CHAPTER 7

Gender and Work Stress: Unique Stressors, Unique Responses

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Managing stress is a major problem in organizations for both employers and employees (Gyllensten & Palmer, 2005). Around 30% to 40% of workforces in the USA and Europe are exposed to workplace stress, and those levels appear to have risen over the past 20 years (Melchoir et al., 2007). As a result, considerable research has been devoted to investigating the causes and consequences of workplace stress, particularly the role that gender plays in the relationship between stress and its dysfunctional effects. The bulk of this research has found that gender moderates (or changes) the relationship between stress and strain in the workplace. While stress is an inevitable component of most any workplace, both men and women must learn to manage it in order to be successful.

It is important that we clarify the differences between healthy stress that serves to stimulate and unhealthy stress that often has harmful effects. Stress that tends to arouse or motivate individuals to meet certain challenges, for example, is referred to as ‘eustress’, a term with origins from the ancient Greek word, euphoria. For all intents and purposes, this is viewed as ‘positive’ stress. On the other hand, unmanaged stress often leads to ‘distress’ or ‘strain’ (Nelson & Quick, 2008). Whether the response to strain is to ‘fight
or flee’ or ‘tend and befriend’ (e.g., Taylor et al., 2000), what we’ve gleaned from research in a variety of fields is that women face similar, yet unique stressors when compared with men (Gyllensten & Palmer, 2005; Nelson & Quick, 1985; Swanson, 2000); and that women tend to respond differently (Swanson, 2000). The ways in which women manage job stress have been a topic of much discussion within the past 30 years, in part because women have entered the labour force in record numbers over that same period. In addition, the issue of women’s health has been the focus of increased government interest and private advocacy (Parker-Pope, 2007), also resulting in increased attention to women’s stress responses.

The literature documents three unique stressors to which working women are exposed: multiple conflicting roles; lack of career progress; and discrimination and stereotyping. This chapter discusses these unique stressors for women in the workplace and the ways in which they tend to cope. While our primary emphasis is on unique stressors for women, we will call attention to stressors that affect men and women. The first part of the chapter describes the unique stressors that plague many women in organizations. Following is a discussion of the most documented reactions that working women have to these stressors. We conclude the chapter with a discussion of within-gender-group differences in the potential causes and consequences of job stress.

7.1 UNIQUE STRESSORS FOR WORKING WOMEN

7.1.1 Multiple Conflicting Roles

Balance is hard. It’s one of the biggest issues for women. They get the majority of home responsibilities put on their shoulders, and understandably single moms in particular are torn between what they owe to family and what they owe to work (Bettye Martin Musham, Former CEO Gear Holdings, Inc).

Indeed, balance is hard. Achieving some level of balance between work and family, work and leisure time, and work and any number of non-work activities is an important goal for both women and men in organizations worldwide (Hall, 2003; Lockwood, 2003). Sixty percent of Hoechst Celanese employees surveyed reported that the ability to balance their work and family responsibilities was an important factor in their decision to stay with the company (Lockwood, 2003). A survey conducted by the UK Department of Trade and Industry found that 69% of employees reported that work–life balance was an important consideration when evaluating potential job opportunities.
GENDER AND WORK STRESS: UNIQUE STRESSORS, UNIQUE RESPONSES

(Hall, 2003). A major reason why so many working women seek balance in their lives is due to inter-role conflict.

Inter-role conflict is defined as ‘conflicting expectations related to two separate roles’ (Nelson & Quick, 2008, p. 223). A sick child presents the mother who works outside the home with a conflict between her role as a mother and that of an employee. The first-grade teacher who is also planning a wedding and house-hunting with her future husband experiences conflicts between her roles as teacher, spouse and homeowner (WebMD, 2005). According to one researcher (Langan-Fox, 1998), the more roles one takes on, the higher the potential for stress. That women experience more role conflict than men is well documented (e.g., Cleveland et al., 2006; Davidson & Cooper, 1984; Frone, Russell & Cooper, 1992; Noor, 2004). An early study of managers in the UK (e.g., Davidson & Cooper, 1984) found that the female managers in their sample reported significantly higher occupational stress levels than their male counterparts, including those who dealt with the conflicting responsibilities associated with juggling a home and career. Interestingly, whether working women have spouses/partners who also work tends to have little or no effect on women’s experiences with role conflict. Spousal employment played no role in reducing the perceptions of role conflict experienced by women faculty (Cleveland et al., 2006); suggesting family responses are borne more by women. ‘For too many women, being sick or having an ill family member presents an untenable choice: stay at work when you shouldn’t, or lose pay (and perhaps a job) by staying home’ (Institute for Women’s Policy Research, 2007, p. 1).

