Sibieta sec. 3). The right to free education is later extended to all children aged between five and 16 with a free place at a state school ("Types of School" par. 1). Nevertheless, education-related costs put a strain on parents' finances. Regional variations within the UK aside, when considering the total cost of sending a child to school (Year 1–11), the average cost of a child's education for parents in the UK is £17.374 ("How Much?" par. 2). This figure represents costs for public schools; even more is required for children enrolled in a private day school.[7] Fees for higher education in Austria range from approximately €20 to €365 per semester (or €726.72 for Non-EU students), depending on the type of tertiary educational institution and criteria such as citizenship and duration of study. In

[7] While in the UK public schools are fee charging, in this context the Austrian differentiation is used: public school therefore refers to state-funded and private school to fee-charging schools.

contrast, in the UK student undergraduate fees go up to £9.250 annually for national citizens, and between £20.000 and £32.000 for international students (UCAS sec. 2; University of Manchester par. 2). On all levels of education in the UK, it is evident that families are encumbered by significant costs for their children's education despite having more and longer access to free childcare in the early stages. Consequently, this means fewer assets for UK mothers despite earning as high an income as women without children. The pandemic and its manifold financial strains and insecurities further minimized overall income for many women.

As the pandemic caused severe changes for many economic sectors, which led to situations where employers had to let employees go, a question in my survey asked whether the working hours or employment situation of the participants changed during the pandemic. While a small number of women (UK: 7.9%, Austria: 12.2%) were no longer employed, for most women in both countries (UK: 79.1%, Austria: 70.1%) the income situation did not change between the start of the pandemic and May 2022. Furthermore, there was no observable difference between mothers and women without children in terms of the employment situation during the pandemic.

	Austria (N = 147)	UK (N = 139)
Yes, I was no longer employed	12.2%	7.9%
Yes, I was working in Kurzarbeit	6.1%	5.8%
Yes, I was put on furlough		
Yes my working hours have changed	11.6%	7.2%
No, my situation hasn't changed	70.1%	79.1%

Table 1 – Change in Working Hours

This correlates with the participants' employment sectors. The majority of women in the overall sample did not work in domains that were severely affected by the pandemic in terms of complete closures (as for example restaurant or tourism) but rather in sectors that were deemed essential, namely health, education, or public administration. The results of this survey confirm the information provided in the theory chapters and demonstrate that a great number of women works in essential sectors.

Domestic Labour

All participants were asked to indicate whether they live with another adult person in one household. In the UK (N = 126), 82.5% of the participants lived with another adult, while 17.5% did not. Likewise did 84.4% of the surveyed women in Austrian live with another adult (N = 135) and 15.6% did not. These numbers reflect the results of the participants' relationship status, as for 78.9% in the UK and 84.7% in Austria these adults were romantic partners. The significant majority (80.4%) of women in Austria (N = 153) indicated to be in a relationship, as did 73.8% of the women in the UK (N = 160). Still, cohabitation with blood relatives (UK: 12.2%, Austria: 9.2%) and roommates (UK: 8.9%, Austria: 6.1%) was also represented amongst the participants. The women who shared a household with another adult were then asked to indicate which domestic chores they primarily fulfil and which tasks they share with another person, as well as how the frequency of them performing these tasks developed during the pandemic.

Domestic Tasks	Austria (N = 114)		UK (N = 102)	
	Participants	Shared	Participants	Shared
Laundry	52.6%	45.6%	78.4%	32.4%
Grocery Shopping	25.4%	74.6%	70.6%	37.3%
Cleaning	36.8%	57.9%	68.8%	37.3%
Dishwashing	34.2%	75.4%	55.9%	54.9%
Cooking	34.2%	64.0%	62.7%	45.1%
Caring for relatives	2.6%	13.2%	11.8%	6.9%
Childcare	12.3%	36.8%	40.2%	21.6%
Mental load tasks	40.4%	37.7%	73.5%	22.5%

Table 2 – Division of Domestic Tasks

While Austrian women reported that these tasks were more equally distributed, results in the UK show significant disparities. 78.4% of UK participants stated that they were solely responsible for doing the laundry, compared to 52.6% in Austria. While in Austria only the chores "laundry" and "mental load tasks" have a higher percentage for women's sole responsibility than the shared practice, the results for women's sole responsibility in the UK are significantly higher for all domestic tasks. Participants, then, were asked to indicate how their workload developed during the pandemic, and whether the frequency of fulfilling these tasks changed. In both countries, the majority chose the answer "remained the same" (UK: 62.7%, Austria: 77.2%). The percentages for the option "the frequency decreased" were similar for the UK (6.9%) and Austria (5.3%), whereas an increase of workload was experienced by more women in the UK (30.4%) than in Austria (17.5%). Even though the majority indicated that the workload

or frequency with which they perform the domestic tasks remained the same, a significant number of women reported an increase, with almost twice as many in the UK than in Austria. This suggests a problematic trend, particularly as women in the UK stated that they had been predominantly responsible for domestic chores in their daily lives before the pandemic. Looking at these numbers, Austrian households seem to be much more egalitarian than British households are.

The results of the open question support previous findings on the disproportionate division of domestic labour for mothers:

> Husband unable to do homeschooling with the children whilst I was working from home before being furloughed. I had to micro manage how homeschooling was occurring and working from home. It was a blessing when I was furloughed so I could fully manage homeschooling. (41-years old mother of two, England)
>
> My partner was often short tempered and unhelpful. Being home all day meant his excuse for not helping with household jobs or the children was gone, but he still didn't pitch in. (41-years old mother of two, England)
>
> My husband and I were both working from home throughout the pandemic. I did all the childcare and home education even though we were both at home. I did all the snacks and meal prep too. (Age unknown, mother of one, England)

Both the management of family tasks and suppression of feelings (in the following example) are exemplary for emotional labour, which Hochschild defines as the control or management of emotional expressions with others as a component of one's professional work function (20). These statements specifically mirror the quantitative results for the sole responsibility of childcare (40.2% compared to 21.6% of shared responsibility) and mental load tasks (73.5% to 22.5%) for women in the UK.

> Homeschooling - I did all of it while my husband worked upstairs. I was also working but he didn't have the patience to be interrupted constantly so it just seemed easier for me to do it all. That saved on arguments! But it wasn't right or fair, it was just how we coped. (40-years old mother of two, England)

This quote shows that for many mothers, despite being aware of how ‘unfair’ it was to have to assume responsibility for these tasks in addition to their paid jobs, it still was the lesser evil compared to creating spousal disputes. Emotional labour is typically done by women, as sectors that require such work, such as service or care occupations, are female dominated branches and

> “requir[e] one to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others— … the sense of being cared for in a convivial and safe place. This kind of labor calls for a coordination of mind and feeling.” (Hochschild 20)

Yet, the concept of emotional labour has long transcended women's professional work function. In the private realm of their lives, women perform emotional labour as well as cognitive labour, which is "the work of (1) anticipating needs; (2) identifying options for meeting those needs; (3) deciding among the options; and (4) monitoring the results" (Daminger 610). While not a sole responsibility, these tasks are still predominantly performed by women in a relationship (Daminger 610). Emotional and cognitive labour combine to make up the mental load, the accumulation of responsibilities and decisions that need to be managed daily as well as the regulation and management of one's own emotions for the good of others.

Other examples from the survey confirm that mental load is a burden for women, and especially mothers, who, alongside a consideration of their partner's needs and feelings, take on the responsibility for their children's wellbeing:

> I also think myself and friends and family became more anxious about day to day life. My son who is profoundly deaf was furloughed and he struggled with being at home and feeling isolated especially as the daily coronavirus announcements from the government were not signed so it made it difficult for him understand what was happening. *This impacted on me as I tried to support his worries*. (53-years old mother of two, England; emphasis added)

> My husband was shielding and not working. Despite this it was still me who did the majority of childcare, housework and emotional labour*. He would do things if asked but the point is that if one has to ask then thats [sic] still work - thinking about what needs to be done and keeping track of when and what*. (42-years old mother of one, England; emphasis added)

This is in accordance with other studies (Hjálmsdóttir and Bjarnadóttir; Pfefferbaum and North; Clark et al.; Parlak et al.) which illustrate that the experience of an increased mental load during the pandemic is not specific to the context of the UK, but is a universal trend. Mothers in other countries (e.g. Iceland, Ireland, or Turkey) reported similar experiences: women attempted to maintain family harmony by withholding their worry and anxiety from their children and other family members (Hjálmsdóttir and Bjarnadóttir 276). As can be seen in the previous UK examples and in the following personal account from Austria, the women who shared these statements were all mothers, suggesting that the pandemic especially challenged mothers to provide emotional and cognitive labour:

> During the pandemic, it became very clear to me again that the main burden falls on women. In addition to everything else, I had to do all the school work (teaching, studying, assignments, deadlines,...). Furthermore, the emotional support of the children, trying to provide structure in the chaos,... My workload as a nurse increased at the same time. (Age unknown, mother of three, Austria; my translation and emphasis added)

However, one participant without children pointed to the fact that performing mental load is a gendered phenomenon in general and not only an exclusive experience of women with children:

> Even as a woman without children I do feel that since the pandemic the amount of domestic and emotional labour expected of me has increased. This is interesting to me as prior to the pandemic I would have considered my (heterosexual) relationship fairly 'modern' with regards to gender roles etc. but I feel that the pandemic has had a negative impact upon this. (30-years old woman, England)

If women without children felt the manifold burdens during the pandemic, it stands to reason that women with children were even more adversely affected.

