*Canadian Journal of Nursing Research, 2002, Vol. 34, No. 1, 47–65*

# Employed Mothers: Stress and Balance-Focused Coping

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Ancré dans une perspective féministe critique, le projet de recherche dont cet article fait l'objet visait à analyser comment les mères réussissent à concilier les multiples responsabilités liées à la famille, à la santé et au travail rémunéré. Pendant une période de deux ans, 20 mères travaillant comme employées de soutien dans un établissement public ont participé à une série d'entrevues individuelles menées en personne et par téléphone, ainsi qu'à un groupe de discussion. Les entrevues ont été transcrites et analysées au moyen de méthodes comparatives constantes. Les exigences continues liées au travail rémunéré et au bien-être des membres de la famille sont une source de stress pour les femmes, une condition exacerbée par les contraintes de temps, les attentes inflexibles ou contradictoires, les concessions relatives aux ressources personnelles et l'insuffisance des moyens de soutien. Dans la plupart des cas, les stratégies d'adaptation sont individuelles, comme celle qui consiste à se concentrer sur les priorités; certaines femmes recourent toutefois à la prise de décisions partagée en famille. Les résultats appuient les théories courantes sur le stress et l'adaptation en lien avec l'individu et la famille, tout en soulignant la nécessité d'expliciter l'incidence de facteurs socioécologiques tels que les relations de pouvoir. L'article fournit à l'intention des infirmières qui travaillent auprès des femmes et des familles des stratégies visant à rehausser le degré d'adaptation et à réduire les facteurs de stress.

This critical feminist grounded theory study examined how employed mothers coped with the stress of managing multiple responsibilities in family, health, and paid work. Over a 2-year period, 20 mothers employed as support staff in a large, publicly funded institution participated in repeated individual in-person and telephone interviews and in a focus group. Interviews were transcribed and analyzed using constant comparative methods. The women experienced stress from continuous demands in paid and family health work compounded by time constraints, inflexible expectations, conflicting demands, compromised personal resources, and inadequate support. Most of their coping strategies were individual, such as focusing on priorities, but some women used shared family decision-making. Findings support both individual and family stress and coping theory, yet underscore the need to explicate social-ecological influences such as relational power. Strategies that can enhance coping and reduce stress are described for nurses who work with women and families.

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The inequitable division of paid and family labour between women and men as partners and parents remains problematic for women trying to create work-family balance (Higgins, Duxbury, & Lee, 1994). Even as women are expected to make commitments "just like men" in the workplace (Duxbury & Higgins, 1991), they are normatively expected to make priority commitments to family caregiving roles. Their acceptance of social ideals about women's caregiving work may limit their use of social support (Neufeld & Harrison, 2000; Wuest, 1997). When women are socially disadvantaged by greater exposure to stress and lower education — for example, women in non-professional positions such as clerks and factory workers — they may limit health-promoting self-care (Woods, Lentz, & Mitchell, 1993). Yet, in investigations of individual and family stress and coping, researchers have not routinely focused on these conditions or critically examined their social construction.

The health and social science literature reveals two perspectives on stress and coping: an individual perspective and a family perspective. Antonovsky (1987) proposed a salutogenic model of individual stress and coping based on an inherent uncertainty in daily life and a potential for the health-promoting consequences of stress. The central concept, a sense of coherence, reflected an individual's confidence in his or her ability to anticipate, find meaning in, and cope with life challenges. Successful coping resulted when the individual selected appropriate strategies to deal with stressors or experiences that were seen as unpredictable, overwhelming, or difficult to resolve. A family perspective on stress and coping (McCubbin, Thompson, & McCubbin, 1996) assumes that families have patterns of behaviour that promote growth and development and enable family members to respond to stresses such as illness of a member or inadequate financial resources. Family coping reflects coordinated behaviour within the family system and synergistic efforts of individual members to secure and use resources to maintain individual and family well-being.

Women's health research has focused predominantly on individual coping. Coping skills such as asking for and accepting help or altering self-expectations are described as important factors in women's health (Woods et al., 1993). In a study with employed and at-home women, Killien and Brown (1987) found substantial diversity in patterns of stressors, experiences of stress, and coping strategies. Employed mothers, both lone and partnered, tended to take action to "fix the problem," whereas unemployed mothers tended to "talk out the problem" with someone other than their spouse. Both of these types of coping were individual strategies. Killien (1999) advocates the use of a role-resilience perspective in "women, work and health" research to

support an integrated focus on beneficial and harmful effects of multiple social roles. This perspective, however, still focuses on individual coping. Implicitly, the family is viewed as a recipient of care by women rather than as a partner with women in coping with life stress.

