

Social Stress

DEFINITION OF STRESS

The term **stress** is used in almost countless ways. It can refer to events or circumstances, such as an examination, that cause us unease; to the general unease we feel during such events; to the specific bodily responses to such events, such as rapid heartbeat; or to the mind's and body's attempts to deal with the unease in order to recapture a sense of wellness.

Most researchers include in the concept of stress some reference to the resulting state in an individual who has experienced various demands. Stress, therefore, has been defined as “a state of imbalance within a person, elicited by an actual or perceived disparity between environmental demands and the person's capacity to cope with these demands.”

The configuration of the stress process can be stated in this way: various stressful situations (or stressors) occur and are appraised by the individual as to their degree of threat. Individuals are forced to cope with those involving some threat; stressors that are unsuccessfully resolved lead to negative stress outcomes. Throughout this process, social support can help mediate the stress-stress outcome relationship.

STRESSORS

A primary concern of many sociologists is the identification of **stressors**—social factors or social forces that contribute to stress. Cataloging these forces is a difficult task, however, as they range from the broadest of social forces and large-scale social organization (a macro perspective), on the one hand, to the personal social environments in which people function on a day-to-day basis (a micro perspective), on the other hand.

Stress and the Sociological Perspective

Attempts to understand human behavior must, of course, consider the importance of broader social forces and social organization. A key insight of sociology is that all human behavior, even that which seems to be very individualistic, is shaped by larger forces in the social environment.

The French sociologist Emile Durkheim (1858-1917) helped stimulate interest in identifying ways that individual behaviors are shaped by larger social forces. In his book *Suicide*, first published in 1897, Durkheim focused on what might seem the most individual of human behaviors and described how it is influenced by social forces. Durkheim asked these questions: If suicide is an entirely personal, individual behavior, why do rates of suicide vary from social group to social group? Why are suicide rates higher among men than women, higher among the unmarried than the married, and higher among Protestants than Catholics? And, why do patterns in suicide rates persist over time?

While acknowledging the many possible motivations for suicide, Durkheim emphasized that suicide rates exhibit clear patterns among social groups. Apparently, he

reasoned, there must be something about the social organization of groups that has an influence on the individual behavior of their members. Durkheim hypothesized that the extent to which an individual is integrated within a group affects the likelihood of suicide. On this basis, he identified three primary types of suicide:

1. *Egoistic suicide*, which occurs when an individual is insufficiently integrated within a group and has few social bonds (e.g., an elderly person whose lifetime partner dies and who feels as if there is little reason to go on living).
2. *Altruistic suicide*, which occurs when an individual so identifies with a social group that he or she is willing to sacrifice life for the group (e.g., kamikaze pilot).
3. *Anomic suicide*, which occurs during times when society's norms and values are undergoing upheaval or rapid change so that individual society members may feel a sense of **anomie**—normlessness—and society's constraints against suicide weaken (e.g., Durkheim detected that suicide rates increase during times of economic prosperity as well as economic downturn—both periods of upheaval).

Durkheim's analysis is an excellent example of what American sociologist C. Wright Mills (1916-1962) later referred to as the **sociological imagination**. It is an ability to see how personal troubles (thoughts of suicide) are influenced by wider social forces (changes in the state of the economy or extent of social integration). While it is tempting to look only at what is going on inside a person experiencing high levels of stress, it is essential also to examine the influence on the social context.

Types of Stressors

In recent years, sociologists have distinguished between two major types of stressors: specific **life events** and more enduring life problems called **chronic strains**.

Life Events. *Life events* are important specific events or experiences that interrupt an individual's usual activities and require some adjustment. A distinction is now made between anticipated (or scheduled) life events (such as marriage, divorce, and the beginning or ending of a school year) and unanticipated (unscheduled) life events (such as the death of a loved one, a sudden failure, the sudden loss of a job, or learning of a terminal illness).

In order to determine the effects of these specific life events on stress level, researchers have employed three kinds of techniques: (1) studies of the psychiatric effects of specific events such as reactions to combat and natural and human disasters, (2) comparison of the number and types of life events experienced by psychiatric patients prior to their hospital admission to those for a nonpatient control group, and (3) general population surveys examining the relationship between life events, stress, and illness.