To test the hypothesis of this thesis, namely that mothers experienced more gender inequality during the pandemic, a linear regression analysis was run to determine whether this claim holds true in the aspect of increased domestic work. However, no significant correlation between the amount of domestic work and women who are mothers and women without children was found, neither in Austria ($B = 0.087$, $p = 0.469$), nor the UK ($B = 0.184$, $p = 0{,}104$). While this result already indicates that being a mother did not heighten women's experiences of increased domestic labour, another multiple linear regression analysis was run to determine whether the number of children a woman has, and the children's ages significantly moderate the frequency with which women are performing domestic tasks. The basis for this analysis is the results of Collins et al. who found that mothers of younger children (aged between 6 and 12) reduced their paid working hours more than mothers of older children (aged 13 to 17), suggesting that the domestic workload, especially childcare-related duties, increased for mothers of younger children during the pandemic (105-107). Yet, in the Austrian sample neither the number of children ($B = -0.044$, $p = 0.718$) nor their ages ($B = 0.051$, $p = 0.423$) significantly influenced the frequency of women performing certain domestic tasks. The findings from the UK support this result for the number of children ($B = 0.065$, $p = 0.607$) as well as their age ($B = 0.028$, $p = 0.826$). Additionally, women's age did not affect the variable of "frequency change in domestic tasks" in Austria ($B = 0.134$, $p = 0.197$), nor in the UK ($B = 0.042$, $p = 0.702$). Consequently, this suggests that an increase in women's domestic workload does not depend on their age or on them having children or not. The results indicate that it rather was a common experience for women in general during the pandemic. While the question on domestic work included mental load tasks, the effects of this work might be more accurately presented in the results of the pandemic's effects on women's mental health.

Following the general questions about domestic work, women without children were directly forwarded to questions about their mental wellbeing, while mothers were asked specific questions about the forms of childcare they had used before and during the pandemic. Before the pandemic, mothers in the UK (N = 48) had relied on grandparents (25%), all-day school types (16.7%), parental supervision (12.5%) and extracurricular courses (14.6%) as childcare options. However, half of the mothers (43.8%) responded that their children "do not need childcare", which mirrors the children's average ages asked prior. This changed drastically during the pandemic. On the one hand, the number of women who had given their children within the care of grandparents decreased to 8.3%. Similarly, all-day school types (6.3%) as well as extracurricular courses (2.1%) were used less than before. Babysitters and children's groups as childcare options fell away completely. On the other hand, the numbers for parental supervision more than doubled (27.7%), while, at the same time, there was a slight increase in mothers who reported that there was no (longer a) need for childcare (46.4%). Similar results were obtained for mothers in Austria (N = 80) when asked about their utilized childcare options before and during the pandemic. Regarding the circumstances before the outbreak of the pandemic, the majority of women (42.6%) reported that childcare had not been needed. This is followed by a significant percentage of mothers (37.5%) whose children had been supervised in kindergarten or by their grandparents (30%). Almost a quarter (22.5%) had resorted to parental supervision and 11.3% had used all-day school types. During the time of the pandemic, these numbers decreased slightly. Fewer children attended kindergarten (35%) or were no longer looked after by their grandparents (25%). Likewise, all-day school types were less popular during this time (7.6%). Furthermore, the percentage of mothers who claimed that their children do not need childcare anymore decreased slightly (40.7%). Whereas the parental supervision slightly increased (23.8%) as did other childcare options:

- Nursery: from 5% to 6.3%;
- Childminder: from 1.3% to 2.5%; and
- Babysitter: from 5% to 7.5%.

Childcare in form of children's groups and extracurricular courses fell away completely. While it was not a significant number of women in this sample who used these options, it is still important to note that these forms of childcare were no longer available during the several lockdowns in Austria, therefore, those parents who had relied on them had

to find alternative solutions. Contrary to the UK, in Austria no significant increase in parental supervision was indicated for the time during the pandemic when given several options to choose from. The mothers who indicated that parental supervision had been one of their care methods prior to and during the pandemic were asked who was primarily responsible for this task, and given the options “mostly me”, “mostly the other parent” and “both equally” to choose from. When asked about the task distribution before the pandemic, UK mothers (N = 37) had been mainly responsible for parental care (78.4%), with a significantly lower percentage (16.2%) of parents who had shared parental care equally amongst them. Only a small percentage (5.3%) of the other parents were listed as predominant parental caregiver before, as well as during the pandemic. However, a positive trend towards equality can be observed for parental care during the pandemic. Fewer of the mothers (71.1%) responded that it was them mostly performing parental care, with the deviation now being reflected in the option “both equally” with 23.7%. In comparison, for mothers in Austria (N = 18) a negative trend during the pandemic was recorded. While 66.7% of mothers had performed the primary parental care before the pandemic, this number increased to 73.7% during the pandemic. Hence, a redistribution away from an equal parenting mode is observed, decreasing from 27.8% prior to the pandemic to 21.1% during. As in the UK, 5.3% of mothers stated that the other parent was mostly responsible for childcare before and during the pandemic. Judging from these findings, it can be seen that while mothers in Austria experienced an increased responsibility for childcare, while their co-parents did not.

Mental Health

In order to gain an understanding of women’s workload and its impact during and after the peak of the pandemic, participants were presented with 15 items from the *BAT inventory*. In Austria (N = 142), the total score (2.6 out of 5) indicates that the participants were at high risk of burnout. This is a high score compared to the statistical norms indicated in the BAT-12 user manual as comparative data from Flemish employees. According to the results for the Flemish working population, which serves as an orientation for this interpretation, a low level of burnout ranges between 1.00 – 1.60 points, followed by an average level of burnout ranging between the scores 1.61 – 2.40 (Schaufeli et al., *User Manual* 14). Accordingly, a score between 2.41 and 3.29 denotes a high level of burnout, and one between 3.30 and 5.00 indicates a very high level (Schaufeli et al., *User Manual* 14). The table also shows the evaluation of the

data based on the clinical cut-off values visualized by colours. For the UK sample (N = 136), the score is even higher (2.9 out of 5), also indicating a high risk of burnout among the participants.

Items	Austria (N = 142)	UK (N = 136)
I feel mentally exhausted.	3.02 – high	3.45 – very high
Everything I do requires a great deal of effort.	2.53 – high	3.01 – high
At the end of the day, I find it hard to recharge my energy.	2.54 – high	3.32 – very high
At the end of the day, I feel mentally exhausted and drained.	2.84 – high	3.36 – very high
I feel physically exhausted.	2.94 – high	3.16 – high
I struggle to find any enthusiasm for my work.	2.46 – high	2.74 – high
I have trouble staying focused.	2.68 – high	2.91 – high
I'm forgetful and distracted.	2.77 – high	2.84 – high
I make mistakes because I am distracted by other things.	2.43 – high	2.51 – high
I feel unable to control my emotions.	2.40 – high	2.64 – high
I get upset or sad without knowing why.	2.25 – average	2.69 – high
I have trouble falling or staying asleep.	2.75 – high	2.91 – high
I feel tense and stressed.	3.19 – high	3.22 – very high
I feel anxious and/or suffer from panic attacks.	1.85 – average	2.47 – high
I suffer from headaches.	2.37 – high	2.49 – high

Table 3 – Results BAT

To gain insights on whether these symptoms and burdens had already existed before the pandemic, the participants were asked to assess whether any changes occurred. In Austria, the majority (41.5%) indicated that these symptoms had already existed before the pandemic and that they stayed the same. A significant percentage (31.7%) reported that these feelings deteriorated during the pandemic. Only an insignificant minority experienced an improvement (1.4%). When asked about the frequency of these thoughts and emotional states, the majority of Austrian women (31.7%) felt that

the frequency increased, while for 6.3% these symptoms first occurred. 8.4% stated that these emotions occurred less frequently during the pandemic than before. The responses for the UK (N = 138) were slightly more negative. While 21.7% reported that their emotional state stayed the same, 28.3% experienced a deterioration and only 7.2% an improvement. Regarding the frequency of experiencing the above listed states, for half of the women (49.3%) the occurrence of these emotional states became more frequent during the COVID-19 pandemic, for 2.2% they first occurred and 2.9% reported a decrease in frequency.

In addition to the burnout inventory, 15 items of the BDI were selected, to which the participants responded with the frequency they felt or experienced the given statements ranging from never to always. The highest possible points for this section are 75 (or 5 points per item), which indicates a severe depression. The Austrian (N = 137) mean lies at 34.34 indicating moderate depressive symptoms.
The statements with the highest points, thus, most negative assessment are:

- I feel irritated and annoyed: 2.80.
- I am tired and apathetic: 2.64.
- I put off decisions: 2.59.

Then, the women were asked to compare these feelings to their lives before the pandemic and half of them (49.6%) reported that they stayed the same. Nevertheless, a significant number (32.8%) of women experienced a deterioration of their mental state. Only 0.7% felt that these feelings improved during the pandemic, and none of the participants felt them with a lesser frequency. In fact, for a quarter (26.3%) their occurrence became more frequent, and for 3.6% these symptoms of depression occurred for the first time.

A similar, yet slightly more negative result was obtained for the UK (N = 129). Out of the 75 possible points, the average score of the participants is 38.93, which is classified within the level of severe depressive symptoms. The three statements with the highest points are, except for the second, different from Austria, namely:

- I criticise myself for my mistakes and weaknesses: 3.01.
- I feel irritated and annoyed: 2.98.
- I feel discouraged about the future: 2.91.