Role conflict has been identified as a common stressor for both men and women (Nelson & Burke, 2000), so why do we pay so much attention to studying inter-role conflict for working women? An important reason is the significant change in labour force demographics, particularly in the United States. Women comprise 59.4% of the US labour force (US Bureau of Labor Statistics, 2007). The labour force participation rate of mothers with dependent children (under the age of 18 years) rose substantially from 1975 through 2006, from 47% to 71% respectively (ibid., 2007). This change in workforce demographics has led to an overwhelming need by many workers, both women and men, to understand and find ways to strike a balance between expectations at work and those at home. Because women tend to bear the majority of home and childcare responsibilities (Chafetz, 1997), adding paid work to their responsibilities creates additional conflicts and stress.

A number of researchers have found negotiating multiple roles to be a unique source of stress for many working women (Gyllensten & Palmer, 2005; Nelson & Quick, 1985; Smith, 2000). The influx of women into the labour force makes them susceptible to the same occupational stressors (prolonged exposure to stressful working conditions) as men. While men’s work
consists primarily of paid employment, women’s work tends to be diffused between paid work, childcare and housework (e.g., Krantz, Berntsson & Lundberg, 2005). This diffusion has had a detrimental effect on women’s health in the form of increased exhaustion, heart disease, depression, anxiety, increased and sustained stress. Sixty percent of women in a US Department of Labor survey reported that job stress was their number one problem (cf. Swanson, 2000).

Though the issue of work–family balance is not exclusive to women, working women remain by far, our families’ primary caregivers and are still responsible for the majority of household duties despite the increasing numbers of stay-at-home dads (Institute for Women’s Policy Research, 2007; Shelton, 1992; Smith, 2000). According to Gyllensten and Palmer (2005, p. 278), ‘Although there have been big changes in family structure and labour force participation, there have been only minor changes in responsibility for domestic chores’ (see also Chafetz, 1997; Hochschild, 1989; Shelton, 1992). In addition to regular care-giving, for nearly half of all working mothers, it is still their responsibility to take time off work to care for a sick child or take their child(ren) to doctors’ appointments. This is compared to 30% of working fathers. As a result, the challenge of balancing work and family remains a major stressor for many working women (e.g., Davidson & Cooper, 1984).

Although increasing numbers of jobs are becoming more flexible with regard to work hours, there generally remains a lack of flexible benefit programmes available to women who work outside the home. The Institute for Women’s Policy Research (2007) reports that 40% of working women have no paid sick days and in the industries that employ the majority of women (retail and food service), that number rises to 55% and 78%, respectively. The lack of paid organizational leave programmes and policies in these industries exacerbates this issue. Unfortunately this situation has not improved much over the years. A recent study conducted by the Families and Work Institute (Galinsky et al., 2008) found no change in the length of time employers offered parents and caregivers and that only 16% of employers provided full maternity benefits, down from 27% in 1998.

7.1.2 Lack of Career Progress

We find more and more that women ‘drop out’ of the corporate pipeline when they reach middle management, some because of lifestyle decisions, but many out of frustration (Gretchen Tibbits, President, National Association for Female Executives (NAFE)).
A second unique source of stress and strain for many working women is the lack of progress towards achieving their career goals (Gyllensten & Palmer, 2005; Nelson et al., 1990). Despite having similar credentials, women managers fail to move up corporate hierarchies as quickly as men managers (Stroh, Brett & Reilly, 1992). How does failing to achieve one’s career goals translate into negative stress? A look to the field of medicine can help explain how the process works. It begins with one’s appraisal of a demand. When a worker is presented with a particular demand (career mobility in this instance) and she perceives that giving in to the demand outweighs the rewards, stress is often the result (cf. Nelson & Quick, 1985). Our bodies are remarkably resilient instruments that, under normal circumstances, have natural defences that help us withstand certain demands and retain the body’s normal steady state balance (homeostasis). However, certain demands have the capability of throwing our bodies out of their normal balance and setting off an alarm response in the form of increased heart rate, elevated blood pressure and a weakening of the immune system among other manifestations (Cannon, 1935). For many working women, doing what they believe are all the ‘right’ things to achieve higher organizational levels yet failing to achieve a level representative of their efforts can result in frustration and distress.

The literature points to certain aspects of the organizational culture as major contributors to a lack of career progress for women. We discuss two of the most commonly cited ones in the next sections, glass ceilings and social isolation.