Chronic Strains

The second major type of stressor—now often referred to as *chronic strains*—has been defined as “the relatively enduring problems, conflicts, and threats that many people

face in their daily lives.” The most common bases for these types of stressors are family problems with spouse, parents, or children; love or sex problems; problems on the job or in school; and problems in any site that involve competition.

One researcher, Pearlin (1989:245) has recommended that focus be placed on “problems that arise within the boundaries of major social roles and role sets.” These are likely to be important problems because the relationships that exist in role sets usually are enduring. Because they also tend to be extremely important relationships (e.g., spouse, child, boss, teacher), strains that develop are likely to be of great significance to the individual.

Pearlin (1989:245) uses the concept of **role strain** to refer to “the hardships, challenges, and conflicts or other problems that people come to experience as they engage over time in normal social roles.” The five most common types of role strains are discussed next.

Role Overload. **Role overload** occurs when the combination of all the role demands placed on an individual exceed that individual’s ability to meet them. Within the workplace, there is evidence that work overload is most likely to be felt by those at opposite ends of the spectrum: salaried, white-collar workers and the least-skilled blue-collar workers. For different reasons, both may feel little control over work demands—an important predictor of job stress. Excessive workload may also be experienced by the homemaker in overseeing house maintenance, food preparation, and child-rearing functions, as well as increasingly playing the caregiver role for parents unable to live independently.

Perception of role overload is influenced by the level of economic return on one’s labors. Brenner (1973) has shown that both the absolute level of economic reward and the perceived fairness with changes in the amount of reward influence level of stress. Teaching and nursing are good illustrations of careers that pay more than the national average, but are stressful, in part, because the level of training required and the amount and intensity of work demanded are not always commensurately rewarded. Likewise, a frustration of many homemakers is that the value of their contributions often is not rewarded at all—either in monetary fashion or in terms of genuine appreciation.

Interpersonal Conflicts within Role Sets. **Interpersonal conflicts within role sets** often touch people most deeply, as they include problems and difficulties that arise within complementary role sets, such as wife-husband, parent-child, and worker-supervisor.

Marriage is typically the center of our most intimate relationships, the context of many of our most far-reaching decisions (e.g., children, major purchases, degree of equalitarianism), and the role set in which many spend the most time. Therefore, it has the potential for great bliss as well as for significant interpersonal conflict. Rates of separation and divorce, emotional and physical abuse within families, and reported levels of marital dissatisfaction all reflect high levels of stress.

Pearlin (1983) identifies other common sources of strain in marriages: (1) a perception that the spouse does not recognize or accept “quintessential” elements of one’s self—that the spouse fails to authenticate what is judged to be an especially prized aspect of the self-image; (2) a belief that the spouse is failing to fulfill basic marital expectations

such as wage earning or housekeeping, and (3) a feeling that the spouse is failing to provide even minimal levels of affection or that sexual relations are insufficiently satisfying. The lack of physical as well as emotional intimacy clearly relates to marital stress.

Interrole Conflict. **Interrole conflict** occurs when the demands of two or more roles held by a person are incompatible, and the demands cannot simultaneously be met. On a small scale, genuine conflict occurs whenever any health care worker is “on call” and gets called in to the hospital just as he or she is about to participate in a family function (let’s say a one-showing only of a play or dance for which the youngest child has earnestly practiced for months). Being a responsible health care worker and being a loving parent are both very important roles, but on the night in question, the child will be disappointed. In a marriage of two persons equally dedicated to careers, an elderly parent or young child who requires significant attention during the day, will force some resolution of an interrole conflict.

Role Captivity. Pearlin uses the term **role captivity** to describe situations in which an individual is in an unwanted role—he or she feels an obligation to do one thing but prefers to do something else. A retired person who wished to continue working and a person working who wished to retire are both held in role captivity. A college student forced to attend college by parents and a college-age person who want to go to college but cannot afford it are role captives. Anyone hating his or her job and longing for another is a role captive.

