

Experiences and Consequences of Working Mothers in Healthcare Settings: A Qualitative Content Analysis

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Abstract

Background:

Working mothers in healthcare settings face complex role demands arising from the simultaneous responsibilities of professional duties, motherhood, and marital roles. These overlapping expectations may result in both challenges and benefits that influence family functioning and occupational well-being. This study aimed to explore the lived experiences and perceived consequences of employment among mothers working in healthcare settings.

Materials:

This qualitative study employed a conventional content analysis approach and was conducted in hospitals affiliated with Qazvin University of Medical Sciences, Iran, in 2025. Thirty employed mothers with at least one child were selected through purposive sampling. Data were collected through semi-structured, face-to-face interviews and analyzed using Graneheim and Lundman's method until data saturation was achieved.

Results:

Analysis yielded 820 initial codes, which were organized into 23 subcategories and 7 categories under two main themes: negative and positive consequences of employment. Negative consequences included social deprivation, deterioration of family stability, family members' dissatisfaction, and threats to well-being. Positive consequences included health improvement, economic strengthening, and social support.

Conclusion:

Employment among mothers working in healthcare settings generates a complex set of both constraining and enabling consequences for family functioning and individual well-being. While occupational demands contribute to role conflict and family strain, employment also enhances health literacy, financial independence, and social support. These findings highlight the importance of developing family-centered and gender-sensitive workplace policies to promote work–family balance among female healthcare workers.

1. Background

The family is considered a fundamental social institution that plays a central role in maintaining social stability and shaping individual well-being. From the perspective of structural functionalism, the family serves key functions such as socialization, emotional support, and stabilization of adult personalities, all

of which contribute to the overall health of society. Disruption in family functioning can therefore lead to broader social and health consequences (1, 2).

A healthy family provides physical, psychological, and emotional support for its members and contributes to the stability and development of communities. In this context, women play a central role as caregivers and primary figures in childrearing and family cohesion, making their well-being a critical determinant of family health and societal development (3, 4).

Women's health is closely linked to the well-being of future generations, as mothers are the primary caregivers and early-life health influencers of children. Therefore, neglecting women's physical and psychological health may lead to long-term consequences not only for families but also for population health and sustainable development. Health, as a multidimensional concept, is influenced by social, economic, and occupational factors that shape individuals' life conditions (5, 6).

In recent decades, women's participation in formal employment has increased globally as part of economic and social development processes. Employment provides women with financial independence, social engagement, and improved self-efficacy. However, it may also create role strain due to the simultaneous expectations of being a worker, spouse, and mother. This dual or multiple role responsibility can lead to work–family conflict, especially among married women with children (4, 7, 8).

There is an ongoing debate regarding women's employment and its impact on family functioning. Some scholars argue that employment enhances women's autonomy, decision-making power, and psychological well-being, which can positively affect family relationships. In contrast, others suggest that employment may reduce women's availability for household responsibilities and childcare, potentially weakening family cohesion and increasing stress within the family system (9, 10).

These challenges are particularly evident among healthcare workers, who face high job demands, shift work, emotional labor, and occupational stress. Nurses and other healthcare professionals often experience long working hours, night shifts, exposure to suffering and death, and high psychological pressure. These conditions may intensify role conflict for women who simultaneously manage professional duties and family responsibilities (11–13).

From a theoretical perspective, the experiences of working mothers can be understood through the integration of Role Theory (14) and Work–Family Conflict Theory (15). Role Theory posits that individuals simultaneously occupy multiple social roles such as worker, spouse, and parent, each with distinct expectations. When these expectations conflict, individuals experience role strain and role conflict, which may negatively affect psychological well-being and family functioning. Building on this, Work–Family Conflict Theory conceptualizes role incompatibility as a bidirectional process, including work-to-family and family-to-work conflict, with time-based, strain-based, and behavior-based dimensions (8). Healthcare workers, particularly women, are highly vulnerable to such conflicts due to shift work, emotional labor, and occupational demands.

Globally, work–family conflict is highly prevalent among healthcare workers. Previous studies suggest that a substantial proportion of nurses experience moderate to high levels of work–family conflict, particularly in shift-based healthcare systems. In addition, female labor force participation has increased to about 47% worldwide, but this increase has been accompanied by rising reports of occupational stress and role overload among working mothers (15, 16).

In Iran, nursing is one of the most stressful healthcare professions. Evidence from Iranian hospitals indicates that occupational stress and work–family imbalance are highly prevalent among nurses working in hospital settings. Studies have also shown that work–family conflict scores among Iranian nurses are significantly associated with job burnout and intention to leave the profession (13, 17).

Previous studies have shown that work–family conflict in healthcare settings can be associated with increased psychological distress in mothers and behavioral or emotional difficulties in children. At the same time, some research suggests that effective time management and strong family support systems can mitigate these negative outcomes and improve family functioning (10, 18, 19).