**Glass ceilings**

The ‘glass ceiling’ is a metaphor used to describe the largely invisible barriers that limit the career advancement of women, particularly in large organizations and in male-dominated professions such as engineering and medicine. Some have described the glass ceiling for women in corporations as having the executive suite within their grasps but not being able to break through to the top, calling attention to just ‘how far women haven’t come in corporate America’ (Hymowitz & Schellhardt, 1986, p.1). The issue transcends the notion that fewer women are represented at all levels of management; the term, ‘glass ceilings’, suggests that women face increasingly more difficulty gaining access to the highest rungs of organizational hierarchies, those that represent ‘real’ power (Wright & Baxter, 2000).

Though invisible, glass ceilings are very apparent to women who experience them and have bona fide effects on their career mobility. Ninety percent of women managers surveyed responded that the glass ceiling was the most significant problem that they faced (cf. Smith, 2000). One need only look at
INDIVIDUAL DIFFERENCES AND HEALTH

Figure 7.1  US women in business pyramids
Source: © Catalyst, December 2008.

Catalyst Research
Catalyst, 2008 Catalyst Census of Women Corporate Officers and Top Earners of the Fortune 500
Catalyst, 2008 Catalyst Census of Women Board Directors of the Fortune 500

the small proportion of women who hold leadership positions in business as an example. Catalyst (2008a) published a very revealing pyramid depicting the diminishing proportions of women leaders in US business, from a large proportion of women in the labour force (46.3%) to only 2.4% of women CEOs in Fortune 500 companies during the same reporting period (See Figure 7.1). Only one woman headed a Fortune 500 company in 1985; she acknowledged that it was due to the fact that her family owned a controlling share of the firm (Hymowitz & Schellhardt, 1986, p. 1).

The situation is similar for working women in other countries. In Canada, women comprise 47.1% of the labour force. Yet they hold 35.3% of all management positions and 30.5% of senior level management positions. Their presence in higher positions is considerably smaller. Canadian women held 15.1% of corporate officer positions in 2006 and 12% of FP500 board seats in 2005 (Catalyst, 2008b). Women in the UK are 34.7% of the country’s managers and senior level officials. Of the 100 FTSE companies, women hold 10.4% of board of director positions. Only 2% of FTSE 100 companies have
CEOs who are women (Catalyst, 2007). ‘The virtual absence of women at the top of the organization is thus the result of discrimination that is intensified and concentrated in the middle of the organization, not simply the cumulative effect of discrimination at all levels’ (Wright & Baxter, 2000, p. 816).

The motives of women themselves have been advanced to explain the persistence of the glass ceiling. Two studies conducted by van Vianen and Fischer (2002) indicated that some women examine the cultural preferences (whether masculine or feminine) of organizations to determine whether they were attracted to one cultural dimension or the other. These researchers speculated that it was this acceptance of the organizational culture that had the most impact on whether women achieved management positions. Nevertheless, many women seem to have a defeatist attitude when asked about their chances of achieving the highest levels of management in organizations. Some of them suggest that ‘Even women who seem very close to the top concede that they don’t have a shot at sitting in the chief executive’s chair’ (Hymowitz & Schellhardt, 1986, p. 1).

**Social isolation**

It seems lonely at the top – especially for women leaders. Evidence indicates that when women achieve higher organizational levels, they are often the first (and only) ones in their positions. The result is often a type of exclusion in the workplace with limited opportunities to form interpersonal relationships or receive other subtle communication and informational cues required to achieve high levels of performance. The loneliness and isolation that women leaders suffer reduces their overall well-being (Nelson & Quick, 1985). This is especially the case when women either lead or are members of male-dominated work groups (McDonald, Toussaint & Schweiger, 2004). In essence, this situation sets up these women as tokens in their organizations. Kanter’s (1977) seminal work established ‘tokens’ according to numerical representations of demographic groups within organizations; organizational members are tokens if they represent 15% or less of an organization and, as a result, are disadvantaged as a result of discrimination by the dominant group. The argument is that ‘tokens’, simply by being less numerically represented, will receive increased attention, their actions in the workplace will be scrutinized more, and their personal characteristics will be contrasted more carefully than those in the majority.

Being a ‘token’ in a workforce has been found to have more negative consequences for women compared to men in the same situation. Some evidence has shown that men may actually benefit from their token status as a result of the status ascribed to men relative to women. Even men who work
in traditionally ‘female’ professions are tracked to higher positions deemed more suitable (e.g., male school teachers guided towards administrator positions) – a phenomenon referred to as the ‘glass escalator’ (Maume, 1999; Williams, 1992). McDonald et al. (2004) found that it was social status rather than gender that accounted for the differential outcomes for women in token situations. In contrast to women, men receive favourable outcomes in part because of their social identification with other men who generally hold higher status positions in organizations (Budig, 2002).