Role Restructuring. There are many situations in which long-established patterns or expectations undergo considerable change as a result of **role restructuring**. Pearlin offers such examples of a rebellious adolescent who desires more independence; an apprentice who grows frustrated with his or her mentor as the craft is learned; and adult children who must take on increased responsibilities for aging parents. He notes that the transition can be more difficult when it is forced by circumstances (rather than voluntary effort) and when the transition involves some redistribution of status, privilege, or influence over others.

Final Points on Chronic Stress. Three final points deserve attention.

1. Chronic strains are a more powerful determinant of depressive disorders and other health problems than are discrete life events. Their persistence, emergence in important areas such as marriage and work, and presence throughout the course of each day gives them powerful force within our lives.
2. Valid and reliable measurement of chronic strains (like life events) is complicated. For example, it may be difficult to determine the actual “chronicity” of a strain. Interpersonal conflict within a marriage rarely can be represented as a linear phenomenon—it often ebbs and flows, sometimes swinging back and forth between bliss and misery, and does so with very uneven degrees of intensity. How then does one accurately measure the length of time for which discord has occurred? What may seem rather straightforward actually is quite complex.

3. Life events and chronic strains may often overlap. The occurrence of specific life events may alter the existence or meaning of chronic strains. An example is the effect of sudden job loss (a discrete life event) on division of labor within the household (possibly a chronic strain). Moreover, life events may create new strains or magnify existing strains, as might occur if the sudden job loss created marital discord.

APPRAISAL OF STRESSORS

Appraisal and the Sociological Perspective

Within sociology, **symbolic interactionism** is a micro-level perspective that focuses on “small-scale patterns of social interaction in specific settings.” Symbolic interactionists believe that social life is comprised of a myriad number of episodes of daily social interactions in which people communicate verbally and nonverbally and engage in a constant process of interpreting others’ messages and responding to these interpretations. According to symbolic interactionism, the world is not so much imposed upon the individual, dictating or strongly influencing behavior, as it is created by the individual through the exchange of these verbal and nonverbal symbols. Berger and Luckmann (1967) assigned the term **social construction of reality** to identify this pattern.

A classic example of the symbolic interactionist perspective is found in the work of W. I. Thomas (1863-1947). Thomas recognized that individuals are affected by events only to the extent to which they are perceived. In other words, neither life events nor chronic strains are in and of themselves stressful. They are simply situations or occurrences in which the likelihood of a stressful response is increased. It is the perception of these events and their interpretation—what an individual believes the implications of the events/strains to be—that is stressful. The **Thomas Theorem** is often summarized as: “if situations are defined as real, they are real in their consequences.” It is the perceived world, whether it is perceived accurately or not, that become the basis for response.

The Appraisal Process. Whenever any potentially stressful life event or chronic strain occurs, we immediately evaluate or *appraise* its significance for us. We may attempt to recreate the circumstances that surrounded some similar event in the past and recall how it affected us then or attempt to systematically remember anything that we have heard or read about the event. We may ask ourselves : Have I ever handled anything like this before? If so, what happened? Can I get through this on my own? Do I need help? Who can help?

This is done in order to determine whether the current situation is irrelevant to our personal well-being, is benign in its implications, or is stressful. If it is stressful, we likely will calculate how much damage has already occurred and what threat for additional damage remains. We may assess the availability of resources to help deal with the event. We will calculate the stressfulness of the event in absolute terms but also relative to whatever helping resources are available.

The **appraisal** process does not involve the “real” event, but the individual’s *perception* of the real event. To the extent that perceptions differ, individuals will

respond differently to the same “real” circumstances. Being laid off from the job may be perceived by some as a tragic event; others may view it as an unsolicited step in searching for a better job.

MEDIATORS OF STRESS: COPING AND SOCIAL SUPPORT

The same stressful circumstances do not lead to the same **stress outcomes** in all people. Other factors exist that modify the stressor/stress outcome relationship. These additional factors are referred to as **mediators** of stress; they are so identified because research has demonstrated their potential to influence or modify (i.e., mediate) the effects of stressors. This section concentrates on coping and social support, the two types of mediators that have received the most attention.