To better understand the experiences of working mothers in healthcare settings, this study is guided by Role Theory and Work–Family Conflict Theory as its conceptual framework. Role Theory (14) explains how individuals simultaneously occupy multiple social positions such as employee, mother, and spouse, each accompanied by specific and sometimes competing expectations. When the demands of these roles are incompatible, role strain and role conflict may emerge, leading to psychological stress and reduced role performance. In addition, Work–Family Conflict Theory (8) provides a more specific explanation of how inter-role conflict occurs in both directions, namely work-to-family and family-to-work conflict. This theory also highlights three key dimensions of conflict, including time-based, strain-based, and behavior-based interference. Together, these theoretical perspectives provide a comprehensive lens for interpreting how occupational demands in healthcare settings interact with maternal and familial responsibilities, shaping both the positive and negative consequences experienced by working mothers.

Despite extensive research on work–family conflict among healthcare professionals, existing studies have predominantly focused on quantitative associations between occupational stress, burnout, and family outcomes. However, these studies have not adequately captured the multidimensional lived experiences of mothers working in diverse clinical roles, particularly within hospital shift systems. Furthermore, there is a lack of context-sensitive qualitative evidence from Iran, where cultural norms surrounding motherhood and caregiving remain strong while women’s workforce participation continues to expand. Therefore, this study aimed to explore the lived experiences and perceived consequences of employment among mothers working in healthcare settings through a qualitative content analysis approach, to provide a deeper understanding of how role integration shapes family and occupational well-being in this context.

2. Methodology

2.1. Study Design

This study employed a qualitative research design using conventional content analysis to explore the perceived consequences of employment among mothers working in healthcare settings in Qazvin Province, Iran, in 2025. A qualitative approach was selected to gain an in-depth understanding of participants' subjective experiences and interpretations, which cannot be adequately captured through quantitative methods.

2.2. Participants

The study population consisted of employed women working in hospitals and healthcare centers in Qazvin affiliated with Qazvin University of Medical Sciences. A total of 30 participants were included. Purposive sampling was used, and semi-structured interviews were conducted concurrently with data analysis. After 27 interviews, preliminary analysis suggested that data saturation had been reached. However, three additional interviews were conducted to further confirm the stability and completeness of the emerging categories. Maximum variation sampling was applied to ensure diversity in age, clinical background, educational level, marital status, and number of children.

2.3. Inclusion and Exclusion Criteria

Inclusion criteria were willingness to participate, employment as healthcare staff at Qazvin University of Medical Sciences, at least 3 years of continuous professional experience, being married, and having at least one child aged one year or older. Exclusion criteria included withdrawal of consent during the study or inability to continue participation due to physical or psychological conditions.

2.4. Data Collection and Analysis

Data collection and analysis were conducted over an 8-month period from June 2024 to February 2025. Data were collected through semi-structured face-to-face interviews. Interviews began with an open-ended question, followed by probing questions to deepen participants' responses (Supplementary File 1). The initial guiding question was: "Please describe your experience of simultaneously managing roles at home and at work in the hospital."

Participants were recruited from six hospitals affiliated with Qazvin University of Medical Sciences. Interviews were conducted in a quiet and private environment at participants' convenience. Each interview lasted between 45 and 90 minutes. With participants' consent, all interviews were audio-recorded and transcribed verbatim. Transcription was performed shortly after each interview to ensure accuracy and immersion in the data. Interviews were conducted by trained qualitative researchers. The semi-structured interview guide was specifically developed by the research team based on the study objectives and a review of the relevant literature on work–family conflict and maternal employment. The guide was reviewed by two experts in qualitative research and pilot-tested with two participants to ensure clarity and relevance. The final English version of the interview guide is provided as Supplementary File 1.

Data analysis was performed concurrently with data collection using Graneheim and Lundman's conventional content analysis approach (20). This process involved repeated reading of transcripts to achieve immersion, followed by identification of meaning units, condensation, coding, and categorization. Codes with conceptual similarity were grouped into subcategories and categories, and latent meanings were interpreted to develop final themes. MAXQDA software (VERBI Software, Berlin, Germany) was used to facilitate data management, coding, and organization throughout the analysis process.

Throughout the process, constant comparison between data and emerging analysis was maintained until no new conceptual insights emerged. To enhance analytical rigor, preliminary codes and categories were discussed within the research team and refined based on consensus and alignment with the study objectives. Member checking was conducted by returning extracted codes and interpretations to participants to ensure consistency with their experiences. The researchers maintained reflexivity throughout the study by critically reflecting on their assumptions and minimizing the influence of their professional backgrounds during data interpretation.

2.5. Data Trustworthiness

The trustworthiness of the study was ensured based on Guba (21) and Lincoln's criteria, including credibility, dependability, confirmability, and transferability. Credibility was enhanced through prolonged engagement with the data and member checking. Dependability and confirmability were strengthened through peer debriefing, iterative coding review, and external audit by qualitative research experts. Transferability was supported through thick description of the research context and participant characteristics, enabling readers to assess applicability in similar settings.