Much of the research that uses a family perspective on coping has focused on families in crisis due to chronic illness of a child or parent, immigration, or war trauma (McCubbin et al., 1996). Family coping with everyday demands in employment and family roles has received limited attention. Anderson (1998) used a family perspective on stress and coping to study family quality of life after a diagnosis of chronic illness in an adult family member. Maintaining a stable family sense of coherence supported family quality of life. Antonovsky (1998), however, contends that the concept of a family sense of coherence remains problematic as data have reflected aggregated individual family member experience rather than family processes. For example, Gottlieb (1998) studied family coping in lone-mother families of a child with a disability. A strong sense of family coherence was associated with a greater frequency and variety of coping strategies used by mothers; larger, more helpful support networks; higher maternal education and economic stability; and more cohesive mother-child relationships. Although this study was conducted to examine family coping, in reality individual coping strategies used by the lone mothers were identified.

The purpose of this study was to describe how employed mothers cope with the stress of managing multiple responsibilities in family, health, and paid work. The research questions were: *What types of stress do mothers employed in support positions have? What coping strategies do these mothers describe using on an individual basis and/or as a family?* This study was part of a larger study of meanings and social contexts in personal and family health decision-making.

## Research Design

A critical feminist grounded theory method was used in the study. Recent discussion among feminists of the need to consider sociocultural as well as gender influences on women's circumstances (Marshall, 1994), and the discussion among critical theorists that gender has been neglected (Morrow, 1994), supported the integration of feminist and critical social theory inquiry. Critical analysis of social pressures in the workplace and society was integrated with an understanding of action and interaction in a woman's social world. The use of grounded theory methodology was based on the compatibility between grounded theory

and feminist theory (Keddy, Sims, & Stern, 1996; McMahon, 1995; Wuest, 1995; Wuest & Merritt-Gray, 2001). A critical feminist perspective promoted development of a non-hierarchical "friendly stranger" (Cotterill, 1992) research relationship between the first author and the women in the study, and a focus in the interviews on the experiences of each woman through her eyes (Reinharz, 1992; Seibold, Richards, & Simon, 1994).

### *Data Generation and Analysis*

Data were generated with employed mothers who described individual and family health, stress, and coping experiences relevant to their everyday decision-making about family, health, and paid work. Obtaining family-level data from an individual family member, typically a parent, is an accepted strategy (Patterson & Garwick, 1998), and mothers' reports on family health and activities have been found to be consistent with family reports (Denham, 1999).

The sampling strategy focused on women who worked as support staff in clerical, laboratory assistant, or janitorial positions with a large, publicly funded employer. These women may experience greater stress than women employed as professionals or managers, as they have less control over working conditions and fewer economic and social resources (Meleis, Norbeck, & Laffrey, 1989). Following approval by the Ethics Review Board, union and employer support was secured. Notices describing the study were distributed through the union newsletter and administrative offices. Women who cared for at least one child under 18 years of age were recruited. Theoretical sampling following preliminary data analysis guided the selection of women, who varied in their hours and type of paid work, their family income, the number and ages of their children, and whether a partner contributed to their family work.

Twenty women participated in the study. All but one, who withdrew due to serious family illness after the initial interview, agreed to follow-up interviews. All women held support positions that were considered working-class (McMahon, 1995). Most women held full-time clerical positions. A few were employed in laboratory or janitorial work. During the study, two women changed jobs. The women ranged in age from 27 to 45 years. The majority cared for two or more school-aged children. Three women were lone mothers. The rest were partnered with men employed in trades or professions. Most women managed chronic personal and family health concerns such as asthma and caring for a child with developmental problems or for an aging

parent. Social-class differences among women were of interest in the study, but class description is complicated in Canadian society by the lack of widely accepted criteria. Based on education and occupation, five women were considered working-class (McMahon). All women, however, had family incomes above the Statistics Canada (2001) low-income cut-off and the low-income measure.