Items	Austria (N = 137)	UK (N= 129)
I am sad.	2.53	2.79
I feel discouraged about the future.	2.21	2.91
I feel like a failure.	1.89	2.48
It is hard for me to enjoy things.	2.24	2.39
I feel guilty.	2.18	2.72
I am disappointed in myself.	2.11	2.68
I criticise myself for my mistakes and weaknesses.	2.43	3.01
I cry.	2.36	2.56
I feel irritated and annoyed.	2.80	2.98
I lack interest in other people.	2.06	2.24
I put off decisions.	2.59	2.89
I have insomnia.	2.39	2.24
I am tired and apathetic.	2.64	2.73
I worry about my health.	2.42	2.61
I have no appetite.	1.49	1.70

Table 4 – Results BDI

When asked to give a temporal comparison, approximately as many women reported that the situation stayed the same (31.5%) as indicated that it deteriorated (29.2%). A very small percentage (3.1% each) reported an improvement and a decrease in frequency, whereas for the majority (40%) the occurrence of these feelings became more frequent. None of the women responded that these feelings occurred for the very first time during the pandemic. Unsurprisingly, there also were other reasons than gender-related inequalities for a deterioration of mental health during the pandemic. One mother reported to have lost her husband to cancer at the beginning of the crisis and then not being able to mourn in-person with and find comfort in loved ones:

> My husband died during the pandemic, right at the start., not of covid but of an unknown cancer. It was very hard. I felt I got support as best from my family and friends. It was very hard as my children and myself couldn't see anyone for 6 weeks after he died. But we did it and got through for everyone. It made me cross when I found out that the government couldn't do the same. (43-years old mother of two, England)

While the following example was not COVID-19 related, the pandemic brought death in close proximity to everyone’s lives:

> [The pandemic] [c]aused me intense stress due to personal and work factors including the death of a parent during the pandemic. Life as a lone parent is really hard. And generally it is one struggle after another with no light at the end of the tunnel. (Age unknown, mother of one, England)

As the health emergency entailed an incredibly high mortality rate with around 600 million deaths globally, as of 7 September 2022 (“WHO Coronavirus Dashboard”), loss and grief were omnipresent emotions.

Following the questions eliciting participants’ negative emotions, two sets of questions on positive psychology followed. Firstly, with the AHI, participants had to choose between five statements to describe their mind-set most accurately. Thematically the five parts dealt with “joy and sorrow”, “general life success”, “work”, “routine” and “general life satisfaction”. For example, the participants had to choose the statement most fitting for their life such as “I have more joy than sorrow”. Contrary to the previous inventories, for this scale, the higher the score the better the state of happiness with a maximum of five points for each item or a total of 25 points. The results for Austria (N = 136) were rather positive as the average score was 16.74 out of 25. In the UK (N = 122), the results are slightly worse with 14.69 out of 25 points, but still indicate an average level of happiness.

When I think about my own happiness, I feel like...	Austria (N = 136)	UK (N = 122)
I have sorrow in my life.	11%	13.1%
I have neither sorrow nor joy in my life.	8.1%	9%
I have more joy than sorrow in my life.	36%	38.5%
I have much more joy than sorrow in my life.	33.8%	35.2%
my life is filled with joy.	11%	6.6%
By objective standards,		
I do poorly.	1.5%	1.6%
I do neither well nor poorly.	3.7%	15.6%
I do rather well.	14.7%	34.4%
I do quite well.	57.4%	44.3%
I do amazingly well.	22.8%	5.7%
When I consider my work life,		
I do not like my work.	6.6%	6.6%
I feel neutral about my work.	15.4%	17.2%
I like my work for the most parts.	40.4%	42.6%
I really like my work.	27.9%	22.1%
I truly love my work.	9.6%	12.3%
When I think about my day,		
I do not enjoy my daily routine.	8.1%	9%
I feel neutral about my daily routine.	17%	25.4%
I like my daily routine, but I am happy to get away from it.	64.4%	52.5%
I like my daily routine so much that I rarely take breaks from it.	9.6%	13.9%
I like my daily routine so much that I almost never take breaks from it.	0.7%	0.8%
Overall, my life is		
is a bad one.	/	1.6%
is an OK one.	13.2%	17.2%
is a good one.	26.5%	46.7%
is a very good one.	41.9%	26.2%
is a wonderful one.	18.4%	8.2%

Table 5 – Results AHI Scale

In addition to the AHI, all participants were also asked to respond to a second set of questions on positive emotions, the PERMA scale. The twelve items were grouped into three subsections and the participants positioned themselves on a 10-point Likert scale (either never-always, not at all-always or not at all-completely). For most items on this scale, the higher the points meant the better the state of mental wellbeing of the participants. One question (marked with an asterisk in the table below) asked about loneliness and, thus, the lower the score the better. All the scores for both Austria and the UK fall within the categories normal functioning (6.5 - 7.9 or 3 - 5 for negative emotions) and sub-optimal functioning (5 - 6.4 or 5.1 to 6.5 for negative emotions).

Items	Austria (N = 133)	UK (N = 118)
In general, how often do you feel joyful?	7.02	6.54
How often do you achieve the important goals you have set for yourself?	7.36	5.96
In general, how often do you feel positive?	6.88	6.43
How often are you able to handle your responsibilities?	7.95	7.56
How often do you lose track of time while doing something you enjoy?	6.69	6.58
To what extent do you receive help and support from others when you need it?	7.34	6.15
In general, to what extent do you feel that what you do in your life is valuable and worthwhile?	7.55	6.62
In general, to what extent do you feel excited and interested in things?	7.36	6.87
*How lonely do you feel in your daily life?	3.54	5.07
To what extent do you feel loved?	8.29	7.51
To what extent do you generally feel you have a sense of direction in your life?	7.38	6.35
Taking all things together, how happy would you say you are?	7.96	6.93

Table 6 – Results PERMA Scale

My findings so far show that women in the UK had more responsibilities and negative experiences during the pandemic than women in Austria. It is likely that the overall results for the UK are more negative because the percentage of mothers in the sample is higher.

In a next step, the general results for the women in Austria and the UK were further analysed. For all four scales under the category of "mental health," a linear regression analysis was conducted to evaluate the hypothesis that women were disproportionately impacted by the pandemic. Furthermore, it was then examined whether the general results were influenced by other external factors such as the number of children, the age of the children, the mother's age, and their relationship status. For the interpretation of the results, it is crucial to have a working knowledge of the following components: The beta coefficient shows how much the predicted value of the variable x rises when the variable y rises by one unit. A linear relationship exists if the value of Sig. is less than 0.05, indicating that one variable influenced the other.

In Austria, no significant correlation between women who are mothers and women without children was found for the positive psychology scales. For the AHI, a linear regression to test the correlation of these scores with the variables mothers vs. child-less women, did not produce significant findings, $B = -0.187$, $p = 0.068$. Likewise does the analysis of the PERMA not show any noticeable relation between being a mother and these scores, $B = -0.159$, $p = 0.126$. In short, being a mother did not make women happier and more satisfied with life than women without children. However, the analysis showed a significant relation between motherhood and the BDI and BAT. The results show that being a mother significantly increased women's experience of depression, $B = 0.348$, $p = 0.002$ and burnout, $B = 0.348$, $p = 0.001$. Subsequently, several moderation analyses were run using the software PROCESS macro, which uses ordinary least squares regression, yielding unstandardized coefficients for all effects. The aim of the first analysis was to determine whether being in a relationship moderated Austrian women's experience of depressive symptoms. Although the overall model was significant, $F(3, 92) = 5.0831$, $p = 0.0027$ predicting 13.30% of the variance, there was no significant interaction between these variables, $\Delta R^2 = 0.0022$, $F(1, 92) = 0.3213$, $p = 0.5722$, 95% CI[-0.0821, 0.1586]. Another moderation analysis was run to determine whether women's age moderated depressive symptoms. Similarly, despite the significance of the model, $F(3, 76) = 4.7088$, $p = 0.0046$ predicting 14.28% of the variance, no significant interaction

between the variables was found, $\Delta R^2 = 0.0004$, $F(1, 76) = 0.0233$, $p = 0.8791$, 95% CI[-0.0294, 0.0201]. Neither the number of children a woman had, nor their age influenced women's subjective experience of depression. Closer examining the correlations on women's experience of burnout showed that neither age nor the relationship status of mothers moderated or intensified these results.

The results for the UK sample are slightly different. Like for Austria, the correlation between motherhood and experiencing burnout was significant in this sample, $B = 0.241$, $p = 0.022$. These results show that being a mother significantly increased women's experience of burnout. Whether UK mothers were in a relationship or not did not significantly influence the symptoms of burnout, $\Delta R^2 = 0.0242$, $F(1, 87) = 2.27$, $p = 0.1354$, 95% CI[-0.1305, 1.0733]. Likewise, a moderation analysis did not yield a significant result between mother's age and the experience of burnout, $\Delta R^2 = 0.0004$, $F(1, 72) = 0.0400$, $p = 0.8420$, 95% CI[-0.0221, 0.0248]. Contrary to Austria, no significant effect was found between being a mother and depression, $B = 0.126$, $p = 0.234$. In fact, the analysis showed a positive correlation, $B = 0.246$, $p = 0.023$, between being a mother and the score of the positive psychology AHI scale. Hence, women with children in the UK indicated to be happier than women without children. A moderation analysis showed that this was neither influenced by age nor relationship status. For the other positive psychology scale, between the PERMA scale and having children no linear relationship was found, $B = -0.060$, $p = 0.587$, thus, no further calculations were done. As the results of the depression scale are significant, and, at the same time, this research demonstrates that having children or not having children had little bearing on the results, it shows that mental health support for women should be widely accessible given that a crisis affects the whole demographic.