2.6. Ethical Considerations

Ethical approval

was obtained prior to data collection. Participants were informed about the study objectives and assured that participation was voluntary and that they could withdraw at any time without consequences. Written informed consent was obtained for participation and audio recording of interviews. Confidentiality and anonymity were strictly maintained throughout the study in accordance with ethical guidelines for human research.

3. Results

Thirty employed mothers working in hospitals affiliated with Qazvin University of Medical Sciences participated in the study. Participants represented a range of healthcare professions, including nursing, anesthesia, operating room technology, midwifery, laboratory sciences, radiology, microbiology, surgery, and medicine. Most participants were aged between 30 and 45 years, and approximately two-thirds held a bachelor's degree. Participant characteristics are presented in Table 1.

Table 1
Description of Participants' Demographic Characteristics

Interview Code	Age	Education	Specialty	Years of Service	Number of Children	Spouse's Occupation	Spouse's Education
1	35–40	Associate	Anesthesia	13	2	Factory Worker	Bachelor's
2	40–45	Associate	Operating Room	13	1	Employee	Bachelor's
3	30–35	Bachelor's	Nursing	9.5	1	Freelance	Bachelor's
4	45–50	Bachelor's	Nursing	22	1	Emergency Medicine	Bachelor's
5	40–45	Bachelor's	Midwifery	12	1	Freelance	Bachelor's
6	40–45	Associate	Anesthesia	21.5	2	Employee	Bachelor's
7	35–40	Bachelor's	Anesthesia	15.5	1	Employee	Bachelor's
8	35–40	Bachelor's	Nursing	17	1	Student	Diploma
9	35–40	Bachelor's	Nursing	14	1	Factory Worker	Bachelor's
10	35–40	Master's	Surgical Internal	13	1	Employee	Doctoral Student
11	35–40	Bachelor's	Nursing	14	2	Architect	Bachelor's
12	35–40	Bachelor's	Nursing	14	2	Employee	Bachelor's
13	30–35	Bachelor's	Nursing	13	2	Employee	Bachelor's
14	20–25	Master's	Surgical Internal	4	1	Freelance	Diploma
15	40–45	Bachelor's	Nursing	23	2	Military	Master's
16	35–40	Bachelor's	Nursing	15	1	Employee	Master's
17	20–25	Diploma	Services	3	1	Freelance	Diploma

Interview Code	Age	Education	Specialty	Years of Service	Number of Children	Spouse's Occupation	Spouse's Education
18	35–40	Bachelor's	Midwifery	15	1	Employee	Bachelor's
19	40–45	Associate	Operating Room	17	2	Factory Worker	Associate
20	35–40	Bachelor's	Operating Room	17	2	Freelance	Diploma
21	25–30	Bachelor's	Nursing	6	1	Teacher	Bachelor's
22	40–45	Master's	Nursing	20	2	Military	Associate
23	40–45	Master's	Microbiology	13.5	2	Employee	Master's
24	35–40	Bachelor's	Laboratory Science	12	2	Employee	Master's
25	35–40	Bachelor's	Radiology	14	2	Freelance	Bachelor's
26	35–40	Bachelor's	Radiology	14.5	3	Freelance	Bachelor's
27	45–50	Bachelor's	Nursing	24	1	Factory Worker	Master's
28	50–55	Doctorate	Medicine	24	1	Physician	Doctorate
29	45–50	Master's	Surgical Internal	24	3	Employee	Bachelor's
30	40–45	Bachelor's	Operating Room	23	2	Employee	Bachelor's

Table 1: *Description of Participants' Demographic Characteristics*

Analysis of the interview data generated 820 initial codes, which were condensed into 23 subcategories and seven categories. These categories were further integrated into two overarching themes representing the negative and positive consequences of employment among healthcare-employed mothers. The coding framework is presented in Table 2.

Table 2
Categories and Subcategories Related to the Consequences of Employment for Women with Children in Healthcare Staff

Negative Consequences	Categories	Subcategories
Negative Consequences	Social Deprivation	Diminished leisure and recreational time
		Limited interactions with others
	Deterioration in Family Stability	Neglect of domestic responsibilities
		Self-neglect
		Instability in spousal role
		Inadequate Childcare
		Conflicting parenting approaches
	Family Members' Dissatisfaction	Husband's Dissatisfaction
		Unavailability for spouse and children
	Threats to Well-being	Emergence of physical ailments
		Manifestation of cognitive problems in child
		Development of behavioral disorders in child
		Feelings of loneliness and reduced resilience
		Lack of structured support in healthcare settings
		Tensions arising from child separation and employment demands
		Weakness in Government Regulation of Work Policies and inadequate support for families
Positive Consequences	Health Improvement	Physical Health
		Mental Health
		Social Health
	Economic Strengthening	Increased welfare
		Financial Independence
	Social Support Engagement	Support from Family Members
		Support from the Workplace

Table 2: Categories and Subcategories Related to the Consequences of Employment for Women with Children in Healthcare Staff

1.1 Social Deprivation

Participants consistently described social deprivation as one of the most prominent consequences of employment in healthcare settings. Heavy workloads, rotating shifts, and limited free time reduced opportunities for leisure activities and social interactions. This category comprised two subcategories: diminished leisure and recreational activities, and limited interaction with others.

