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Chronic stress and the social patterning of women's health in Canada

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Abstract

Existing research on the social patterning of women's health draws attention to the significance of social roles and socioeconomic position. Although we know a great deal about health differences according to the occupancy of these positions, we know a lot less about *why* such patterns exist. This paper addresses this gap by examining the pathways through which social structure is linked to health using data from a 1994 Canadian national probability sample of women, aged 25–64 years. We begin by charting differences in women's self-rated ill-health, distress, and reports of long-standing health conditions by socioeconomic position and social role occupation. We then assess the extent to which these patterns can be understood in relation to the chronic stress arising from these social locations. Socioeconomic position, assessed by housing tenure, education, and household income, was positively related to health. Employment enhanced women's health, as did being currently married and a mother living with children. The ongoing stressors that distinguish the experiences of various structural locations accounted for some of the health effects of social structure, particularly for socioeconomic position. However, chronic stress was largely irrelevant to the pathways linking social roles to health. In fact, employed women and parents living with children enjoyed better health *despite* their greater stress.

Keywords: Women's health; Roles; Chronic stress; Canada

Introduction

Two areas of research dominate the literature on the social patterning of women's health. The first and most widely researched examines the health effects of the gendered division of labour. Predominant in this "gender" model is an interest in social roles and health that has resulted in a legion of studies documenting the health rewards and costs associated with being a paid worker, a partner, and a mother. The second area of research on health differences among women concerns the social division of work in the public sphere and its associated distributive inequalities. Because of its focus on the labour market, it has often been called the "job" model of health differences.

While existing research draws attention to the significance of social roles and socioeconomic position for health, its focus on their *occupancy* tells us only part of the story. That is, we know a great deal about the social patterning of health according to major institutionalized roles and unequal distribution of resources, but much less about *why* such health patterns exist. Where effort has been directed toward assessing the meaning of social positions and their implications for health, it has been limited to the quality of social roles, while the socioeconomic dimensions of women's lives remain relatively unexplored. Any compelling explanation of the health consequences of the social division of labour must consider what it is about *both* key structural contexts that give rise to health inequalities among women.

The conceptual and methodological tools of social stress theory and research are relevant to investigating

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the pathways linking social structure and health. An important underlying assumption of this work is that well-being is deeply affected by socially patterned differences in life circumstances, including "the relatively enduring problems, conflicts, and threats that many people face in their daily lives" (Pearlin, 1989, p. 245). Hence, social roles and socioeconomic position are consequential for health because they signify differential exposure and vulnerability to the problems of daily life. Despite its widespread use in the mental health literature, especially to examine gender differences in health, social stress has received less attention when it comes to health disparities among women.

This paper contributes to research on the social patterning of women's health by examining pathways through which social structure may be linked to health. We begin by charting differences in women's health by socioeconomic position and social role occupation. We then assess the extent to which these patterns are accounted for by chronic stress arising from these social locations.

Social roles and health

Early interest in the relationship between social roles and health was sparked by women's entry into the labour force on a massive scale, beginning in the 1960s. Proponents of role strain theory worried that this social change would harm the health of women because of the additional stress of multiple, competing roles (Gove, 1984). In contrast, those supporting the role accumulation hypothesis suggested that multiple roles were beneficial to health because they provide additional opportunities to enhance individuals' sense of purpose and meaning in life (Waldron, Weiss, & Hughes, 1998). Empirical testing of these divergent views suggests that women's experiences are more complex than this simple dualism implies. On average, employed women enjoy better health than those who are not employed (Arber, 1997; Waldron, 1991; Walters, Lenton, & McKeary, 1995). Some of this relationship can be explained by the selection of healthier women into the labour force, but longitudinal research supports the view that women's health benefits from the instrumental and symbolic rewards of paid work (Repetti, Matthews, & Waldron, 1989; Waldron & Jacobs, 1989). Although men derive greater advantage, marriage is also health-protective for women, mainly because of the social support and increased material well-being that it provides and the health-promoting behaviours that it encourages (Waite, 1995; Umberson, 1992; Waldron, Hughes, & Brooks, 1996). In contrast to worker and partner roles, the health effects of being a parent are less clear. Some studies find parental status unrelated to women's health (Bullers, 1994), others report an inverse association between parenthood and health (Noor, 1996), while still others show motherhood to be health-enhancing under some conditions and health-damaging under others (Rosenfield, 1989; Walters et al., 1996; Bartley, Sacker, Firth, & Fitzpatrick, 1999). Recently, Evenson and Simon (1999) added another dimension of complexity to the social roles debate with their finding that noncustodial parents were most disadvantaged in mental health terms, compared with parents living with their children, parents whose grown-up children had left home, and nonparents.

The contingent nature of the relationship between health and social roles has led researchers to attempt to unpack these structural positions. Some suggest that the quality of social roles, rather than their mere occupancy, is fundamental to understanding the relationship between roles and health (Barnett & Marshall, 1991; Barnett, 1994). Taking up this theme, Walters and colleagues (Walters et al., 1997; Walters, Eyles, Lenton, French, & Beardwood, 1998) found that time pressures in family roles, unappreciated work, multiple, competing demands, and the feeling of being too available to other people were inversely related to women's mental health. In contrast, having a good relationship with a partner, including being able to talk about worries and confide in him/her, getting along in general, and his/her understanding of work demands were health-enhancing.

Related research on occupational health tells a similar story. Although it is better to be working than not, the health-promoting effects of employment are conditional on the type of job one has (Loscocco & Spitze, 1990; Griffin, Fuhrer, Stansfeld, & Marmot, 2002). For example, lack of control over work is particularly problematic for health when jobs are also psychologically demanding, that is, time-pressured, fast-paced, and intense (Schnall, Landsbergis, & Baker, 1994). Although the health effects of work have been examined extensively for men, there has been much less research on women, despite the fact that women are much more likely than men to be exposed to conditions of high job strain (Karasek & Theorell, 1990).

Socioeconomic position and health

The second focus of research on social patterns in women's health is socioeconomic position. We know that socioeconomic disadvantage harms women's health, although there is some disagreement about the strength of the gradient, relative to that for men (for reviews, see McDonough, Williams, House, & Duncan, 1999; Arber, 1997). The relationship between women's socioeconomic position and health has not received as much research attention as social roles, partly because of the difficulty in conceptualizing and measuring the class position of those without direct labour market ties.