A final question was dedicated to the help women received during the pandemic. For women in Austria (N = 133) as well as in the UK (N = 119) the biggest help during the pandemic was the support of the people around them. The biggest support for women in both countries were their families (Austria: 65.2%, UK: 74.8%) who helped them through these tough times by providing emotional and financial support and by spending time together. Likewise, friends (Austria: 60.6%, UK: 66.4%) provided refuge during the time of the pandemic through communication, emotional and mental support as well as distraction by doing sports together and offering an escape from the pandemic by giving a sense of 'normality'. Women's partners, who helped the respondents of this survey in the aspects of childcare, emotional support, coping with

daily chores and by giving love and affection, scored third highest in the ranking (Austria: 56.8%, UK: 61.3%). Even though, when asked to specify how these people helped them, emotional or mental support were mentioned most often, only a very small number of participants indicated that they had therapy as support during the pandemic. As stated in chapter 2, the task of emotional labour was often taken on by female healthcare professionals rather than mental health experts. This shows that adequate mental health support is still not as easily accessible to the broad public as it should be, particularly as the need for it is high. This was even explicitly stated by one of the survey participants: “The lack of mental health support is astounding” (Age unknown, woman, England). In fact, governments should re-evaluate their help for the public in general, but specifically for women and mothers, as in both countries the category of professional mental health support in the form of therapy was not chosen by many (Austria: 6%, UK: 12.6%). Reiterating Chisholm’s quote, “without mental health there can be no true physical health” (3), mental health policies should be integrated in public health measures. Mental wellbeing translates into several other areas of life, proving that not only individuals but also society as a whole would profit from an improved public mental health. Another resource that was listed as one of the factors that helped women during the pandemic in Austria as well as in the UK was work. Especially the option of working from home and having flexible hours was mentioned frequently as support. Hence, working from home is a development brought along by the pandemic that should remain available to employees. The findings that emerged from this analysis point to several easily (at least if prioritized) implementable areas in which targeted support for women would have a significant impact on the advancement of gender equality and general wellbeing.

Conclusion

Although many anticipated that COVID-19 would be the “Great Equalizer” (Galasso 376), which sadly, as I have demonstrated, it was not, it has at least increased the awareness of gender inequity, which is the first step towards change. This thesis has offered insights into the question whether the COVID-19 crisis could upend traditional patriarchal structures that disadvantage women in the professional and private realm.

At the beginning of this thesis, I presented a general contextualization of the COVID-19 pandemic followed by a detailed summary of the circumstances in Austria and the UK. In order to perform the empirical research, this thesis first established a

solid theoretical framework based on an extensive literature review that provided in-depth insights into the definitions and conceptualizations of Cultural and Social Studies. Building on this theoretical base, the methodology of the empirical research was explained, followed by the presentation and discussion of the results. The aim of this thesis was to illustrate how gender (in)equality for women both in the workplace and in the domestic sphere deteriorated during the pandemic, and what effects this decline had on women's mental wellbeing. The underlying assumption of my research was that mothers were disproportionately affected by the pandemic and that gender inequality for this demographic exacerbated drastically.

The results of my empirical study show that the research question, namely "How have women in Austria and the UK been affected by the COVID-19 pandemic in the realms of paid professional and unpaid domestic labour?" including a specific focus on the difference between mothers and childless women, cannot be answered definitively. The reason for this is that the effects on both subgroups were similar and differed only in a small number of areas. However, the study shows that mothers had the additional burden of providing childcare, managing education, and ensuring their children's mental wellbeing during lockdown. In my sample, a trend showing that women with children experienced more stress and mental health strains than women without children, is observable. It then follows that the main area in which the pandemic affected mothers differently than women without children was in the domestic sphere, and, specifically, that the increase in domestic labour led to a deterioration of their mental health. For the professional realm, results vary across the countries. Overall, this thesis has made five significant findings:

Firstly, the findings show a main difference between Austria and the UK in terms of the effects the pandemic had on women in the professional realm. Results in Austria show that whether a woman has children had a negative impact on her income. In contrast, having children did not have a detrimental effect on women's income in the UK. It was demonstrated that policies regarding parental leave and the educational systems in both countries affect these findings. Austrian mothers lose slightly more income for a longer period when going on parental leave while in the UK parents' additional educational expenses are far higher than in Austria.

Secondly, the findings suggest that with regards to private life, Austrian homes are far more egalitarian than British households. The results for the UK indicate

considerable inequalities in the division of domestic labour prior to the pandemic, which increased during the crisis. In contrast, Austrian women reported that domestic responsibilities had been handled more fairly before as well as during the pandemic. In both countries, the increased domestic workload was independent of women's age and whether they had children.

Thirdly, childcare proves to be a relevant factor in the experience of lockdowns for mothers. For UK mothers, the distribution of parental supervision prior to the pandemic revealed that they had been the primary caregivers, with a significantly lower proportion of parents who had shared parental care equally. There was a noticeable trend in favour of equality when it comes to parental care during the pandemic. Fewer mothers indicated that they were primarily responsible for providing parental care but shared it equally with the other parent. Hence, for single mothers especially both professional work and the mental load carried at home increased substantially. Comparatively, mothers in Austria had shared childcare more evenly before the pandemic but experienced a negative trend towards a more unequal division during the pandemic, which saw mothers increasingly perform childcare duties on their own.

Furthermore, results in the mental health section vary between Austria and the UK. In Austria, having children did not negatively influence women's scores for the positive psychology scales, while having children considerably heightened women's experience of depression and burnout. Similarly, in the UK sample, a substantial link between being a mother and experiencing burnout can be seen. The main difference between the countries is that for women in the UK no correlation between having children and experiencing depression was found. On the contrary, the results revealed a favourable relationship between being a mother and the AHI scale score in positive psychology. For women in both countries, having children is unrelated to their scores on the PERMA scale.

Lastly, none of these results were influenced by any external factors as hypothesized in the additional guiding questions whether women's age and their relationship status had an impact on women's experiences of workload and mental burden. Moreover, it was tested whether the number of children and the children's ages affected mothers' wellbeing. All results were unaffected by women's relationship status, their number of children, or the children's age.

With this thesis, I have made three relevant scholarly contributions. First, I have provided new insights into the effects of the pandemic on gender inequality by focusing on the intra-gender differences of mothers and women without children. Second, this research contributes to the growing interest in motherhood studies and the medical humanities by adopting an interdisciplinary approach that incorporates Cultural, Social, and Economic Studies. Third, with the cross-cultural comparison of Austria and the UK I have given insights into the effects of COVID-19 beyond borders, showing parallels as well as differences, and thus was able to offer concrete examples for improvement. In addition to the academic contributions, one of the aims of this thesis was to raise awareness for the situation of women during the pandemic and help make their experience heard and acknowledged in an academic context. When looking at some of the comments women made in the optional field for open responses such as, “Thank you for this opportunity “ (Age unknown, mother of one, England), it seems as if this intention was successful.

Limitations and Further Research

One of the limitations of this study is that participants were self-reporting their subjective experiences of the pandemic in the questionnaires. Such self-evaluations are always susceptible to certain biases and perceptual mistakes. When compared to the beginning of the pandemic, work intensification or mental health burdens were probably perceived differently after two years when working from home, distance learning and social distancing measures have become more routine parts of everyday life. Data was obtained mid-May 2022, and it needs to be acknowledged that the same questionnaire distributed some months earlier or later might have yielded different results. This limitation was even addressed by some of the participants:

> I find it a bit difficult to answer because pandemic 03/2020 was different from pandemic 03/2022, with many gradations and shades in between. (41 years-old mother of three, AUT, my translation)

> I also perceived the pandemic very differently at different stages or times. (25 years-old woman, AUT, my translation)

Thus, a longitudinal approach including multiple follow-up surveys might offer a more holistic view of the pandemic. Moreover, as the questions of the survey were process-oriented towards attempting to trace the changes during the pandemic compared to the situation prior to it, temporal biases are likely to occur. This, too, must be considered as the current answers might give a distorted impression of the severity of the actual effects in earlier months and years. Therefore, expanding the period under

study would undoubtedly result in a more complete picture of the gender disparities caused by the pandemic in Austria and the UK.

Another limitation concerns the composition of the sample in terms of size and demographics of the participants. Firstly, the group of participants was very homogenous. For instance, the socio-economic background of all participants was very similar considering educational level and income. Especially, the women's ethnic backgrounds were limited in diversity, thus, further research is needed to investigate the effect the pandemic has had on BAME (Black, Asian, and minority ethnic) people and expand previous findings (House of Commons, *Unequal Impact*; Flotzinger et al.). Secondly, despite 155 (in Austria) and 165 (in the UK) participants being a considerable number, more women need to participate for the results to be representative for whole nations. To this end, a bigger sample size is recommended for future research to guarantee a higher reliability and generalizability of the results. It is also suggested to ensure completion of the questionnaires in the future as the varying number of participants throughout the questionnaires posed a difficulty for generalizing the results.

It is self-evident that, given the novelty of the COVID-19 pandemic and it being a highly complex social phenomenon, more research in this area will be required. Even retrospective investigations of the situation prove difficult given that the situation has been evolving dynamically over the last two years and that local conditions in Austria and the UK have subsequently been changing rather rapidly. Furthermore, the long-term repercussions on economies, gender inequality and individuals remain to be seen and need to be revisited and continuously reassessed in the coming years. In general, the area of gender inequality is much researched and multiple solutions have been offered already (e.g., women's quota, legislations, promoting diversity, etc.). Yet, further research could shed light on other ideas that go beyond current policies and approaches to gender equality. As this thesis has shown, current measures are not successful at the speed and rate that is needed.

Having narrowed this research to the comparison of Austria and the UK, this thesis is a starting point for cross-cultural comparison in the bilateral relationship between Austria and the UK. Future research might add to the comparison of these countries and further investigate whether interaction between the UK and Austria is fruitful in achieving gender equality given their several parallels and advances in other

areas. Nevertheless, cross-cultural analyses of other Anglophone countries might lead to new resources and approaches that have remained hidden as of yet.