Diminished Leisure and Recreational Activities. Participants reported that demanding shift schedules, limited leave opportunities, and financial constraints reduced family leisure time.

Participant 15 stated: "Sometimes we'd plan to go somewhere with the family, but I couldn't take time off or free myself up. These things affect your life. We can't go to parties because my work schedule is set a month in advance, and I can't ask for time off in the middle of it. After getting married and having kids, my time got even more taken up."

Limited Interaction with Others. Participants described a marked reduction in social interactions with friends and extended family due to fatigue, long working hours, and scheduling difficulties.

Participant 27 stated: "Before working in the hospital, I visited family often, but now I rarely have time because of fatigue and shift work."

1.2 Deterioration of Family Stability

Participants described deterioration in family stability as a major consequence of working in healthcare settings. This category included five subcategories: neglect of domestic responsibilities, self-neglect, instability in spousal roles, inadequate childcare, and conflicting parenting approaches.

Neglect of Domestic Responsibilities. Participants reported difficulties in fulfilling household responsibilities due to long shifts and physical exhaustion.

Participant 18 stated: "You leave work and still have to figure out dinner. The kids' homework is waiting. Honestly, I'm so overwhelmed. Our job has long hours. Like, after a night shift, when you get home, you're completely drained. The kid says, 'I want water, I want food...'"

Self-Neglect. Participants described self-neglect as a consequence of prioritizing work and family responsibilities over personal needs.

Participant 16 stated: "You basically have no time for yourself or your personal stuff anymore—you're either at work or dealing with the kids at home."

Instability in Spousal Roles. Participants reported reduced time and emotional availability in marital relationships due to work demands.

Participant 25 stated: "We barely see each other anymore. This is how it goes—my relationship with my husband has decreased. The few hours we're together are spent supporting the kids and getting food ready."

Inadequate Childcare. Participants expressed concerns about insufficient time and attention devoted to their children.

Participant 11 stated: "I always feel guilty because I cannot spend enough time with my child."

Conflict

ing Parenting Approaches. Participants reported inconsistency in child-rearing practices due to multiple caregivers.

Participant 9 stated: "My son has switched between a few different daycares, gone to my sister's house, and also to my sister-in-law's place, experiencing all sorts of different styles and behaviors."

1.3 Family Members' Dissatisfaction

Participants reported dissatisfaction among family members, particularly spouses and children, as a consequence of work-related absence and limited family time. This category included two subcategories: husband's dissatisfaction and unavailability for spouse and children.

Husband's Dissatisfaction. Participants reported that their husbands expressed dissatisfaction with their work schedules and perceived lack of involvement in household and childcare responsibilities.

Participant 3 stated: "My husband says I don't keep up with the house or the kids, and he's always saying, I wish you could change your job."

Unavailability for Husband and Children. Participants described reduced availability for their spouses and children due to long working hours and shift schedules.

Participant 14 stated: "My son keeps asking, can you not go to work? He wants me to spend more time with him and be home more."

1.4 Threats to Well-being

Participants described multiple threats to their personal and family well-being associated with employment in healthcare settings. This category comprised seven subcategories: emergence of physical ailments, cognitive problems in children, behavioural problems in children, feelings of loneliness and reduced resilience, lack of organisational support, stress associated with separation from children, and insufficient policy and family support.

Emergence of Physical Ailments. Participants reported experiencing physical health problems, which they attributed to demanding working conditions and prolonged exposure to hospital environments.

Participant 23 stated: "We are constantly exposed to blood, body fluids, and infections. Even though we try to protect ourselves, I still worry about bringing these risks home."

Manifestation of Cognitive Problems in Children. Participants perceived that prolonged maternal absence and work-related stress affected their children's cognitive and emotional development.

Participant 14 stated: " The daycare manager says that your son seems to have some kind of void or need that he tries to fill by talking a lot."

Behavioral Problems in Children. Participants described behavioural changes in their children that they associated with maternal work demands.

Participant 18 stated: " My son has recently started sucking his fingers, and I think it's because of the stress from being away from me. It happens less when I'm around."

Feelings of Loneliness and Reduced Resilience. Participants described persistent feelings of loneliness, emotional exhaustion, and reduced ability to cope with daily challenges.

Participant 6 stated: " Well, with so many shifts and our schedule being so packed, it's made us really irritable and on edge. We have a high-stress job, and it's bound to affect the family."