Mediators and the Sociological Perspective

Several sociological concepts and perspectives contribute to an understanding of the mediating role of coping and social support. A classic illustration of the way the social environment influences our self-image (and, thus, our feelings of confidence in dealing with social stress) is Charles Horton Cooley’s (1864-1929) theory of the **looking-glass self**. Cooley illustrated the way that reality is socially constructed by describing the process by which each person develops a self-image. According to this theory, we come to see ourselves as we believe other people see us. Consciously or subconsciously, we attempt to interpret how we are viewed by others (and the judgment being placed on that view), and we gradually develop a self-image consistent with what we perceive. If I believe people with whom I interact see me as a very humorous person, I will likely see myself that way. However, if others never laugh at my jokes and convey to me that I need a sense-of-humor transplant, I’m not likely to see myself as being very funny.

Coping

Most people develop a repertoire of personal responses that can be activated when stressful circumstances arise. This repertoire consists of responses which have been learned through socialization experiences and evolves over time as particular techniques work or fail to work to mediate stress.

Coping refers to things people do to prevent, avoid, or control emotional distress and includes three basic objectives:

1. Efforts to eliminate or modify the stressful situation so that it will not be a continuing problem.
2. Efforts to control the meaning of the problem, by “cognitively neutralizing” the situation.
3. Efforts to control the stress created by the situation (e.g., through stress management techniques).

Specific Coping Techniques. There are three types of specific coping techniques: psychological resources, cognitive techniques, and behavioral techniques.

1. ***Psychological resources*** are the “personality characteristics that people draw upon to help them withstand threats posed by events and objects in their environment.” Three such characteristics have received the most attention:
 - a. Individuals with positive feelings about self—positive self-esteem—have been shown to cope better with stressful situations. This may be due to greater self-confidence, a feeling that one is held in high regards by others, and a real or perceived assessment of one’s previous ability to handle the stressful situation.
 - b. Individuals with a feeling of being in control, of controlling their own destiny, of being able to master situations (i.e., internal controls) have been shown to cope better with stressors than individuals who see themselves as being less competent and who believe that their life is controlled by luck, fate, or others outside themselves (i.e., external control).
 - c. Individuals characterized by a trait referred to by Kobasa (1979) as *hardiness* are better able to handle stress. Hardy individuals exhibit strong commitment to work, family, friends, and other causes and interests; accept change as a challenge rather than as a foe; and have a feeling of personal control over life (internal control).
2. ***Cognitive techniques*** involve the assignment of specific interpretations to a stressful event in order to control its meaning (i.e., to neutralize its stressfulness). In light of some potentially stressful event, one might respond by denying that the event is happening, or by telling herself that the event is not as crucial as it might seem, that it will over soon, that is might even be a good challenge, or that other people have been in this situation and survived. Many people rely on their spiritual beliefs or participation in religious activities to help find meaning in uncontrollable life events.
3. ***Behavioral techniques*** also can be used to help cope with a stressful event. Some individuals use biofeedback or yoga or other meditative techniques to help reduce stressfulness; many persons try to get their mind off the object of despair by engaging in some alternative, distracting activity, such as listening to music, engaging in some physical activity, or using alcohol or some other drug.

Are all coping techniques equally effective in all situations? No. Research has shown that different coping techniques are most effective in different situations. In fact, most people use different coping techniques in different situations (e.g., in parental versus marital situations) and different people effectively use different coping techniques in the same situation. Accordingly, the larger and more varied the coping repertoire, the more likely it is that an individual can cope with any stressful situation.

Social Support

Most people do not deal with stressful situations on their own but rather receive assistance from others. While the extent to which persons are integrated into families, friendship networks, occupational or school groups, and religious and civic groups varies, research confirms that **social support** is an extremely important mediator of the effects of stress.

Social support as a Concept. Pearlin and Aneshensel (1986:418) consider social support as the “social resources one is able to call upon in dealing with...problematic conditions of life,” particularly those that overwhelm the individual’s own coping ability. Social support includes: (1) *emotional support* (feelings of comfort, respect, love, caring, and concern); (2) *cognitive support* (information, knowledge, and advice); and (3) *materials support* (products or services to assist in handling specific problems).

The Effects of Social Support on Stress and Stress Outcomes. People with positive social support tend to have better physical and mental health and are better able to adjust to such events as loss of spouse, unemployment, serious illness, and criminal victimization. Two primary models have been developed to explain this relationship.