Repeat interactive, in-person and telephone interviews were conducted over 2 years. In keeping with the women's preferences, most interviews were held in the workplace after working hours or during scheduled breaks. During the initial interviews, the women were asked to describe a "typical" day including their family, health, and paid-work responsibilities and how they made decisions to cope with these responsibilities. In subsequent interviews, the women were asked to describe changes in their circumstances and coping methods. Consent was obtained in writing prior to the initial individual interview and reaffirmed verbally at the end of each interview. All women were asked if they would like to join a focus group at the end of the interviews, and four women consented. In the focus-group discussion, the women were asked about workplace policies, benefits, and conditions such as supervisor or co-worker relationships that supported coping or contributed to stress. Interpretive summaries of data were presented to the women for their review and feedback prior to the follow-up interview and the focus-group discussion. The women developed a shared awareness about their experiences that stimulated further reflection and helped develop data interpretations.

All in-person interviews and the focus-group discussion were audiotaped and transcribed verbatim with pauses and emotions. Pseudonyms were chosen by the women or by the researcher with the women's verbal consent. Field notes recorded telephone interview data. The interviews, focus-group discussion, and field notes were analyzed for themes using constant comparative techniques (Glaser, 1978), and the analysis was guided by a critical feminist questioning of underlying values and social conditions that affected women's experiences (Campbell & Bunting, 1991). Information about employer-provided benefits and policies such as personal and family leave and health-promotion programs was provided by the union and was publicly available. Gender-sensitive strategies (Status of Women Canada, 1998), focused on the impact of workplace policies and social conditions on women's lives, were used to analyze information about employer-provided benefits and policies. Reflective memo-writing was used to document researcher responses that were relevant to but not necessarily specified in the data. Concurrent data analysis guided the topics

explored in subsequent interviews. Theoretical sampling, data generation, and analysis continued until new data no longer contributed to further theoretical development.

## Findings

### *Sources of Stress and Unbalanced Solutions*

The women faced multiple sources of stress: time pressures, inflexible expectations, conflicting demands, compromised personal resources, and difficulty accessing support from the family, the workplace, and health and social services. Because of the constraints of their situations, they frequently were unable to find solutions that decreased their stress and benefited their family. As a result, the women felt a sense of imbalance between what they believed they *should* do and what they found they *could* do in any given situation.

All women acknowledged stress imposed by time pressures. They experienced conflict between concurrent demands and time to deal with those demands. Lea reflected: "Time constraints are a major factor in decisions on when to take care of things and how. I would like to not have everything compressed in such a tiny ball where you have to make decisions based on the clock, rather than practicality or necessity." Lea attended to her son's health but neglected self-care. Under time pressure, the women coped by making ill-considered decisions that satisfied immediate demands without reducing the stress from multiple demands.

Many women experienced stress related to inflexible expectations of themselves, particularly as mothers and employees. They felt guilty when they did not meet these expectations and responded by placing priority on family and paid work. The women felt pressured to be available to their children, to support their social and emotional well-being and be seen as a good mother. Leandra, a lone mother, said, "The work and the children are going to come first and what little time there is left...there's not going to be a whole lot of time for me." Leandra's struggle to take care of her own needs was common to many women, who believed that family and work responsibilities should take priority over their personal needs. At times, the women faced intense stress from these multiple demands. Lea noted, "I fell into the superwoman trap way early. I never learned about boundaries and it's hurt me really badly. It's hard when you're getting different messages from all around you." Several women had accepted idealized views of women's work

and habitually minimized self-care to cope with family and job demands.

Conflict between family and job responsibilities increased the women's stress. This stress was compounded by high personal expectations and guilt. Daria said, "There's a lot of guilt in not getting things done to a certain specification. I don't want anybody else to pick up my job partway through. There's guilt when it comes to the pressures of everyday life and being tired and wanting to be by yourself.... There's guilt in wishing I could be more involved with my kids' school. I should maybe be doing more things for my grandmother [and] visiting my parents more often. I should be doing more around the house. My biggest guilt is from falling asleep. And there's guilt that you don't spend enough time with your husband." Daria's catalogue of guilt reflected her stress from expecting she should do more in each aspect of her life. Stress from continuously attending to paid, personal, family, and volunteer work was a recurrent experience for many women.

For several women, stress arose from compromised personal resources such as their need to conserve energy to deal with chronic health problems. Daria talked about the stress of an extended convalescence: "It's very, very hard for me right now because I am doing so many medical things myself that I don't have the time for medical things for my kids unless they are sick-sick." Daria had always "saved" her sick time for dealing with family health issues but now felt pressured to delay their less serious concerns. This pressure increased her guilt and stress. Other women faced stress from inadequate financial resources. For example, Lea said, "One of the biggest balancing acts for me is between what I need and what I want, because what I may want is to pay a sitter so I can get out and what I may need is to not spend any money."