Lack of Organisational Support. Participants perceived that organisational policies and managerial practices did not adequately consider their dual responsibilities as healthcare professionals and mothers.

Participant 8 stated: " Their perspective is that you're just a worker and should come and work hard. Basically, they think the hospital needs to keep running, and since I'm in charge, I need staff. They don't really care that this employee has kids, a personal life, and is married."

Tensions arising from child separation and Employment Obligations. Participants described emotional distress resulting from prolonged separation from their children because of work obligations.

Participant 6 stated: " Anyway, I used to leave my baby without milk for long periods, and that itself was stressful. The baby would often go hungry, and I was stressed out the whole time I was at the hospital."

Limited Policy and Family Support. Participants perceived that existing workplace and governmental policies provided insufficient support for employed mothers.

Participant 10 stated: " Their policies really don't support having more children. The hospital officials we talk to directly ask, 'What are you going to do with a second child?' Meanwhile, we keep hearing on TV that having more kids is better for life."

Despite these challenges, participants also identified several positive consequences of employment that strengthened their individual, family, and social well-being.

2.1 Health Improvement

Participants described several positive health-related outcomes associated with employment in healthcare settings. They attributed improvements in physical, mental, and social health to increased health knowledge, psychological well-being, and social engagement.

Physical Health. Participants reported that professional knowledge acquired through their work enabled them to better manage their own health and that of their family members.

Participant 6 stated: "The good thing about our job is that we have a lot of medical and health knowledge. So, if a minor issue comes up for us or our loved ones, we can usually make a preliminary diagnosis and take initial steps to treat it, or guide others on what to do."

Mental Health. Participants perceived that employment promoted psychological well-being by increasing social participation, reducing feelings of isolation, and enhancing their sense of purpose.

Participant 5 stated: "When you go to work, you get a good feeling from being out in society, you think less about personal problems, you lose symptoms of depression, and you're happier."

Social Health. Participants reported that employment enhanced their social identity, independence, and sense of acceptance within the community.

Participant 14 stated: "Being out in society has made me feel independent, and as a working woman, others respect me and I have a good social standing in the community. It feels great."

2.2 Economic Strengthening

Participants consistently identified financial benefits as an important positive consequence of employment. This category included two subcategories: increased welfare and financial independence.

Increased Welfare. Participants reported that dual incomes improved their family's living conditions and enabled them to better meet household needs.

Participant 14 stated: "Honestly, one person can't provide everything needed for a good life on their own, so I need to work alongside my husband. Together, we can manage life better and reach our goals."

Financial Independence. Participants described financial independence as enhancing their autonomy and reducing financial dependence on their spouses.

Participant 18 stated: "Having my own money helps me have a better relationship with my husband. My financial independence means less pressure on him, and I don't need to ask him for money for every little purchase."

2.3 Social Support

Participants emphasized the importance of support from family members and colleagues in helping them balance work and family responsibilities. This category included two subcategories: support from family members and a supportive work environment.

Support from Family Members. Participants described practical support from parents and extended family members as essential for managing childcare responsibilities.

Participant 22 stated: " My mother and mother-in-law took care of my children while I was at work, and without them it would have been very difficult."

Support from the Workplace. Participants reported that understanding colleagues and flexible teamwork reduced work-related stress and helped them cope with family responsibilities.

Participant 26 stated: " My colleagues were really understanding of my situation, and often when I had to take time off, they'd cover my work. They even helped me figure out how to manage my circumstances, which was really helpful."

4. Discussion

This study explored the consequences of employment among mothers working in healthcare settings and revealed that employment generates both adverse and beneficial outcomes extending beyond the workplace to influence individual well-being, family functioning, and social life. The findings indicate that while demanding work schedules, rotating shifts, and caregiving responsibilities contribute to social deprivation, family instability, dissatisfaction among family members, and threats to well-being, employment also promotes health literacy, financial security, and social support. Viewed collectively, these findings illustrate the complex nature of balancing professional and maternal roles within healthcare settings.

These findings can be interpreted through the perspectives of Role Theory and Work–Family Conflict Theory. Role Theory suggests that individuals simultaneously perform multiple social roles, each associated with distinct expectations. For healthcare-employed mothers, the professional role often competes with responsibilities as mothers and spouses, creating role strain when available time, energy, and emotional resources are insufficient to meet competing demands. Similarly, Work–Family Conflict Theory explains that occupational and family responsibilities may interfere with one another through time-based, strain-based, and behavior-based conflicts. The experiences reported by participants reflected all three dimensions, while the positive findings also suggest that employment may enrich family life by strengthening women's resources, self-efficacy, and social identity.

Social deprivation emerged as one of the most prominent consequences of employment. Participants described reduced opportunities for leisure activities, family gatherings, and social interactions because of demanding workloads, rotating shifts, and limited personal time. These findings are consistent with those reported by Parhizkar et al. (13) and McWilliams et al. (22), who similarly found that employment-

related demands restricted social participation among employed mothers. Comparable observations have also been reported among healthcare professionals, where irregular schedules and shift work limit opportunities for maintaining social relationships and achieving work–life balance. From a theoretical perspective, these experiences primarily reflect time-based work-to-family conflict, in which occupational demands consume the time required for social and family participation.