The **main effects model** asserts that social support contributes directly to well-being and positive health and that these beneficial effects occur even in the absence of stress. The overall sense of well-being that social support provides, the feeling of being accepted, the knowledge that others care and are available, and the degree of comfort within one’s social environment may contribute to inner feelings of contentment and outer expressions of good health.

The alternative model, the **buffering effects model**, asserts that the beneficial effects of social support occur only in the presence of stress. By acting as a buffer, social support may decrease the likelihood of negative stress outcomes occurring as a response to high stress levels. The support offered by others, according to this model, provides some sense of security and confidence that stressful circumstances can be handled and, perhaps, even that specific assistance in handling the situation will be available.

While research findings are not completely consistent, the wealth of evidence shows that both types of effects occur—that social support does contribute directly to positive health and it serves an important buffering effect in times of high stress.

How Social Support Affects Health. There are three specific mechanisms through which social support directly or indirectly affects health: (1) *behavioral mediators* (which encourage an individual to engage in or to change behaviors such as quitting cigarette smoking); (2) *psychological mediators* (which attempt to restore a person’s self-esteem and to provide a satisfying shared interaction); and (3) *physiological mediators* (which help relax the fight or flight response or strengthen the immune system). Although it has not been empirically confirmed, social support may be an adequate stimulus for the release of certain bodily hormones (certain neuropeptides) that bolster the immune system.

As is true with specific coping mechanisms, the most effective means of social support are situationally determined. Wellman and Wortley (1990) have shown the most relationships provide specialized forms of support. For example, friends are more likely

than parents to provide companionship but less likely to offer financial assistance, and women are more likely than men to provide emotional support.

Finally, the complexity of the relationship between social support and stress must be emphasized. Often, it is impossible to disentangle stressors and their mediators. This is something of a “double whammy”—certain circumstances both add to the stressfulness of life and detract from available social support at the same time. For example, much research has confirmed the stressfulness of unemployment and its relationship to depression. However, research has demonstrated that unemployment carries an extra burden: Following job loss, social support from spouse and from fellow workers often diminishes. At the very instant when social support is especially needed, it becomes less readily offered. Thus, the psychological distress traditionally tied to job loss and the reduction in social support that often accompanies it.

STRESS OUTCOMES

In one sense, identification of specific “outcomes” or “ills” of stress is remarkably simple: All of us can relate various ailments we have suffered with stress. In another sense, however, making specific linkages can be quite difficult because stress leads to a wide variety of outcomes through a wide variety of pathways. In any case, it is clear that when one’s level of stress cannot successfully be mediated through coping and social support, negative stress outcomes are likely to occur.

In attempting to bring some order to the variety of ills produced by stress, Brown (1984) suggested the following categorization:

1. ***Bona fide emotional disturbances*** include anxiety, insomnia, tension headaches, neuroses, phobias, hysterias, and hypochondriasis and are major factors in aging, sexual impotency, alcoholism, drug abuse, sleep disorders, and learning problems.
2. ***Abnormal behaviors*** such as compulsive behaviors, aggressions, withdrawal, criminal activities, battered child/spouse/parent syndrome, and sexual deviation.
3. ***Psychosomatic illnesses*** such as hypertension, coronary heart disease, ulcers, and colitis.
4. ***Worsening of genuine organic illnesses*** such as epilepsy, migraine, herpes zoster, coronary thrombosis, and rheumatic arthritis.

Grouped somewhat differently, we might say that unchecked stress increases the likelihood of psychological morbidity (e.g., anxiety and depression); physical morbidity (e.g., coronary heart disease and cancer); and mortality.

THE ROLE OF SOCIAL CLASS, RACE, AND GENDER IN SOCIAL STRESS

Social Class

People in the lower classes have high rates of psychological distress and mental health problems than the more affluent. Two explanations for this pattern have been advanced. The first, the **exposure hypothesis**, states that lower-class people exposed to more stressful life experiences than those in the middle or upper classes, and that higher rates of distress are a logical result of this exposure. While research has confirmed that

stressful life experiences are more common in lower SES groups, this fact has not been found to explain the higher levels of reported stress.