The open question at the end of the survey also provides many impulses for future research. An interesting area of investigation, for example, would be the question to what extent the healthy lifestyle the pandemic promoted was 'healthy' and how it affected women: "There was a very real toxicity with 'health' and othorexic [sic] behaviour being promoted especially in lockdown one "(Age unknown, woman, England). In keeping with the trend of following a healthy lifestyle amidst the chaos, the prevalent self-care narrative proves equally problematic. In the following two quotes, the women elaborate on the positive developments the pandemic has brought to their lives, such as cooking, acquiring new skills and tapping their creative side:

> Positive WFH spend more time with my daughter. Being able to stay home without feeling guilty. Not having to interact with lots of people Reconnecting with family (zoom weekly quiz, lots of facetimel [sic] Cooking Learning new things - making jam/chutneys etc Reevaluating what is important in life. (53 years-old mother of one, England)

> I got more in touch with myself and tried new things, e.g. yoga and painting, things that I still do now. (25 years-old woman, AUT, my translation)

On the one hand, these are beautiful experiences and the fact that these women did not only experience the pandemic negatively is encouraging. On the other hand, they reflect the privileged socio-economic background of the participants, as these acts of 'self-care' were a luxury that was not available to all women:

> [T]he pandemic revealed some very odd ideas around what was generally termed *'opportunities' for self-improvement*. *This was the experience for a very limited number of people*. (Age unknown, mother of one, England; emphasis added)

As can be seen, there is much need for further investigation on the pandemic's effects on the different areas of women's lives.

Outlook

In general, the availability of gender-sensitive resources during the crisis was scarce in both Austria and the UK. Previous studies as well as the responses in this survey showed that government responses need to expand and strengthen their gender-responsiveness. The pandemic has highlighted that "patriarchal culture will accord mothers resources if they use them on behalf of children" (O'Reilly, *Twenty-First-Century Motherhood* 369). Yet not only are these resources insufficient in supporting

mothers' needs for the care of their children, but mothers also deserve adequate support for themselves.

One goal of this thesis was to identify areas where further political action is required to advance gender equality and what resources are helpful to women. Rather than suggesting overall financial support for women, I will suggest specific areas in which systemic change will result in more gender equality based on the results of the survey. In the professional realm, this change includes overcoming the gendered occupational segregation. Higher paying industries are still male-dominated, and thus, more women need to be informed about, encouraged to and supported in entering these employment sectors. As elaborated earlier, women had to manage additional burdens caused by the pandemic while having to maintain the required levels of professional performance during the exceptional circumstances. Many women, especially mothers, reported that working from home was a development that helped them negotiate and manage the manifold responsibilities. Hence, on the way to achieving gender equality in the professional as well as the private realm, options for flexible working locations and working hours should remain available to employees. In addition to this, it is important to expand childcare availabilities. It is imperative that these options are affordable, or ideally free, so that they are accessible to all mothers and do not favour richer families. While it is true that personal networks often step in to help with childcare when other options are unattainable, this survey has shown that childrearing is still a task disproportionately often performed by women. This includes situations where non-working mothers shoulder the caring responsibility for several children so that their mothers are able to hold steady jobs and earn enough money to make a living. Hence, an expansion of external facilities would reduce this responsibility and grant mothers more freedom to pursue an adequate split between professional employment and family, which would contribute to closing the parts of the gender pay gap that are caused by differing working hours. Another policy change that would compensate for mothers' lost working time caused by childrearing duties and, at the same time, enhance gender equity at home, is shared parental leave. While it is possible to share parental leave in both Austria and the UK, it remains optional. Mandatory, shared parental leave would not only level the playing field for mothers professionally as both parents miss equal amounts of time but also strengthen the father-child relationship.

Women's unpaid domestic work has long been recognized as a major contributor to gender inequality as it has a direct correlation with lower levels of education, poorer mental health, and lower income (United Nations 15). Thus, it is imperative to acknowledge this invisible labour and compensate women for their efforts. One step to achieve this is to make emotional labour and the mental load women are carrying explicit in society. Women urge that domestic work is recognized publicly: “Emotional labour I feel is something that is not recognized enough and needs further attention, including in the media” (31-years-old woman, England). By raising awareness, a more equally shared division of labour can be achieved. This would not only alleviate burdens in the domestic sphere, but it would also encourage equality in the professional realm:

> [I]t seems that gender equity in the home is more often a determinant of employment success than family-friendly policies in the workplace. When asked what enabled them to achieve success in academia, the overwhelming majority of respondents identified not workplaces policies but the support of their partners. (O’Reilly, *Twenty-First-Century Motherhood* 377)

The personal accounts in this study show that the biggest support for women in both countries were their families. A major contribution that was mentioned numerous times in the participant’s answers was mental support. This has made clear that neither Austria nor the UK have provided adequate and easily accessible mental health support to the public. Accessible and affordable professional mental health support is vital not only in face of future crises, but also as a measure to improve daily life and public health in general. During the pandemic, waiting periods for therapy have risen to almost a year in both locales, thus demonstrating that mental health resources need to be extended given their urgent necessity. Additionally, to reduce the stigma around this subject, awareness and education of the available resources and are required.

This thesis is only a small contribution to the much greater undertaking of working towards gender equality. A new report by United Nation Women and the UN Department of Economic and Social Affairs shows that it will take approximately another 300 years at the current rate of progress to achieve full gender equality, one of the Sustainable Development Goals intended to be accomplished by 2030 (UN Women and UN DESA 2). I have demonstrated that women need policy changes that go beyond economic measures and include public recognition of their efforts as well as support of their mental wellbeing. By and large, gender-sensitive actions are needed

by governments as well as individuals to decrease daily challenges for women and to build adequate support systems and prepare for future crisis management.

Despite the numerous negative changes and implications of the pandemic, it also entailed several positive effects, especially regarding the environment. Studies have shown that the economic inactivity resulting from global lockdowns has led to unexpected positive effects for the environment (Loh et al.). The pandemic has granted earth time for recuperation of the anthropogenic damages of the last decades. Practices to mitigate infections, especially travel bans and the lack of touristic and leisure mobility, have drastically reduced human carbon emissions (Loh et al. 3). Both nature and humanity have benefited from this development:

> I liked the quiet that came about because there was much less traffic on our already overcrowded roads. I also enjoyed the lack of noise from aircraft as we are directly below flight path for Heathrow. (68 years-old mother of six, England)

Apart from the environmental improvements, for some, reduced personal contacts and remote working meant a relief from anxiety and social stress as well as more time spent with family:

> Everything became much more positive for me - *lots of work pressures were eased, social expectations were much easier to meet* and I found it easy to follow the rules and expectations. (34-years old woman, England; emphasis added)

> I've never had as much time with my family as I did in the first Lockdown and I enjoyed it. (Age unknown, mother of one, AUT, my translation)

> In the beginning, solidarity in society was a good experience and very positive! (61 years-old mother of two, AUT, my translation)

> There is always a positive [sic] side but *unfortunately once a situation improves people tend to forget about it. Let's hope that the pandemic made us more aware of the poitive [sic] things we have.* (58-years mother of two, England; emphasis added)

Continuing with this positive attitude, it can be said that the pandemic has highlighted how crucial community cohesion is. By working together towards a common goal, whether that is not having to enter another lockdown and gaining back freedom, overcoming a pandemic, or achieving gender equality, awareness and education are the most valuable tools. The investments governments and individuals make now will determine the success of dealing with future global problems and crises, whether they be social or medical. Furthermore, the COVID-19 pandemic provides a chance to question traditional structures and ideologies. Being aware of inequalities in how different populations and minorities are affected by social interruptions and

acknowledging that dismantling current belief systems has a vital part in overcoming these inequalities is essential. It is our shared responsibility to spread awareness and collectively shape the ‘new normal’ of the post-pandemic era.

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Table of Figures

Appendix

Abstract

The long-standing social phenomenon of gender inequality is one of several inequities that continue to exist in our society. Even prior to the outbreak of the novel coronavirus, the majority of unpaid domestic work, including childcare, housework, and caring for the elderly, was borne by women. This thesis undertakes empirical research of the effects of the COVID-19 pandemic on gender inequality in Austria and the UK. While the question of how women have been affected differently by the drastic changes of lockdowns and other containment measures than men was and is an interesting topic in the discussions of the COVID-19 pandemic, this paper will investigate the different experiences of women with and without children. The premise of the present study was that mothers experienced more difficult hardship during the pandemic than women without children. This thesis examines the salient differences of these two groups both in the professional realm and in unpaid domestic labour. The results suggest that mothers were, in fact, disproportionately impacted by the pandemic's developments, especially in the area of mental health. Furthermore, building on and intertwining with previous research on gender inequality and COVID-19, this paper will also take into account the unique characteristics of motherhood and other cross-country factors in Austria and the UK and propose actions on governmental and individual level to advance gender equality.

Zusammenfassung

Geschlechterungleichheit ist eine von vielen sozialen Ungerechtigkeiten, die in unserer Gesellschaft weiterhin bestehen. Bereits vor dem Ausbruch des neuartigen Coronavirus wurde der Großteil der unbezahlten Haus- und Familienarbeit, einschließlich Kinderbetreuung und der Pflege älterer Angehöriger, von Frauen geleistet. In dieser Masterarbeit wird eine empirische Untersuchung der Auswirkungen der COVID-19-Pandemie auf Geschlechterungleichheiten in Österreich und dem Vereinigten Königreich durchgeführt. Die Frage, inwieweit Frauen von den drastischen Veränderungen anders betroffen waren als Männer, war in der Diskussion um die COVID-19-Pandemie besonders präsent. In dieser Arbeit geht es nicht um die geschlechtsspezifischen Auswirkungen der Pandemie zwischen Männern und Frauen, sondern um die unterschiedlichen Erfahrungen von Frauen mit Kindern und kinderlosen Frauen. Die Prämisse der vorliegenden Studie war, dass während der Pandemie Frauen mit Kindern größere Schwierigkeiten hatten als Frauen ohne Kinder. In dieser Arbeit werden die Unterschiede zwischen Müttern und Frauen ohne Kinder im beruflichen Kontext und im Bereich der unbezahlten Hausarbeit untersucht. Die Ergebnisse deuten darauf hin, dass Mütter in der Tat unverhältnismäßig stark von den Entwicklungen der Pandemie betroffen waren, insbesondere im Bereich der psychischen Gesundheit. Des Weiteren werden in dieser Arbeit, aufbauend auf früheren Forschungsergebnissen zu Geschlechterungleichheit und COVID-19 sowie unter Berücksichtigung der besonderen Merkmale der Mutterschaft und der länderübergreifenden Faktoren zwischen Österreich und dem Vereinigten Königreich, Maßnahmen auf staatlicher und individueller Ebene zur Förderung der Gleichstellung vorgeschlagen.