Researchers have found a persistent link between social isolation and psychological health. A recent study (Hitlan, Cliffton & DeSoto, 2006) examining the effect of workplace exclusion on work attitudes and psychological health found that the effect differed according to the gender of the worker. Results indicated that at high levels of social exclusion, men were affected more negatively than women. This finding would seem to contradict what we know about women and their desire for affiliation and social support particularly under conditions of stress (e.g., Taylor et al., 2000). Hitlan et al. (2006) offer two explanations for this contradictory finding. First, women as a whole do not identify with their work as much as men do; and second, women may be accustomed to receiving limited support in organizations and thus have become adept at coping.

7.1.3 Discrimination and Stereotyping

The failure of women to have reached positions of leadership has been due in large part to social and professional discrimination (Rosalyn Sussman Yalow, 1977 Nobel Laureate in Medicine).

Related to the lack of career progress for working women is the issue of discrimination and gender stereotyping. Perceived discrimination has been linked to a variety of outcomes, including psychological distress (e.g., Fischer & Holz, 2007). Being the object of discrimination (perceived or actual) is harmful in many ways. When women perceive they are the object of sex discrimination, they tend to have more negative views of themselves as individuals and as a member of the group (Fischer & Holz, 2007). Such negative views can lead to increased psychological distress and feelings of worthlessness which can lead to reduced performance (e.g., Kaiser, Major & McCoy, 2004).

A different, more subtle form of discrimination for women leaders is the ‘glass cliff’ (Ryan & Haslam, 2006). Whereas glass ceilings describe boundaries for many women managers, glass cliffs describe the precarious nature of the organizational roles in which women leaders are placed in what
some believe is a deliberate attempt to highlight their deficiencies. Ryan and Haslam (2006) sought to investigate claims that women board members in the UK had been reducing the effectiveness of corporations in the country, specifically comparing the share price of the companies in question before and after the leader was put in place. They found evidence to the contrary. Appointments of women to the corporations’ boards actually had a positive effect on share price. What was more interesting during this examination of share prices was the pattern of corporate performance prior to the appointments of women board members. The researchers found that women were appointed to the boards of companies that had experienced consistently poor performance compared to men board members whose appointments occurred during relatively stable performance. Based on this pattern of appointment, the researchers surmised that women were differentially selected for leadership positions in times of crisis where failure is an almost certain outcome (e.g., Ryan & Haslam, 2006). The researchers argue that men are placed in safer, more secure jobs while women are put in positions where they feel they have been set up for failure because the assignment comes with such a high risk of failure.

Another form of discrimination against women with negative effects is gender stereotyping. Women in leadership positions often find themselves in a bit of quandary in terms of how they should behave in the workplace. The case of Ann Hopkins, a highly successful business manager with Price Waterhouse, is a prime example. Hopkins amassed more billable hours than any other prospective partner and was successful in bringing in $25 million in new business, yet she was denied partnership on the basis that she wasn’t feminine enough (cf. Ryan & Haslam, 2007). She was told to wear makeup and carry a purse instead of a briefcase to increase her (unsuccessful) chances of making partner the next year (Babcock & Laschever, 2003; Gentile, 1996). This outcome for Hopkins is consistent with other research that has found less favourable evaluations for women leaders than their male counterparts even when they behave in exactly the same manner (e.g., Eagly, Makhijani & Klonsky, 1992). However, a woman who is caring, cries, or otherwise shows her ‘feminine’ side is deemed as not possessing the traits associated with being an effective leader. Rosener (1995) believes that many women who aspire to higher positions of power will support the dominant culture and behave as the dominant culture does. Men are often uncomfortable with differences in the ways that women lead (e.g., building consensus, sharing power and information, multi-tasking). This difference equates to a perceived deficiency in leadership with the result being discrimination, although sometimes at the subconscious level. Women are painfully aware of this view; and in an effort to defend against this kind of treatment, women may consciously minimize displaying aspects of their femininity and succumb to
the ‘one best model’, thinking and acting not as themselves but as the men who maintain the dominant culture (Rosener, 1995).