Research has tended to support an alternative explanation, the **vulnerability hypothesis**, which states that stressful life experiences have a greater impact on those in the lower class and a greater capacity to lead to negative stress outcomes. This greater vulnerability has been traced to three factors: inadequate financial resources, greater use of ineffective coping strategies, and less access to social support.

First, lower-SES persons not only experience more of several stressful life events (e.g., job instability and loss, chronic health problems, and poorer quality of housing), but by definition have fewer financial resources available to deal with these problems. For example, purchasing health insurance might be recognized as a partial solution to health care worries, but financial limitations may eliminate this option.

Second, people from the lower social classes are less likely to have psychological traits (such as high self-esteem, internal control, and confidence in dealing with stressors) that buffer stress and are more likely to use ineffective coping strategies (such as avoidance) in responding to stressful situations. These patterns may be linked to socialization experiences. For example, growing up in a family unable to secure needed health care may encourage feelings of powerlessness and external control.

Finally, aspects of living in the lower class may reduce the likelihood of establishing or maintaining supportive social resources. While evidence is mixed on this point, it does appear, for example, that lower-SES persons are less likely to have a confidant on whom they can rely.

Race

For more than 30 years, research has demonstrated that African Americans have higher rates than whites of psychological distress. A key question is whether this difference can solely or largely be attributed to an economic disparity or whether race exhibits an independent effect on stress level. In other words, do low economic status and racial discrimination contribute individually to stress levels?

Beginning in the 1970s and, in part, continuing today, much research on racial differences has supported the position that the higher rates of distress in African Americans are due entirely, or almost entirely, to economic differences. These studies have concluded that when social class is controlled, the racial disparity in distress is eliminated.

However, Ronald Kessler and Harold Neighbors (1986) have challenged this view. Offering theoretical justification in the fact that the effects of social class on many outcomes (e.g., educational attainment and financial achievement) vary depending on one's race, they have contended that class and race are interactive factors. They posited that racial differences in distress might be largest in the lower class or in the upper class. Their analysis of eight studies determined that race continues to be an important predictor of distress even when class is controlled, and the African American experience more distress than whites at all levels of income.

Furthermore, some research continues to find that African Americans respond differently than whites to stressful situations. For example, Krieger (1990) reported that black women were much more likely than white women to respond passively to unfair

treatment, and that black women who did respond passively were more likely than those who responded actively to report hypertension.

On the other hand, there is evidence to support the pattern that African Americans are more likely than whites to have access to social support. The group solidarity that often exists among members of minority groups have been important stress-buffering effects. This may help explain the pattern that African Americans often evidence higher levels of stress than whites but not higher levels of mental disorder.

Gender

Women have higher rates (perhaps double) than men of psychological distress and depression. As Rosenfield (1989:77) summarized, these differences are found “across cultures, over time, in different age groups, in rural as well as urban areas, and in treated as well as untreated populations.” Consistently, these differences are greater among the married than the unmarried, although distress is greater in women regardless of marital status.

As important as this pattern is in sociological analysis and clinical application, only recently has significant attention been focused on women as subjects in stress research. This lack of attention has been especially obvious in the area of occupational health research, where early research on women was often conducted primarily to secure a better understanding of men’s stress. The consequence of this inattention is that much remains to be learned about the bases of high rates of distress in women.

A wide variety of plausible explanations for the gender disparity in stress have been advanced and tested:

1. Women are exposed to more discrete, stressful life events than are men. This differential exposure hypothesis has not been supported in most research. However, some research has highlighted the importance of the fact that women are much more likely than men to fill the caregiver role and to be affected by it.
2. Women care more about people in their social network and are more emotionally involved in the lives of people around them. As such, they are more apt to feel stress when others in their network are feeling stress. Women are more likely than men to be both providers and recipients of support, although both men and women rely more on women for support during stressful times. While married women use both spouse and friends as confidants, married men tend to rely on their wives.
3. Women are more vulnerable than men to stress because of their socialization to respond more passively and to introject rather than to express anger and to use less effective coping skills.
4. Continuing power differences between women and men in society and within families lead to the gender disparity in distress. Rosenfield (1989, 1992), focusing on married couples, has argued that women’s relative lack of decision-making power within the family and the lesser resources and decreased prestige

attached to the conventional feminine role of housewife cause and reflect this power differential,