Questionnaires

English Version

0% completed

Dear Participant,

Thank you for your interest in this study.

As part of my Master's thesis in Anglophone Literatures and Cultures at the University of Vienna, I am exploring the impact of the COVID-19 pandemic on women, specifically mothers, in Austria and the UK.

Therefore, your **participation** is only helpful, **if** you:

- live in **Austria** or the **UK**
- identify as a **woman**

If one or more criteria do not apply to you, this means that you cannot particpate in this study and you can close the browser window now.

The following questionnare will take about **10** minutes to complete.

Your information will of course remain **anonymous** and cannot be traced back to your person. Your data will be used and statistically processed solely for the purpose of this Master's thesis. Your participation in this survey is voluntary. You can stop the questionnaire at any time without giving reasons and withdraw permission to use your data (even after the survey has ended) at any time. In this case, your previous answers will be deleted and not included in the study.

Please answer the questions **truthfully**. The questions are about your subjective experiences, therefore there are no right or wrong answers. Please read the instructions carefully. Thank you for your support!

If you have any questions about the survey, please feel free to contact me: Johanna Braunsdorfer (a11712442@unet.univie.ac.at). By clicking Next, you agree that the data collected may be statistically analysed.

0% completed

1. How old are you?

2. What is your ethnic group?

- [ ] Asian or Asian British
- [ ] Black, Black British, Caribbean or African
- [ ] White
- [ ] Mixed or multiple ethnic groups:
- [ ] Other ethnic group:

3. What is your gender?

- ○ Female
- ○ Male
- ○ Diverse

4. Are you in a relationship?

- ○ Yes
- ○ No

6% completed

1. Which country do you live in?

- ○ The United Kingdom
- ○ Austria

2. What are the first two letters of your postal code?

My postal code starts with the letters

11% completed

1. What is the highest level of education you have completed?

- ○ No formal education
- ○ General Certificate of Secondary Education (GCSEs)
- ○ Vocational secondary certification (completion of specialized secondary school/college)
- ○ A-levels/International Baccalaureate, subject-related higher education entrance qualification
- ○ Undergraduate Degree
- ○ Postgraduate Degree
- ○ Other school-leaving qualification: _____

2. Are you currently employed?

- ○ Yes, I am employed.
- ○ No, I am unemployed.
- ○ No, I am retired.
- ○ No, I am a homemaker.
- ○ No, I am still in training.

3. Has your employment situation changed as a result of the pandemic?

[Please choose]

4. What is your monthly net income?

Net income is defined as your total income after tax and social security deductions.

[Please choose]

17% completed

1. What is your employment status?

- ○ Worker
- ○ Employee
- ○ Self-employed
- ○ Other:

2. What are your working hours?

- ○ Full-time
- ○ Part-time
- ○ Freelance
- ○ Other:

3. What job sector/s are you working in?

- ☐ Agriculture, forestry and fishing
- ☐ Banking and finance
- ☐ Construction
- ☐ Distribution, hotels and restaurants
- ☐ Energy and water
- ☐ Manufacturing
- ☐ Public administration, education and health
- ☐ Transport and communication
- ☐ Other:

☐ I am still in school or training

22% completed

1. Please indicate how often you experience the following feelings and attitudes.

	Never	Rarely	Sometimes	Often	Always
I feel mentally exhausted.	○	○	○	○	○
Everything I do requires a great deal of effort.	○	○	○	○	○
At the end of the day, I find it hard to recharge my energy.	○	○	○	○	○
At the end of the day, I feel mentally exhausted and drained.	○	○	○	○	○
I feel physically exhausted.	○	○	○	○	○
I struggle to find any enthusiasm for my work.	○	○	○	○	○
I have trouble staying focused.	○	○	○	○	○
I'm forgetful and distracted.	○	○	○	○	○
I make mistakes because I am distracted by other things.	○	○	○	○	○
I feel unable to control my emotions.	○	○	○	○	○
I get upset or sad without knowing why.	○	○	○	○	○
I have trouble falling or staying asleep.	○	○	○	○	○
I feel tense and stressed.	○	○	○	○	○
I feel anxious and/or suffer from panic attacks.	○	○	○	○	○
I suffer from headaches.	○	○	○	○	○

2. How have these feelings and moods changed compared to prior to the pandemic?

During the pandemic, these moods and emotions

- ☐ stayed the same.
- ☐ deteriorated.
- ☐ improved.
- ☐ became more frequent.
- ☐ became less frequent.
- ☐ first occured.

28% completed

1. Please indicate how often you experience the following feelings and attitudes.

	Never	Rarely	Sometimes	Often	Always
I am sad.	○	○	○	○	○
I feel discouraged about the future.	○	○	○	○	○
I feel like a failure.	○	○	○	○	○
It is hard for me to enjoy things.	○	○	○	○	○
I feel guilty.	○	○	○	○	○
I am disappointed in myself.	○	○	○	○	○
I criticise myself for my mistakes and weaknesses.	○	○	○	○	○
I cry.	○	○	○	○	○
I feel irritated and annoyed.	○	○	○	○	○
I lack interest in other people.	○	○	○	○	○
I put off decisions.	○	○	○	○	○
I have insomnia.	○	○	○	○	○
I am tired and apathetic.	○	○	○	○	○
I worry about my health.	○	○	○	○	○
I have no appetite.	○	○	○	○	○

2. How have these feelings and moods changed compared to *prior* to the pandemic?

During the pandemic, these moods and emotions

- ☐ stayed the same.
- ☐ deteriorated.
- ☐ improved.
- ☐ became more frequent.
- ☐ became less frequent.
- ☐ first occurred.

33% completed

1. Do you have children?

[Please choose]

2. How old is your child/are your children?

Child 1	
Child 2	
Child 3	
Child 4	
Child 5	
Child 6	
Child 7	
Child 8	
Child 9	
Child 10	

39% completed

1. Which childcare options did you use on a regular basis before the pandemic?

- [ ] Nursery
- [ ] Kindergarten
- [ ] Childminder
- [ ] Children's group
- [ ] Babysitter
- [ ] All-day school types
- [ ] Grandparents
- [ ] Other relatives
- [ ] Au-pair
- [ ] Extracurricular courses
- [ ] Parental supervision
- [ ] My child does not need childcare
- [ ] Other

2. Which childcare options did you regularly use during the pandemic?

- [ ] Nursery
- [ ] Kindergarten
- [ ] Childminder
- [ ] Children's group
- [ ] Babysitter
- [ ] All-day school types
- [ ] Grandparents
- [ ] Other relatives
- [ ] Au-pair
- [ ] Extracurricular courses
- [ ] Parental supervision
- [ ] My child does not need childcare
- [ ] Other

44% completed

1. Who took over parental supervision **before** the pandemic?

- ○ Mostly the other parent
- ○ Mostly me
- ○ Both equally

2. Who took over parental supervision **during** the pandemic?

- ○ Mostly the other parent
- ○ Mostly me
- ○ Both equally

50% completed

1. Do you live with another adult person?

- ○ Yes
- ○ No

56% completed

1. What is your relationship with this person?

[Please choose]

2. Which of the following activities do you mainly do in the household?

- [ ] Laundry
- [ ] Grocery shopping
- [ ] Cleaning
- [ ] Dishwashing
- [ ] Cooking
- [ ] Care for elderly or sick relatives
- [ ] Childcare
- [ ] Mental load tasks (e.g. emotional support, keeping the organisational overview etc.)

3. Which of the following activities are shared between you and other people in your household?

- [ ] Laundry
- [ ] Grocery shopping
- [ ] Cleaning
- [ ] Dishwashing
- [ ] Cooking
- [ ] Care for elderly or sick relatives
- [ ] Childcare
- [ ] Mental load tasks (e.g. emotional support, keeping the organisational overview etc.)

4. How has the frequency of the tasks you do changed compared to before the pandemic?

The frequency of me performing these tasks has

- ○ remained the same.
- ○ increased.
- ○ decreased

61% completed

1. When I think about my own happiness, I feel like...

- [ ] I have sorrow in my life.
- [ ] I have neither sorrow nor joy in my life.
- [ ] I have more joy than sorrow in my life.
- [ ] I have much more joy than sorrow in my life.
- [ ] my life is filled with joy.

2. By objective standards,

- [ ] I do poorly.
- [ ] I do neither well nor poorly.
- [ ] I do rather well.
- [ ] I do quite well.
- [ ] I do amazingly well.

3. When I consider my work life,

This includes paid and unpaid labour.

- [ ] I do not like my work.
- [ ] I feel neutral about my work.
- [ ] I like my work for the most parts.
- [ ] I really like my work.
- [ ] I truly love my work.

4. When I think about my day,

- [ ] I do not enjoy my daily routine.
- [ ] I feel neutral about my daily routine.
- [ ] I like my daily routine, but I am happy to get away from it.
- [ ] I like my daily routine so much that I rarely take breaks from it.
- [ ] I like my daily routine so much that I almost never take breaks from it.

5. Overall, my life is

- [ ] is a bad one.
- [ ] is an OK one.
- [ ] is a good one.
- [ ] is a very good one.
- [ ] is a wonderful one.