The impact of social deprivation may be particularly pronounced in the Iranian context, where family gatherings, frequent interactions with relatives, and participation in extended family networks constitute important components of social life. Reduced opportunities to engage in these culturally valued relationships may therefore represent not only a loss of leisure time but also a diminished source of emotional support for working mothers. Together, these findings emphasize the importance of organizational initiatives such as flexible scheduling, adequate staffing, and family-friendly workplace policies to improve social participation and work–life balance.

A decline in family stability represented another major consequence of employment. Participants described neglect of domestic responsibilities, self-neglect, reduced emotional availability for spouses, inadequate childcare, and inconsistent parenting practices as common experiences. Similar findings have been reported by Ahadifaraz (4), Rafiq-uz-Zaman (6), Riaz (19), and Behrouznia (16), who found that employment-related demands reduced the time available for childcare and household responsibilities among healthcare-employed mothers. These findings are consistent with Role Theory, which proposes that competing role expectations increase role strain when individuals are unable to satisfy all responsibilities simultaneously. The demanding characteristics of healthcare work—including rotating shifts, unpredictable schedules, and emotionally intensive clinical duties—appear to intensify this imbalance.

These challenges may be amplified within Iranian families, where mothers are still widely regarded as the primary caregivers and are expected to assume responsibility for childcare and household management regardless of their employment status. Consequently, professional responsibilities are often added to, rather than substituted for, traditional domestic expectations, increasing the likelihood of role strain. An important contribution of the present study is the identification of self-neglect and instability in spousal relationships as consequences of maternal employment, extending previous research that has primarily focused on childcare outcomes.

Family members' dissatisfaction also emerged as an important consequence of maternal employment. Participants explained that long working hours and rotating shifts reduced opportunities for emotional communication and shared family activities, resulting in dissatisfaction among both spouses and children. Similar observations have been reported by Alavipour (16) and Salehi (17), who identified significant associations between occupational stress, burnout, and marital dissatisfaction among nurses. These findings further support Work–Family Conflict Theory by illustrating how occupational demands interfere with family relationships through both limited time and emotional exhaustion.

In addition, cultural expectations regarding maternal availability and emotional presence may intensify family members' perceptions of absence. Within many Iranian families, mothers are traditionally expected to play a central role in maintaining family cohesion, which may increase feelings of guilt among employed mothers when occupational demands limit family interactions. These dynamics highlight the importance of organizational support that enables employed mothers to maintain meaningful family interactions alongside their professional responsibilities.

Threats to well-being constituted the broadest category of negative consequences identified in this study. Participants reported physical health problems, emotional exhaustion, loneliness, concerns regarding their children's cognitive and behavioral development, stress related to prolonged separation from children, and insufficient organizational and policy support. Previous studies by Kim (11), Dehghanizadeh (23), Waghode(5), Nasiri (12), and Naderi (10) similarly documented high levels of work–family conflict, occupational stress, and inadequate institutional support among employed mothers in healthcare settings.

Collectively, these findings suggest that the cumulative effects of professional caregiving and maternal responsibilities extend well beyond occupational stress alone. Within the conceptual framework of Work–Family Conflict Theory, these experiences illustrate strain-based conflict, whereby stress generated in one domain diminishes functioning in another.

These experiences should also be interpreted within the broader sociocultural context of Iran, where formal institutional support for balancing work and family responsibilities remains limited and childcare responsibilities are largely managed within the family. Consequently, employed mothers may rely heavily on personal resilience and informal family support when facing occupational and family pressures. These findings therefore support the implementation of comprehensive organizational strategies, including flexible scheduling, accessible childcare services, supportive leadership, and psychological support programs, to protect mothers' well-being and promote workforce retention.

Despite these challenges, participants consistently described employment as a source of personal growth and empowerment. Employment enhanced physical, psychological, and social well-being by improving health knowledge, increasing social participation, strengthening professional identity, and promoting self-confidence. These findings are consistent with those reported by Mikaeili (24), Kadijani (1), Kyanjo (3) and Sharifpour (25), who found higher levels of psychological well-being and social participation among employed women.

In the Iranian sociocultural context, professional employment may also strengthen women's social identity by increasing opportunities for participation in public life and expanding their decision-making capacity within both the family and the community. These experiences may explain why many participants perceived employment as a source of empowerment despite its associated challenges. Although Role Theory emphasizes role strain, these findings also align with the role enhancement perspective, which suggests that occupying multiple roles can provide additional psychological and social resources.

Economic strengthening represented another major benefit of employment. Participants emphasized that financial independence reduced economic pressure on the household, improved family welfare, and enhanced personal autonomy and decision-making. Similar findings have been reported by Mussida (2), Behrman (26), Machio (9) and Gammage (7), who demonstrated positive associations between women's employment, household economic security, and family well-being.