Experiencing discrimination and being the object of gender stereotypes are common stressors for many working women. However, it should be pointed out that unhealthy job stress is not an inevitable outcome of pressures in the workplace. As we stated earlier, some stress is helpful and provides many benefits for working women. Women who work generally experience fewer health-related illnesses such as cardiovascular disease and enjoy increased emotional well-being through challenging jobs, emotional support and encouragement (Nelson & Burke, 2000). Perhaps the most obvious benefit of work for women is the increase in financial resources (Swanson, 2000). Characteristics of the jobs are also important. Jobs with limited control are inherently more stressful than those with increased amounts of latitude for conducting job tasks (Nelson & Quick, 2005). For example, one study found that women clerical workers experienced higher rates of coronary heart disease (CHD) than their counterparts in professional jobs (Haynes & Feinleib, 1980). Although there may be other potential correlates of higher rates of CHD for women who perform clerical work (e.g., economic stress, a non-supportive boss, family responsibilities), evidence suggests that jobs with decreased autonomy combined with increased demand are important predictors of job strain and employee well-being (cf. Beatty, 1996; Karasek & Theorell, 1990). It would seem reasonable to believe that leadership positions, given their wide autonomy and control over how work is to be accomplished, would be beneficial rather than detrimental to the overall well-being of these leaders. Unlike challenges that are inherent with especially higher level organizational roles, having to downplay important attributes of one’s self (e.g., femininity) and ‘glass cliff’ positions can create stress levels over and above that which is reasonably expected by having a leadership role.

The link between increased risk of failure and increased stress is established by a process called ‘gender-stress-disidentification’ (Ryan & Haslam, 2006, p. 46) which can have damaging effects for the individual and the organization. According to the model, women leaders who are placed in positions where they are destined to fail will experience large amounts of unhealthy stress. This stress results in a distancing from the organization in the form of poor communication, reduced productivity and decreased organizational citizenship behaviour. The effect of this reduction in organizational identification is often physical withdrawal. Having had enough, women workers will simply walk away from their jobs. In sum, being placed in highly stressful leadership situations can lead to increased occupational stress in the form of increased burnout, depression, sick leave and ultimately withdrawal. It may be that ‘as they [women] advance up the corporate ladder women are exposed to greater stress than their male counterparts’ (Ryan & Haslam, 2006, p. 46).
7.2 RESPONSES TO WORKPLACE STRESSORS

Experts place the human stress response into three major categories: physiological (medical); psychological; and behavioural (Nelson & Quick, 2005). Many pressures that individuals face in the workplace can be stressors. New research that followed 1000 Dunedin-born people from their birth to age 32 found that almost half of all the cases of depression and anxiety disorders diagnosed among study participants were directly related to workplace stress and the demands of high pressure jobs (cf. Management, 2007). Schedules, supervision, job characteristics, overload, interpersonal relations – all of these represent stressors that need to be managed. These stressors can result in chronic distress if left unchecked.

Our focus in the next section of this chapter is on the ways in which individuals, particularly working women, cope. Responses to workplace stressors range from positive activities such as using social support, eating healthy diets and exercising (Nelson & Burke, 2000) to engaging in unhealthy practices such as smoking and alcohol abuse – all in an attempt to deal with organizational pressures. In the same way that working women are susceptible to the same organizational stressors as men, they tend to have the same general reactions and coping mechanisms, but with some important differences. In some cases, workplace stress is becoming the great equalizer for men and women with its consequences (e.g., cardiovascular disease, stroke) causing as much damage for women as previously identified for men. First, we highlight an important category of stress responses that reflects the uniqueness of the stress experienced by many working women, specifically, physiological.

7.2.1 Physiological

Both men and women experience physical symptoms when faced with stress and strain. If we look closely at the medical illnesses suffered by workers, we are likely to find that each illness has a stress-related component (Nelson & Quick, 2005). This is a reasonable outcome given Cannon’s (1935) recognition of the sympathetic nervous system as a key component in stressful conditions. As we noted earlier, the human body is wired in such a way that it is capable of protecting itself from any pressures that threaten homeostasis (Cannon, 1935). We can think of this approach to stress as the body preparing itself to fight any potential stressors that threaten to harm it. Blood is redirected to the brain and large muscle groups; visual and auditory senses are sharpened; important sugars are released into the bloodstream to help the body sustain itself during ‘battle’. In times of chronic stress, however,
the ability to do so is made more difficult and often manifests in decreased physical health.

We are somewhat limited in our knowledge of gender differences in terms of health-related outcomes of chronic stress. Two reasons account for this disparity. First, a disproportionate amount of the early research linking job stress to health was conducted using working men as subjects (Swanson, 2000). Next, many medical professionals fail to investigate and attribute health complaints of men and women to work-related causes – further limiting what we know about the causes and consequences of work-related stress. Therefore the evidence that exists for working women is comparatively smaller. Though that is the case, the evidence exists nevertheless; in the following we present some of the most documented medical effects of stress for women.