67% completed

1. Please indicate to what extent you encounter these situations or feel these emotions.

	Never									Always
In general, how often do you feel joyful?	○	○	○	○	○	○	○	○	○	○
How often do you achieve the important goals you have set for yourself?	○	○	○	○	○	○	○	○	○	○
In general, how often do you feel positive?	○	○	○	○	○	○	○	○	○	○
How often are you able to handle your responsibilities?	○	○	○	○	○	○	○	○	○	○
How often do you lose track of time while doing something you enjoy?	○	○	○	○	○	○	○	○	○	○

2. Please indicate to what extent you encounter these situations or feel these emotions.

	Not at all									Always
To what extent do you receive help and support from others when you need it?	○	○	○	○	○	○	○	○	○	○
In general, to what extent do you feel that what you do in your life is valuable and worthwhile?	○	○	○	○	○	○	○	○	○	○
In general, to what extent do you feel excited and interested in things?	○	○	○	○	○	○	○	○	○	○
How lonely do you feel in your daily life?	○	○	○	○	○	○	○	○	○	○

3. Please indicate to what extent you encounter these situations or feel these emotions.

	Not at all									Completely
To what extent do you feel loved?	○	○	○	○	○	○	○	○	○	○
To what extent do you generally feel you have a sense of direction in your life?	○	○	○	○	○	○	○	○	○	○
Taking all things together, how happy would you say you are?	○	○	○	○	○	○	○	○	○	○

72% completed

1. Who or what has helped you during the pandemic in any way? Please also indicate what kind of help you received e.g. financial support.

- [ ] Friends
- [ ] Family
- [ ] My Partner
- [ ] Governmental support
- [ ] Non-profit organizations
- [ ] Other:

78% completed

1. Finally, I would like to give you the opportunity to share your experience of the pandemic.

For example: Do you remember a specific moment during the crisis when you noticed gender inequality? Or did you experience particularly positive changes in the course of the pandemic?

83% completed

Unfortunately, you do not meet the necessary criteria to participate in this study. Nevertheless, we thank you for your support in our study.

You can close the browser window now.

89% completed

1. Thank you for your participation!

If you are interested in the results of this study, you can enter your e-mail address here.

E-mail:

Thank you very much for your participation! We would like to thank you very much for your help. Your answers have been saved, you can now close the browser window.

German Version

0% ausgefüllt

Liebe Teilnehmerin,

vielen Dank, dass Sie an dieser Studie teilnehmen wollen.

Im Rahmen meiner Masterarbeit im Studienfach Anglistik an der Universität Wien, untersuche ich die Auswirkungen der Covid-19-Pandemie auf die Geschlechterungleichheiten von Frauen, insbesondere Müttern, in Österreich und Großbritannien.

Eine **Teilnahme** ist dementsprechend nur sinnvoll, **wenn** Sie:

- in **Österreich** oder **Großbritannien** leben und
- sich als **Frau** identifizieren

Wenn eines oder mehrere Kriterien nicht auf Sie zutreffen, bedeutet dies, dass Sie leider nicht geeignet sind an dieser Studie teilzunehmen. Ich bedanke mich für Ihr Interesse. Sie können das Browserfenster jetzt schließen.

Die Bearbeitung des folgenden Fragebogens wird ca. **10** Minuten in Anspruch nehmen.

Ihre Angaben bleiben selbstverständlich **anonym** und können nicht auf Ihre Person zurückgeführt werden. Ihre Daten werden ausschließlich für den Zweck dieser Masterarbeit verwendet und statistisch verarbeitet. Ihre Teilnahme an dieser Befragung ist **freiwillig**. Sie können die Bearbeitung des Fragebogens jederzeit ohne Angabe von Gründen abbrechen und die Erlaubnis zur Verwertung Ihrer Daten (auch nach Beendigung der Erhebung) jederzeit zurückziehen. In diesem Fall werden Ihre bisherigen Antworten gelöscht und nicht in die Studie miteinbezogen.

Bitte beantworten Sie die Fragen **wahrheitsgemäß**. Es werden Ihre subjektiven Erfahrungen abgefragt, daher gibt es keine richtigen bzw. falschen Antworten. Bitte lesen Sie die Instruktionen genau (insb. auf welchen Zeitraum sich manche Fragen beziehen). Danke für Ihre Unterstützung!

Wenn Sie Fragen zur Erhebung haben, können Sie sich jederzeit an mich wenden: Johanna Braunsdorfer (a11712442@unet.univie.ac.at). Mit dem Klicken auf Weiter, erklären Sie sich damit einverstanden, dass die erhobenen Daten statistisch ausgewertet werden dürfen.

0% ausgefüllt

1. Wie alt sind Sie?

2. Welcher Volksgruppe fühlen Sie sich zugehörig?

- [ ] Österreichisch
- [ ] Kroatisch
- [ ] Slowenisch
- [ ] Ungarisch
- [ ] Tschechisch
- [ ] Slowakisch
- [ ] Volksgruppe der Roma
- [ ] Andere

3. Welchem Geschlecht fühlen Sie sich zugehörig?

[Bitte auswählen]

4. Sind Sie derzeit in einer Partnerschaft?

[Bitte auswählen]

6% ausgefüllt

1. In welchem Land leben Sie derzeit?

[Bitte auswählen]

2. In welchem Bundesland leben Sie derzeit?

- ○ Wien
- ○ Niederösterreich
- ○ Burgenland
- ○ Steiermark
- ○ Oberösterreich
- ○ Salzburg
- ○ Kärnten
- ○ Tirol
- ○ Vorarlberg

11% ausgefüllt

1. Welchen Bildungsabschluss haben Sie?

Bitte wählen Sie den höchsten Bildungsabschluss, den Sie bisher erreicht haben.

- ○ kein Abschluss
- ○ Pflichtschulabschluss
- ○ Abgeschlossene Lehre
- ○ Matura, Hochschulreife
- ○ Bachelor oder gleichwertiger Abschluss
- ○ Master oder gleichwertiger Abschluss
- ○ Anderer Abschluss, und zwar: _____

2. Sind Sie momentan erwerbstätig?

- ○ Ja, ich bin erwerbstätig.
- ○ Nein, ich bin arbeitslos.
- ○ Nein, ich bin pensioniert.
- ○ Nein, ich bin Hausfrau.
- ○ Nein, ich bin in Ausbildung.

3. Hat sich Ihre Erwerbstätigkeit *während* der Pandemie geändert?

[Bitte auswählen] ⌄

4. Wie hoch ist Ihr monatliches Nettoeinkommen ungefähr?

Gemeint ist der Betrag, der sich aus allen Einkünften zusammensetzt und nach Abzug der Steuern und Sozialversicherungen übrig bleibt.

[Bitte auswählen] ⌄

17% ausgefüllt

1. Wie sind Sie beschäftigt?

Bitte geben Sie die Beschäftigungsform an, in der Sie erwerbstätig sind.

- ○ Angestellte
- ○ Selbstständig
- ○ Freie Dienstnehmerin
- ○ Sonstiges: [ ]

2. In welchem Ausmaß sind Sie beschäftigt?

- ○ Vollzeit
- ○ Teilzeit
- ○ Geringfügig

3. In welcher/welchen Branche/n sind Sie tätig?

Bitte wählen Sie den oder die Beschäftigungsbereich/e, in dem/denen Sie momentan tätig sind.

- ☐ Handel, Logistik, Verkehr
- ☐ Medien, Grafik, Design
- ☐ Reinigung, Hausbetreuung
- ☐ Soziales, Gesundheit, Schönheitspflege
- ☐ Textil und Bekleidung
- ☐ Tourismus, Gastgewerbe, Freizeit
- ☐ Umwelt
- ☐ Wissenschaft, Bildung, Forschung und Entwicklung
- ☐ Maschinenbau, Kfz, Metall
- ☐ Landwirtschaft, Gartenbau, Forstwirtschaft
- ☐ Elektrotechnik, Elektronik, Telekommunikation, IT
- ☐ Chemie, Biotechnologie, Lebensmittel, Kunststoffe
- ☐ Büro, Marketing, Finanz, Recht, Sicherheit
- ☐ Bergbau, Rohstoffe
- ☐ Bau, Holz, Gebäudetechnik
- ☐ Andere [ ]

- ☐ Ich bin noch in Ausbildung

22% ausgefüllt

1. Bitte geben Sie an wie häufig Sie diese Stimmung oder Sichtweise erleben.

	Nie	Selten	Manchmal	Oft	Immer
Allgemein bin ich psychisch erschöpft.	○	○	○	○	○
Alles was ich tue, kostet mich große Mühe.	○	○	○	○	○
Am Ende des Tages fühle ich mich psychisch erschöpft und ausgelaugt.	○	○	○	○	○
Am Ende des Tages fällt es mir schwer mich zu erholen.	○	○	○	○	○
Ich fühle mich körperlich erschöpft.	○	○	○	○	○
Ich kann keine Begeisterung für meine Arbeit aufbringen.	○	○	○	○	○
Ich habe Mühe aufmerksam zu bleiben.	○	○	○	○	○
Ich bin vergesslich und leicht ablenkbar.	○	○	○	○	○
Ich mache Fehler, weil ich in Gedanken bei anderen Dingen bin.	○	○	○	○	○
Ich habe das Gefühl, keine Kontrolle über meine Emotionen zu haben.	○	○	○	○	○
Ich werde wütend oder traurig, ohne zu wissen warum.	○	○	○	○	○
Ich habe Probleme einzuschlafen oder durchzuschlafen.	○	○	○	○	○
Ich fühle mich angespannt und gestresst.	○	○	○	○	○
Ich fühle mich ängstlich oder leide an Panikattacken.	○	○	○	○	○
Ich leide an Kopfschmerzen.	○	○	○	○	○