5. A final perspective on this issue asserts that the size of the gender disparity in social stress has been exaggerated and misinterpreted. Aneshenseal, Rutter, and Lachenbruch (1991) argue that most stress research has focused on a single disorder or stress outcome and then has assumed that those who have this disorder are victims of stress and those without the disorder are not. For example, much of the research that has found that women report higher rates of depression than men has concluded that women experience more stress. However, they argue that most research has focused on outcomes that are common in women and neglected to study antisocial personality and alcohol abuse-dependence disorders that are common among men. If the full gamut of stress outcomes is considered, women and men may be found to experience comparable levels of stress.

Gender, Work, and Psychological Distress. An important implication of these explanations is that women's different levels and types of participation in the workplace create conditions that lead to the gender disparity in distress. This suggests an avenue for study: comparing women who are full-time workers outside the home (both married and unmarried) with women who are employed part-time with women not employed outside the home. If it is simply a matter of "social roles," then the benefits and liabilities of working should be the same for men and women. If, on the other hand, the effects of employment are conditional on gender (a sex-role perspective), then other factors related to expectations for men and women must be involved.

Studies addressing these questions have not always produced a coherent picture. Some research has found a reduced disparity in gender distress when the wife is employed, but other research has not. Moreover, some of the research that identifies smaller differences trace them to increased distress in males rather than a decrease in females. Most research has pointed to positive effects for women who work outside the home, but other research has failed to find differences between employed women and housewives. Even when such a difference is discovered, both groups of women have higher distress scores than employed men.

Efforts to sort through these research findings have produced three primary perspectives: role overload, role enhancement, and role context. The **role overload** perspective is based on the proposition that there is only so much time and energy in the day. When women couple homemaking, child-rearing, and full-time employment responsibilities, this is role overload—too much work and too many responsibilities—and obviously stressful situation. The same combination of activities may not overload males since they engage in considerably fewer homemaking and child-rearing activities—even when their spouse is employed. Because many women feel primary responsibility for household obligations, and many men do not, it can be more psychologically distressing for women to occupy the multiple roles of spouse, parent, and worker.

The **role enhancement** perspective asserts that the more roles any person fulfills, the greater are the opportunities for social contacts, satisfactions, and self-esteem, and consequently, better health and psychological well-being. According to this theory,

feelings of anxiety or depression ought to be inversely related to the number of role involvements.

The third perspective, **role context**, asserts that employment outside the home has neither inherently positive nor negative consequences on stress level but rather is dependent on particular factors within the personal, family, and work environments and on the “meaning” that is attached to work and familial roles. What are these additional factors?

1. *The women’s desire to work outside the home.*
2. *The women’s perception of the balance of benefits and liabilities in outside employment.* The greater the “role integration”—the balance of role satisfaction and role stress within and between roles—the greater is the sense of well-being.
3. *Qualities of the work environment itself.* Because women, on average, continue to occupy lower-level positions than men, they are subject to greater stress relative to work conditions, sexual harassment, and job instability.

Two aspects of the working environment that are particularly important are autonomy/control and work complexity. Much research confirms that women are more likely than men to occupy positions with little autonomy or control and that lack of control on the job is related to psychological distress. Work complexity involves the amount of variability on the job and is an indicator of its degree of challenge, its level of interest, the extent to which it is psychologically gratifying, and the likelihood that it will contribute to the individual’s self-esteem. To the extent that men are more likely than women to hold positions high in the occupational hierarchy, they have access to these greater rewards.

It is clear that employment affects women differently and in more complicated ways in situations in which women are expected to be primary household-managers and child-rearers. According to Rosenfield (1989), women’s employment does provide them greater power and a greater sense of personal control. These are health-enhancers. However, something else occurs simultaneously—something that occurs with lesser intensity for men—and that is the likelihood of role overload when work responsibilities are added to being the primary household/child caretaker. This role overload decreases feelings of personal control—a health negater. The complex maze of possibilities within this configuration of roles will require substantial additional research to be fully understood.