The women experienced stress from trying to manage with inadequate support from their family. Ilana said, "We don't really have any extended family here. We have to basically rely on our little family to cope one way or the other." Ilana acknowledged the stress this created when her partner or adolescent children did not provide support. "Everybody assumes that it is the mothers that have to do all these things. I don't think there is going to be any change unless society [plays] some part." Ilana's partner was frequently unavailable due to work requirements and her children were inconsistent in providing requested support. Haley also talked about pressures on women: "I think we end up doing more because our husbands don't worry so much. How our kids turn out is still a reflection on us. I try to delegate

to my husband, who then delegates to my son. It's cooperation as long as it's not interfering with anything he [husband] needs to do." For a few women, stress was compounded by negative actions from family members. Diana had an adolescent with recurrent behavioural problems: "I find it's harder for me to deal with a situation when he's [husband] saying, 'Well, it's your fault'." Diana felt blamed and betrayed by her partner when he made these comments, even though she excused them as an expression of his frustration with parenting. Such negativity effectively limited the women's choices in securing support and increased their stress.

Inadequate support in the workplace, such as lack of relief from co-workers and difficulty using personal or family leave to deal with family issues, created stress. Rose noted, "We've got people away at work, we've got one less supervisor than we did last year, we've got people retiring." Rose, like several women, felt that continual staff issues limited her opportunities to secure workplace support to manage personal and family health concerns. Whereas employer policies provided for personal and family leave and group health-benefit entitlements, the women found that their access to entitlements was limited by supervisor or co-worker attitudes. Cass recalled, "The supervisor, she's got kids herself, but she has a way of saying things...you feel guilty that you left because your child was sick." Cass limited her use of family leave because she believed her supervisor was not supportive. She, like other women in the study, expected employed mothers to be supportive in the workplace but found that this was not always the case. Male supervisors, co-workers, and written policies were seen by a few women as reflecting an orientation in the workplace of relative freedom from family responsibilities. Dol said, "In the last 5 years we have had four different managers. The majority of them wanted you here when they're here in the morning and to stay until they were ready to go home, which wasn't always comfortable to make a home life." Naomi said, "Both my supervisors are males and don't have children themselves. I believe they truly don't understand the entire involvement of that. They don't want to give me extra responsibility [at work]." These women were concerned that acknowledging family responsibilities compromised their position in the workplace and could threaten their job unless they restricted their use of personal and family leave.

Difficulty securing health and social services frequently contributed to time pressures and put additional strain on the women's personal coping resources. Some women expressed frustration with trying to identify resources and dealing with unsupportive professionals or

agency personnel. Leandra recalled her frustration when trying to identify child-care alternatives: "I phoned the City to see if I could qualify for some type of subsidy for daycare, and I phoned 4 days in a row and left messages every day and I never ever heard from anybody. I kind of gave up." In addition to increasing her stress, the time spent seeking child care had conflicted with her workday and raised tensions with her supervisor. Other women experienced similar problems with the education and health-care systems; accessing information and services required extended effort and time.

### *Balance-Focused Coping Strategies*

All the women believed that they would be able to achieve a balance between the demands they faced and their resources if they made use of successful coping strategies. The women used multiple coping strategies directed at meeting expectations and demands, using available resources and working around situational constraints.

***Meeting expectations and demands.*** As illustrated by the women's descriptions of everyday stresses, family and social expectations of the caring, good mother and the productive, good worker were embodied in the women's self-expectations and their family and job demands. The three coping strategies that were used to meet expectations and demands were: focusing on priorities, being fair, and letting go of expectations and demands.

The women described the importance of focusing on priorities in personal and family responsibilities so that immediate health demands could be met without persistently subverting other responsibilities. Although the two priorities of being a good mother and being a good worker were not considered inherently conflictual, the women faced many situations in which they needed to choose between the two. Scarlett said, "It's learning to take that time for your own health, because if you don't, you can't do it with everyone else."