Although many working women find work stimulating, challenging and financially beneficial, the stress of handling multiple roles can have a damaging effect on their health. The damaging physical health effects of workplace stress are well documented in the literature. But why do women react differently to workplace stress than men? It depends on whom you ask. One study of high-ranking employees found that the responsibilities of work and home combined with increased workloads led to elevated levels of norepinephrine (a stress hormone) in women both during and after work (Lundberg & Frankenhaeuser, 1999). The release of ‘stress’ hormones has been noted by medical professionals as one of the most important reasons why men and women react differently to stress. Dr Robert Sapolsky, a professor of neurobiology at Stanford University, suggests that it is the amounts of a particular hormone called oxytocin that make all the difference. When women face stressful situations, oxytocin is secreted at higher levels, countering the production of harmful stress hormones like cortisol and epinephrine and instead promoting relaxation and nurturing. Men also secrete oxytocin under conditions of stress, but the difference, according to Sapolsky, is that the nurturing hormone is released at much lower levels (WebMD, 2005).

Organizational behaviour experts emphasize factors such as role conflicts, structural characteristics of organizations and societal expectations of the genders. Nelson and Quick (1985) indicate that women executives experience health ailments more commonly associated with men and suggest that these women are more likely to fall victims to such medical conditions as ulcers and high blood pressure. In fact, a study of more than 1300 Swedish white-collar professionals found that twice as many women than men surveyed suffered from frequent and severe health symptoms in the form of stomach pain, headaches, lower back pain, loss of appetite and shoulder and neck pain (Krantz et al., 2005). The researchers attributed the severity and frequency of symptoms to the double exposure to paid work and household responsibility.
experienced by the women in the study. A more recent study (Tytherleigh et al., 2007) studied the interactive effects of age and gender on workplace stressors that lead to ill health using, as their sample, academics in two types of university settings. The researchers found a significant interaction of age and gender on the ill health of the study participants. Aside from men in the youngest age group, ill health stemming from stress decreased for men as they got older. However, women reported consistently poorer health as a result of stress across all age groups. This study shed light on additional factors that could potentially explain differential outcomes of workplace stress. It also supports the contention that women tend to live longer but suffer more (e.g., Quick et al., 2008).

Indeed, women are different from men. And although both genders are exposed to the same stressors in the workplace, women react differently to those stressors than men. Their different reaction has an often ill effect on their physical well-being, manifested by increased fatigue, tension headaches, muscle pain and increased work-related injuries. Gaumer, Shah and Ashley-Coteur (2005) suggest that working women’s dual roles have a great dealt to do with the difference in physiological reactions. How is it that men seem better able to unwind after a challenging day at work more quickly than women? Gaumer and colleagues (2005) suggest that the reason is fairly clear. The reason women have difficulty unwinding is that they may be anticipating the ‘second leg’ of their day when they get home, giving credence to the old adage, ‘A woman’s work is never done’.

### 7.2.2 Psychological

According to the World Health Organization (2008), depression is the leading cause of disability and is on course to become the world’s second-highest burden of disease by the year 2020. The connection between depression and work stress has come under investigation recently as a result of changes in the structure and demographic makeup of the workplace. Work stress has been found to precipitate the onset of depression and anxiety disorders in otherwise healthy individuals regardless of socioeconomic position (e.g., Melchoir et al., 2007). A better understanding of the symptoms and causes of depression and other psychological diseases is needed if organizations are to remain productive and healthy places to work – a goal of many – if not all, organizations.

There are stark differences between men and women in the presentation of work-related stress outcomes, particularly depression. Depression reportedly affects nearly five million working women in the United States each year. Some estimate that one in five people will suffer depression or some
form of mental illness during their lifetime (Lunn, 2008). A major research study commissioned by the National Mental Health and American Women’s Health Associations found from their interviews with 751 working women that depression was the number one barrier to their success, greater than care-giving responsibilities, sexual harassment, the glass ceiling and sexism (National Mental Health Association, 2003). Interestingly, the women who failed to seek professional treatment but suffered major symptoms of depression were younger, included more minorities, and worked in more blue-collar jobs. Could it be that their depression was a consequence of sexual harassment, glass ceilings or sexism? While these questions were not a part of the research design, we believe it to be a reasonable assumption. For example, it is estimated that 75% of women have experienced or will experience sexual harassment, which is associated with a host of physical and psychological problems (Shaffer et al., 2000).