Given the increasing economic pressures experienced by many Iranian households, dual-income families may view maternal employment not only as a means of personal fulfillment but also as an essential strategy for maintaining household financial stability. This broader socioeconomic context may partly explain the strong emphasis participants placed on financial independence. These findings indicate that the benefits of employment extend beyond financial gain alone, contributing to greater resilience and more balanced family relationships.

Finally, social support emerged as a critical protective factor that helped participants balance competing occupational and family responsibilities. Support from spouses, parents, extended family members, colleagues, and supervisors reduced emotional burden and strengthened participants' confidence in managing multiple roles. These findings are consistent with previous studies by Singletary (27), Dugan (28), and De Sousa (29), all of which emphasized the importance of family and workplace support for employed mothers.

In Iran, where intergenerational family relationships remain relatively strong, support from grandparents and extended family members often plays a pivotal role in childcare. Such informal support networks appear to compensate, at least partially, for the limited availability of formal childcare services and family-friendly workplace policies. Within the theoretical framework of this study, social support appears to function as an important buffering resource that mitigates the adverse effects of work–family conflict and facilitates successful role integration.

Overall, the findings demonstrate that employment among healthcare-employed mothers is characterized by the simultaneous experience of role strain and role enrichment. Although occupational demands create significant pressures for women balancing professional and family responsibilities, employment also provides valuable economic, psychological, and social resources. This duality highlights the need for integrated organizational and policy interventions that not only reduce work–family conflict but also strengthen the conditions that enable women to benefit from their multiple roles.

5. Conclusion

This study demonstrates that employment among mothers working in healthcare settings is associated with both beneficial and challenging consequences that extend beyond the workplace and significantly influence family dynamics and personal well-being. While occupational demands contribute to role conflict, social deprivation, and strain within family relationships, employment simultaneously enhances health literacy, financial independence, and access to social support.

Overall, these findings suggest that the experiences of working mothers should be understood as a dynamic balance between role strain and role enrichment. Without adequate organizational and policy support, the negative consequences may intensify over time, potentially affecting workforce stability and family functioning. Therefore, healthcare systems should adopt integrated family-centered policies that address the dual roles of female healthcare workers. Interventions such as flexible scheduling, workload management, childcare support, and psychosocial services may help reduce role conflict and improve both employee well-being and quality of care delivery.

6. Limitations

This study has several limitations that should be considered when interpreting the findings. First, participation was influenced by the demanding work schedules and high levels of fatigue among healthcare workers, which limited availability for interviews. Second, some potential participants, particularly those in probationary employment conditions, expressed concerns about confidentiality and workplace consequences, which may have affected recruitment. Although efforts were made to ensure anonymity and provide flexible interview scheduling outside of working hours and clinical settings, these factors may have influenced the diversity of perspectives captured in the study. Finally, as with all qualitative research, the findings are context-specific and reflect the experiences of healthcare-employed mothers in a particular regional and organizational setting in Iran; therefore, transferability to other cultural or healthcare contexts should be made with caution.

Declarations

Ethical Approval and Informed Consent

This study was approved by the Research Committee of the School of Health and Social Welfare at the University of Social Welfare and Rehabilitation Sciences, and ethical approval was granted by the Ethics Committee of the university under the reference number IR.USWR.REC.1401.253. Before obtaining informed consent, participants were provided with information regarding the study's objectives, after which informed consent was secured for their participation. All procedures involving human participants were conducted in accordance with the ethical standards set by the Institutional and National Research Committees, and in compliance with the 1964 Declaration of Helsinki and its subsequent amendments, or equivalent ethical standards. This article does not involve any animal studies conducted by any of the authors.

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Conflict of Interest

The authors declare that they have no competing interests.

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Consent for publication

Conscious consent was obtained from all participants.

Availability of data and materials

The data that support the findings of this study are available from the corresponding author upon reasonable request.

Authors' contributions

M.L.; K.A. and S.E. designed the study. S.J. collected the data. K.A.; S.E. and M.L. analyzed the data. M.L. and S.E. wrote the manuscript draft. All authors read and reviewed the manuscript and contributed to its finalization.

Authors' information

Not applicable

References

1. Kadijani SH, Jafari M. The Role of Women's Employment on Family Social Health; Case Study–Tehran, Districts.
2. Mussida C, Patimo R. Women's family care responsibilities, employment and health: a tale of two countries. *J Fam Econ Issues*. 2021;42(3):489–507.
3. Kyanjo JL, Turinawe A, Hörnell A, Lindvall K. Balancing maternal employment and child nutrition and health: a grounded theory study of rural communities in Northeastern Uganda. *BMC Public Health*. 2025;25(1):769.
4. Ahadifaraz M, Abedi H, Azarbarzin M. Explaining the experiences of working women regarding the role of motherhood: a qualitative phenomenological research. *Qualitative Res health Sci*. 2014;3(2):137–48.
5. Waghode RT, Yadav SS, Ghooi R, Razak SA, Menon KC. Work, motherhood, and nutrition: investigating the association of maternal employment on child nutritional status in south asia—A systematic review. *Nutrients*. 2025;17(6):1059.
6. Rafiq-uz-Zaman M. The Impact of Working Mothers on Children's Social Behaviours, Classroom Interactions, and Empathy in South Punjab, Pakistan. *Inverge J Social Sci*. 2026;5(1):1–14.