The women were concerned about being fair to themselves and their families. Naomi, who tried to consider her partner's perspective in her decisions, said, "Sometimes when you're doing the balancing stuff it's not so much about you. Sometimes it's about the other person... You have this whole thing going about your time, your work, your schedule, your kids, your husband, but then he has this whole other circle that includes everything but in sort of a different world." The women considered how their decisions might affect others in their family and their workplace. They felt less stress when they believed

they were being fair by meeting personal and social expectations of good mothers and good workers.

Letting go meant moderating their self-expectations, particularly in family and volunteer work. Mora said, "I'm doing the best I can. What can I say? I can't say I am perfect, no." Unlike Mora, most women were reluctant to let go of their self-expectations even to relieve persistent stress. Haley said, "I want to take care of my own myself. We are supposed to be able to solve all these things ourselves." The women had high self-expectations, particularly in situations of intense social pressure such as dealing with an ill child or a new supervisor. Focus-group participants agreed with one woman's comment: "You kind of hope when you start a new job nothing goes wrong at home for a while, that the kid doesn't get sick or the school doesn't call, so you have time to prove yourself."

***Using available resources.*** The women used a range of personal, family, social network, workplace, and health- and social-system resources. Coping strategies included accepting support, asking for help, sharing decision-making, emphasizing self-rewards, using spiritual support, choosing work with flexibility and benefits, and securing satisfactory health and social services.

The women were comfortable accepting support from partners, family, and members of their social network who were willing to share family responsibilities. Scarlett recalled an important family decision: "We just said, 'We're gonna do it.' Because we all have to buy into it. It's going to affect us all." Among the women with supportive family and social networks, Dol's comment was typical: "If you have the right network, they will help you and they will support you in your decision, whether they agree or disagree." The women appreciated family and friends who made themselves available without being asked. A global view of reciprocal support enabled the women to accept support without feeling an immediate sense of obligation. The women in the focus group agreed: "You do pay back one way or the other. There is always something that the other person needs. Sometimes it's simply the friendship." Recognition that reciprocity could occur over time and through diverse actions promoted women's comfort in accepting support.

When support was not offered, asking for help was an important strategy. Geri said, "I ask for help. I don't like asking, and it's neither pleasant nor easy." Geri sometimes asked another adult to help balance demands on her as a lone mother. To be able to ask for help, the women had to let go of self-expectations and recognize their need for support.

Half of the women, however, resisted asking and sometimes refused help if they felt they could not "pay back" the support. Leandra reflected: "A lot of friends have extended their support. It's hard for me to take it because I probably know I am not going to give back."

The influence of power in the partnership on shared decision-making was evident in the situations described by several women. Aryn commented: "I have always said to my husband, 'My job is as important as your job. We are in this together'." Women like Aryn, who found that their partners were committed to sharing family and paid-work responsibilities, described a comparative balance in decision-making power within the family. In contrast to other women in the study, Haley talked forcefully about power in the partnership: "You have to start to delegate more to your spouse, but that means you have to give your spouse information and you don't really want his opinion." Haley described her partner as selectively involved in family responsibilities. She and several women saw partner support as a resource qualified by tensions over decision-making and responsibilities, particularly in family work.

Many women spoke of self-rewards such as the satisfaction they derived from their multiple activities, particularly in their paid work. Diana stated, "I've always felt that work has actually been healthy for me. I think it's good to get away from the kids, the husband, and the housework." Although paid work complicated everyday demands on women, it provided time out for them and relief from constant family demands. Women also used individual and social activities for time out. Diana said, "I think this is really important, to be able to disengage from the everyday happenings in your life and say, 'OK, this 2 hours is *my* time and I am going to do with it what I want to do'." These women were able to remove themselves from the stress of demands and maintain a sense of personal balance, which strengthened their resources.

A few women talked about using spiritual support. Dol said, "There are some days you just feel overwhelmed and you say, 'It's time to pull in the big guy, this is up to You.' And it seems to take the load off your shoulders." The sense of connection to life beyond their particular experience supported Dol and other women through very difficult decisions.

Employment with flexibility and benefits provided needed workplace support for the women. Most of the women were employed full-time and valued flexibility in work demands and supervisors and co-workers who supported the use of family-leave policies. Analysis of employer-provided benefits and policies supported the "progressive

workplace" reputation of the employing institution. Women in the study had access to family and personal leave, diverse family medical and alternative health benefits, and family assistance and wellness programs. They valued their employee health benefits. Lea said, "I am very grateful for all the different health-care coverage, because I have options without worrying about, 'How can I afford this?'" In several cases, the woman's employment provided family health coverage.