Instances of depression have also been associated with job strain. The most widely validated model of the link between job stress and health is Karasek and Theorell’s (1990) job-strain model. According to the model, job strain is the result of high job demands and decreased worker latitude. A recent longitudinal study of over 36,000 Canadian working men and women aged 15 to 75 found that a significant proportion of those studied experienced major episodes of depression in the 12 months preceding the study, with the causes of depression differing along lines of gender (Blackmore et al., 2007). While both men and women were negatively impacted (reported instances of depression) as a result of increased job strain, the effect for men was more severe than it was for women. That the researchers did not find a more significant link between increased job strain and instances of depression among women in the study is surprising and conflicts with other studies that suggest women may be more vulnerable to higher amounts of work-related stress and strain than men. Perhaps, as the researchers speculated, the type of job and associated task demands were important predictors of the stress–strain relationship. Women in the latter study were more likely employed in part-time jobs where high task demands and consequently high job strain were unlikely.

Supportive of this view that type of occupation may be the key to understanding job stress for working women are findings from a recent study of 1100 workers in Victoria, Australia to assess the role of job strain on inequalities in mental health (LaMontagne et al., 2008). The researchers were interested in the effects of stressful working conditions defined as high job demands and low control over how to perform the job. They found that more working women experienced job stress than the men perhaps because the women were in lower skilled occupations, representing a high strain condition. Risk of depression increased progressively as the skill level of workers
declined. When it came to depression, 17% of women who suffered from depression attributed their mental state to job stress. This is compared to 13% of men who reported depression as a result of job-related stress. Since women were more likely to experience greater levels of job-related stress, it is likely that women will also bear a greater share of job-related stress depression. While gender differences were found, the study called attention to the prevalence of mental health diseases among both working women and men including those cases of depression in men that may go unreported or unnoticed.

While depression is perhaps one of the most highly popularized psychological stress outcomes, it is not the only outcome of unhealthy workplace stress. Nearly three-quarters of women in Davidson and Cooper’s (1984) study attributed psychological problems such as tension, increased anxiety, sleeplessness, frustration and dissatisfaction with life and work (as well as depression) to high levels of work-related stress. The Whitehall II Study measured psychiatric disorders of 10,308 male and female civil servants in a variety of different occupations using the General Health Questionnaire and found gender differences in the relationships between work characteristics (decision latitude, job demands, social support, effort-reward) and a number of mental health outcomes (Stansfield, Head & Marmot, 2000). Women had higher levels of psychiatric disorders than men in five of six of the occupational groups in the investigation. Although the Whitehall Study II used self-reports of ill health, the study is important as it further established the correlation between work-related factors and the onset of ill mental health outcomes. Findings from these studies imply and are consistent with others that suggest that a wide range of psychological health symptoms are associated with stressors found in the workplace (Swanson, 2000).

7.2.3 Behavioural

Behavioural responses to workplace stress and job strain can fall into two categories, individual and organizational. The effects of chronic workplace stress and strain can be seen almost everywhere. News reports document instances where workers have ‘gone postal’, often accompanied by tremendous shock and disbelief by the public (e.g., Lenz, 2008). Although they are rare, extreme actions such as these represent the aggression that can come as a result of high stress levels. In the same way that gender differences have been found for medical and psychological outcomes, researchers have also found that men and women differ in their susceptibility to certain behavioural outcomes of job stress.
The literature documents both positive and negative ways that women use to cope with the pressures of work and increasingly, work and home. The use of social networks is one of those coping mechanisms. Nelson and Burke (2000) suggest that women’s use of social support systems and exercise has been successful in deterring the negative effects of job-related stress. However, they note that women seem to be particularly vulnerable to tobacco and emotion-based coping strategies such as venting. However, women are less likely to engage in alcohol consumption than men are. There is evidence that women may be mimicking historically ‘male’ behaviours to deal with the pressures they face in the workplace. For each male alcoholic in the United States in 1962, there were five female alcoholics. By the late 1970s, however, there were two female alcoholics for every male alcoholic (Nelson & Quick, 1985). It took less than a decade for women to go from 20% to 50% of reported alcoholics. How can we explain this change in behaviour on the part of women? Perhaps the most comprehensive study of factors that influence workers’ ability to engage in health-enhancing behaviours was conducted by Hellerstedt and Jeffery (1997). The researchers extended prior studies that linked job demands and job strain to cardiovascular disease (CVD) by investigating the effect of body weight in addition to factors previously associated with increased risk of CVD, smoking and lack of physical activity. As they predicted, women who experienced increased demands on the job smoked more, exercised less and had higher average BMI (body mass indicator) numbers, increasing their risk of CVD.