7. Gammage S, Joshi S, Rodgers YM. The intersections of women's economic and reproductive empowerment. Taylor & Francis; 2020. pp. 1–22.
8. Greenhaus JH, Beutell NJ. Sources of conflict between work and family roles. *Acad Manage Rev*. 1985;10(1):76–88.
9. Machio PM. Association between maternal employment and child stunting in Kenya. *BMC Public Health*. 2026.
10. Naderi F, Sadeghi N, Moghimian M. The relationship between workplace psycho-social factors and child aggression among female nursing. *Iran J Pediatr Nurs*. 2021;7(2):58–66.
11. Kim YM, Kim MY. Difficulties Faced by Working Mothers and Potential Solutions to these Problems: A Survey of Nursing Personnel in a Korean Teaching Hospital. *Perspect Nurs Sci*. 2013;10(2):151–7.
12. Nasiri H, Bagheri, Edmaieeli T. Examination of musculoskeletal disorders in nurses and its relationship with occupational stress. *J Mazandaran Univ Med Sci*. 2016;25(132):91–102.
13. Parhizkar A. Comparison of the general health level between the nurses working in the hospitals of Kurdistan University of Medical Sciences and Social Security Hospital in 2018–2019. *Sci J Kurdistan Univ Med Sci*. 2020;25:87–98.
14. Gerhardt U. Parsons, role theory, and health interaction. *Sociological theory and medical sociology*: Routledge; 2022. pp. 110–33.
15. French KA, Allen TD, Kidwell KE. When does work-family conflict occur? *J Vocat Behav*. 2022;136:103727.
16. Islam SMS, Uddin R, Das S, Ahmed SI, Zaman SB, Alif SM, et al. The burden of diseases and risk factors in Bangladesh, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. *Lancet Global Health*. 2023;11(12):e1931–42.
17. Salehi S, Zaharakar K, Asadpour E, Tehranian A. The Effectiveness of Acceptance and Commitment Therapy on Occupational Burnout, Couple Burnout, and Family Resilience Among Nurses. *Sadra Med J*. 2024;12(2):175–92.
18. Manzari MS, Delavarpour M, Talepasand S. Self-regulation and social networking sites addiction: The mediating role of academic resilience and psychological well-being. *J Fundamentals Mental Health*. 2024;26(5).
19. Riaz S, Condon L. The experiences of breastfeeding mothers returning to work as hospital nurses in Pakistan: A qualitative study. *Women Birth*. 2019;32(2):e252–8.
20. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today*. 2004;24(2):105–12.
21. Guba EG, Lincoln YS. Competing paradigms in qualitative research. *Handb qualitative Res*. 1994;2(163–194):105.
22. McWilliams W. Supporting Mothers in the Workplace: Breaking Down Isolation of the Working Mother through Workplace Interventions. Saint Mary's College of California; 2018.

23. Dehghanizadeh HA, Fallah MH, Vaziri S. Mother Guilt Feeling: A qualitative research of women's employment in the mother-child relationship. *J Tolooebehdasht*. 2020.
24. Mikaeili Manee F, Shirzadeh M, Ab Khiz S. The Relationship between Marital Satisfaction and Perceived Social Support with life Satisfaction in Married Women: Investigating the Moderating Role of Occupation and Perceived Socioeconomic Status. *Women's Stud Sociol Psychol*. 2022;19(4):129–69.
25. Sharifpour M, Sadeghi Saghdel H, Agheli L, Ahmadi A. Factors affecting poverty in women heads of households with emphasis on health indicators. *J Appl Econ Stud Iran*. 2024.
26. Behrman J, Gonalons-Pons P. Women's employment and fertility in a global perspective (1960–2015). *Demographic Res*. 2020;43:707.
27. Singletary N, Waqar Farooqi Z, Beliefs. Experiences, and Practices of Lady Health Workers in Facilitating Breastfeeding in Rural Communities in Pakistan. *Qual Health Res*. 2024:10497323241242640.
28. Dugan AG, Barnes-Farrell JL. Working mothers' second shift, personal resources, and self-care. *Community Work Family*. 2020;23(1):62–79.
29. De Sousa Machado T, Chur-Hansen A, Due C. First-time mothers' perceptions of social support: Recommendations for best practice. *Health Psychol open*. 2020;7(1):2055102919898611.

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