28% ausgefüllt

1. Bitte geben Sie an wie häufig Sie diese Stimmung oder Sichtweise erleben.

	Nie	Selten	Manchmal	Oft	Immer
Ich bin traurig.	○	○	○	○	○
Ich sehe mutlos in die Zukunft.	○	○	○	○	○
Ich fühle mich als Versagerin.	○	○	○	○	○
Es fällt mir schwer, etwas zu genießen.	○	○	○	○	○
Ich habe Schuldgefühle.	○	○	○	○	○
Ich bin von mir enttäuscht.	○	○	○	○	○
Ich werfe mir Fehler und Schwächen vor.	○	○	○	○	○
Ich weine.	○	○	○	○	○
Ich fühle mich gereizt und verärgert.	○	○	○	○	○
Mir fehlt das Interesse an Menschen.	○	○	○	○	○
Ich schiebe Entscheidungen vor mir her.	○	○	○	○	○
Ich habe Schlafstörungen.	○	○	○	○	○
Ich bin müde und lustlos.	○	○	○	○	○
Ich mache mir Sorgen um meine Gesundheit.	○	○	○	○	○
Ich habe keinen Appetit.	○	○	○	○	○

33% ausgefüllt

1. Haben Sie Kinder?

[Bitte auswählen]

2. Wie alt ist Ihr Kind bzw. sind Ihre Kinder?

Kind 1	
Kind 2	
Kind 3	
Kind 4	
Kind 5	
Kind 6	
Kind 7	
Kind 8	
Kind 9	
Kind 10	

39% ausgefüllt

1. Welche Betreuungsmöglichkeiten haben Sie vor der Pandemie regelmäßig in Anspruch genommen?

- [ ] Kinderkrippe
- [ ] Kindergarten
- [ ] Tagesmutter/vater
- [ ] Kindergruppe
- [ ] Babysitter
- [ ] Ganztägige Schulformen
- [ ] Großeltern
- [ ] Andere Angehörige
- [ ] Au-pair
- [ ] Freizeitkurse
- [ ] Elterliche Aufsicht
- [ ] Befreundete Eltern
- [ ] Mein Kind benötigt keine Betreuung
- [ ] Andere

2. Welche Betreuungsmöglichkeiten haben Sie während der Pandemie in Anspruch genommen?

- [ ] Kinderkrippe
- [ ] Kindergarten
- [ ] Tagesmutter/vater
- [ ] Kindergruppe
- [ ] Babysitter
- [ ] Ganztägige Schulformen
- [ ] Großeltern
- [ ] andere Angehörige
- [ ] Au-pair
- [ ] Freizeitkurse
- [ ] Elterliche Aufsicht
- [ ] Befreundete Eltern
- [ ] Mein Kind benötigt keine Betreuung
- [ ] Andere

44% ausgefüllt

1. Wer hat vor der Pandemie hauptsächlich die elterliche Aufsicht übernommen?

- ○ Der andere Elternteil
- ○ Ich selbst
- ○ Beide gleich

2. Wer hat während der Pandemie hauptsächlich die elterliche Aufsicht übernommen?

- ○ Der andere Elternteil
- ○ Ich selbst
- ○ Beide gleich

50% ausgefüllt

1. Leben Sie mit einer anderen erwachsenen Person in einem Haushalt?

- ○ Ja
- ○ Nein

56% ausgefüllt

1. In welcher Beziehung stehen Sie zu dieser Person?

[Bitte auswählen]

2. Welche der folgenden Tätigkeiten übernehmen ausschließlich Sie im Haushalt?

- [ ] Wäsche waschen
- [ ] Lebensmitteleinkauf
- [ ] Putzen
- [ ] Abwasch
- [ ] Kochen
- [ ] Pflege von alten oder kranken Angehörigen
- [ ] Kinderbetreuung
- [ ] Mental Load Aufgaben (z.B. Emotionale Unterstützung, den organisatorischen Überblick behalten etc.)

3. Welche der folgenden Tätigkeiten werden zwischen Ihnen und anderen Personen in Ihrem Haushalt aufgeteilt?

- [ ] Wäsche waschen
- [ ] Lebensmitteleinkauf
- [ ] Putzen
- [ ] Abwasch
- [ ] Kochen
- [ ] Pflege von alten oder kranken Angehörigen
- [ ] Kinderbetreuung
- [ ] Mental Load Aufgaben (z.B. Emotionale Unterstützung, den organisatorischen Überblick behalten etc.)

4. Wie hat sich die Häufigkeit der von Ihnen erledigten Aufgaben im Vergleich zu vor der Pandemie verändert?

Die Häufigkeit ist

- ○ gleich geblieben.
- ○ mehr geworden.
- ○ weniger geworden.

61% ausgefüllt

1. Wenn ich an meine eigene Freude und mein Glück denke,...

- habe ich Kummer in meinem Leben.
- habe ich weder Kummer noch Freude in meinem Leben.
- habe ich mehr Freude als Kummer in meinem Leben.
- habe ich viel mehr Freude als Kummer in meinem Leben.
- ist mein Leben voller Freude.

2. Wenn man meine Lebensumstände objektiv betrachtet,

- geht es mir schlecht.
- geht es mir weder gut noch schlecht.
- geht es mir eher gut.
- geht es mir ziemlich gut.
- geht es mir unglaublich gut.

3. Wie fühlen Sie sich wenn Sie an Ihr Arbeitsleben denken? Dabei ist bezahlte und unbezahlte Arbeit gemeint (z.B. Haushaltstätigkeiten).

- Ich mag meine Arbeit nicht.
- Ich fühle mich neutral gegenüber meiner Arbeit.
- Ich mag meine Arbeit großteils.
- Ich mag meine Arbeit sehr.
- Ich liebe meine Arbeit.

4. Wie fühlen Sie sich wenn Sie an Ihren Alltag denken?

- Ich mag meine tägliche Routine nicht.
- Ich fühle mich neutral meiner täglichen Routine gegenüber.
- Ich mag meine tägliche Routine, aber ich bin froh auch wegzukommen.
- Ich mag meine tägliche Routine so sehr, dass ich kaum davon abweiche.
- Ich mag meine tägliche Routine so sehr, dass ich nie davon abweiche.

5. Im Großen und Ganzen ist mein Leben

- schlecht.
- in Ordnung.
- gut.
- sehr gut.
- wunderbar.

1. Bitte geben Sie an, wie oft Sie die nachstehenden Aussagen erleben bzw. Emotionen fühlen.

	Nie									Immer
Wie oft empfinden Sie im Allgemeinen Freude?	○	○	○	○	○	○	○	○	○	○
Wie oft erreichen Sie wichtige Ziele, die Sie sich gesetzt haben?	○	○	○	○	○	○	○	○	○	○
Wie oft fühlen Sie sich im Allgemeinen positiv?	○	○	○	○	○	○	○	○	○	○
Wie oft sind Sie in der Lage, Ihre Aufgaben zu bewältigen?	○	○	○	○	○	○	○	○	○	○
Wie oft verlieren Sie die Zeit aus den Augen, wenn Sie etwas tun, das Ihnen Spaß macht?	○	○	○	○	○	○	○	○	○	○

2. Bitte geben Sie an, in welchem Ausmaß Sie die nachstehenden Aussagen erleben bzw. Emotionen fühlen.

	Gar nicht									Immer
In welchem Ausmaß erhalten Sie Hilfe von Anderen wenn Sie diese brauchen?	○	○	○	○	○	○	○	○	○	○
Inwiefern empfinden Sie das, was Sie in Ihrem Leben tun als wertvoll und lohnenswert?	○	○	○	○	○	○	○	○	○	○
In welchem Ausmaß fühlen Sie sich im Allgemeinen angeregt und interessiert an Dingen?	○	○	○	○	○	○	○	○	○	○
Wie einsam fühlen Sie sich in Ihrem Alltag?	○	○	○	○	○	○	○	○	○	○

3. Bitte geben Sie an, in welchem Ausmaß Sie die nachstehenden Aussagen erleben bzw. Emotionen fühlen.

	Gar nicht									Voll und ganz
Wie sehr fühlen Sie sich geliebt?	○	○	○	○	○	○	○	○	○	○
Inwiefern haben Sie generell das Gefühl, dass Sie in Ihrem Leben eine Richtung verfolgen?	○	○	○	○	○	○	○	○	○	○
Wie glücklich sind Sie, wenn Sie alles zusammengenommen betrachten?	○	○	○	○	○	○	○	○	○	○

72% ausgefüllt

1. Wer bzw. was hat Ihnen während der Pandemie in irgendeiner Art und Weise geholfen? Bitte geben Sie auch jeweils an wie Ihnen geholfen wurde z.B. finanzielle Unterstützung.

- [ ] Freunde
- [ ] Familie
- [ ] Mein/e Partner/in
- [ ] Hilfspakete der Regierung
- [ ] Gemeinnützige Einrichtungen
- [ ] Andere:

78% ausgefüllt

1. Zum Abschluss möchte ich Ihnen die Möglichkeit geben, Ihr Erleben der Pandemie mit mir zu teilen.

Zum Beispiel: Erinnern Sie sich an einen bestimmten Zeitpunkt während der Krise, an dem Ihnen Geschlechterungleichheit besonders aufgefallen ist? Oder haben Sie besonders positive Veränderungen im Zuge der Pandemie erlebt?

83% ausgefüllt

Leider erfüllen Sie nicht die erforderlichen Kriterien, um an dieser Studie teilnehmen zu können. Trotzdem bedanke ich mich für Ihre Bereitschaft, diese Studie zu unterstützen.

Sie können das Browserfenster jetzt schließen.

89% ausgefüllt

1. Vielen Dank für Ihre Teilnahme!

Falls Sie Interesse an den Ergebnissen dieser Studie haben, können Sie hier Ihre E-Mail-Adresse eingeben.

E-Mail-Adresse:

Vielen Dank für Ihre Teilnahme!

Wir möchten uns ganz herzlich für Ihre Mithilfe bedanken.

Ihre Antworten wurden gespeichert, Sie können das Browser-Fenster nun schließen.