Characteristics of the workplace can result in responses to workplace stress that not only harm the individual but can also have a negative effect on organizational competitiveness (e.g., Gaumer, Shah & Ashley-Cotleur, 2005). In response to work–family conflict, low opportunities, discrimination and career frustrations, many women have chosen to become entrepreneurs. In 2006, 30.4% of all US privately held firms were majority (51% or more) owned by women. The number of majority (51% or more) women-owned firms grew 42.3% between the years of 1997 and 2006, nearly two times the rate for all privately held firms in the United States (Center for Women’s Business Research, 2006). Why are so many women leaving their corporate careers? Having been ‘pushed out’ of the organization, many women believe their talents could be best put to use somewhere else. Consider Lois Silverman, who founded CRA Managed Care (now Concentra Managed Care, a company posting more than $1 billion a year). Silverman chose to leave her insurance company job to pursue other opportunities where she would feel less isolated and left out. In her own words, ‘I was working in a male-dominated environment, and I no longer felt as if I was a part of the company. I began to feel that there was something here I could do better’ (cf. Swersky, Gorman & Reardon, 2007).
Another reason that has been cited is the lack of control that many women hold in traditional corporate positions. Sharon Hadary, the executive director of the Center for Women’s Business Research suggests, ‘They [women] don’t want fewer hours, but control over what they do’ (McLaughlin, 2006). Consider also the woman manager who, after several years, reached her goals of a position in the executive office. As a result of her hard work and commitment, she finally makes it. Now she’s in a position that not only tests her physical stamina but also her continued commitment to the organization. As discussed earlier, placing women in ‘glass cliff’ positions has been cited as a primary reason for organizational withdrawal for women (MacRae, 2005). This mass exodus of women from the workplace not only disrupts women’s careers but when organizations lose large portions of their talent, they stand to suffer tremendously (Hymowitz & Schellhardt, 1986). In sum, withdrawing from the organization is one of the responses to workplace stress for many working women. Having put up with more than they can, some women believe that walking away is their only viable alternative.

7.3 WITHIN-GROUP GENDER STRESSORS?

We know more about differences between gender groups on the causes and consequences of job stress than we do about differences within gender groups. Focusing on what we don’t know about these gender differences may be equally important for understanding the variability of workplace stressors and individual outcomes (Quick et al., 2008). Are there organizational factors that affect minority women differently or in a more harmful way than for non-minority women? For instance, does the ‘double-bind’ that black women experience lead to higher levels of job stress? There is a lack of research that has explicitly investigated this topic so we must extrapolate from research on minorities in general.

Some researchers suggest that the unique experiences of minorities, especially being the object of stereotypes and experiencing discrimination, may present psychological stressors and lead to increased ill health among the victims which include increased risk of heart disease and alcohol dependence (Cocchiara & Quick, 2004). Women, in general, have difficulty being accepted as managers and in establishing informal networks in corporate environments. Women of colour may experience even more difficulty. In one survey, five out of every 10 black women reported that they felt accepted as a member of their respective organizations, while eight out of 10 white women felt the same way (Bell & Nkomo, 2001). Gender stereotypes that negatively affect the perceived suitability of women as leaders combine with cultural stereotypes that plague minority women. The perception that black
women will miss work more often because they are single parents or that Hispanic women have lower levels of commitment to the organization because of their family responsibilities, though inaccurate, represents barriers to their acceptance (Cocchiara, Bell & Berry, 2006). When gender or cultural behaviours are at odds with those expected by organizations, and the expected behaviours stem from stereotypes, the result can be undue stress for the individual at the centre of the conflict.

7.4 SUMMARY

Work pressures are more strongly associated with more health complaints than any other life stressor (DiversityInc.com). Both men and women fall victims but there are certain stressors that are more common for working women than men. Although common, are the unique stressors that women face in the workplace linked to specific outcomes? For instance, can we say that women who experience role conflict are the most likely candidates to become heavy smokers? Are women who experience ‘glass ceilings’ or who see men take the ‘glass escalator’ to the top destined to exit the organization or to a life of job-related illness or depression if they remain? As shown in Figure 7.2, three workplace stressors are unique to working women. The responsibilities of raising children, caring for elderly parents, and providing for families present a challenge for women, and more increasingly men, to negotiate and prioritize among these multiple conflicting roles. Though women have been a large part of the labour force for several decades, they have yet to reach organizational levels that are commensurate with their investments in education and experience. Women continue to face inaccurate
stereotypes that dictate how women should behave in the workplace in addition to discriminatory organizational practices. Undue stress accompanied by a wide range of medical, psychological and behavioural health outcomes often follows.

REFERENCES