A few women had secured employment flexibility through altered working hours, typically starting and finishing earlier than regular business hours. This allowed them to be home with their children after school and alleviated child-care concerns. Some women had secured flexibility informally by "making up time" taken for family work or by completing paid-work tasks at home. Aryn was one of the few women with flexible working hours and the opportunity to work at home occasionally: "Where I work they know that even if I am at home and my child is sick, my work gets done and maybe I will take some stuff home at night." The women attributed their ability to obtain support to their good workplace relationships, their reputation as good workers, and their infrequent use of flexible conditions.

All the women described having secured satisfactory health and social services, including access to supportive health and social programs and trusted care providers. The women sought to establish supportive relationships with medical and alternative health providers. Scarlett recounted dealing with a serious illness: "My doctor said, 'We got two ways of treating this.' We did start to treat it with meds and I got very sick. I said, 'I am going to do this holistically'." The physician's willingness to consider available medical and alternative treatments enabled Scarlett to include her preference for various therapies. Women also secured quality child care as an essential support. Aryn recalled, "I had a wonderful babysitter for 5 years and I never worried." The women felt less stress when they knew that their children were in a caring and safe environment.

***Working around constraints.*** The women needed strategies to work around constraints from conflicting demands, time pressures, inadequate available support, and limited access to health and social resources. Their coping strategies included delaying, planning contingencies, using alternatives, and persisting.

To work around inflexible working conditions such as fixed hours, the women selectively used the strategy of delaying their response to family demands. Emily commented, "We have a rule in our house that you do not phone me at work unless you're dying. The 1% of the time

they do call, very calmly I'll say, 'We'll discuss it when I get home'." When demands could not be delayed, she requested leave and hoped her supervisor would support her decision. Emily limited such requests because of inconsistent supervisor support despite the existence of a family-leave policy.

Women used contingency planning to resolve conflicting demands, such as if they had to be at work when a child was ill. All the women acknowledged that the support available from their partners and social network was less than optimal. Geri's response in such situations was typical: "I try to handle things most of the time." The women used contingency planning and their own resources before asking for help.

By using alternatives the women were able to work around limited access to needed resources or services. Alternatives, however, were a compromise. Ilana reflected: "Unfortunately, your choices are kind of limited. You can't often just take time off work even if you are sick. So it leaves me the options that I go back to the doctor and I also try to improve in the other areas, like more rest." To deal with her chronic asthma, Ilana used alternatives because she did not have supervisor support for recurrent use of personal leave. Lea described a similar strategy in dealing with her son's medical needs as she considered "whether or not I will drive across town to the doctor we'd normally see or go to the medi-centre behind our place where I don't trust the diagnosis." Alternatives provided relief but did not ensure resolution of concerns.

Persistence helped the women to work around stressful family situations or difficulty accessing needed resources. Geri said, "Some things are easy to access and others are not." She described her approach as "putting on armour and doing battle." The women identified needed services and persisted in their requests for access until they succeeded. Persistent attention to constraints was stressful, however, even when a sense of successful coping was achieved.

The women developed routine decision and coping strategies that gradually changed in response to their children's development or focal events that raised their awareness of inadequacies in their routines. All the women described changes in their coping as their children matured. Whereas women with young children coped by taking responsibility for their well-being, women with school-aged children included them in decisions about family and health issues. In contrast, women with older children focused on facilitating their adolescents' independent health decision-making. Olivia, the mother of adolescent twins, recalled these changes: "It's really neat, because there are stages. You could

probably graph it with the age of the kids." Many women also described changes in their coping routines, particularly in relation to self-care, when faced with a crisis or cumulative events that revealed inadequacies in established routines. Ilana considered the impact of a personal-health crisis: "I was at a point physically and mentally that I could take no more than I was already handling. After that, I kind of reviewed my practices." Women knew that their coping routines changed as they obtained greater support, typically from partners and children, in managing multiple responsibilities.

## Discussion

In this study, social expectations that define caregiving as women's work reinforced women's sense of obligation to manage family, health, and paid-work demands on their own. These findings are consistent with other research on women's use of social support (Harrison, Neufeld, & Kushner, 1995; Neufeld & Harrison, 2000; Wuest, 1997, 1998, 2000). Social ideals continue to orient women towards nurturing and caring for others over themselves, implicitly supporting a hierarchy of caring that fosters self-neglect among women. The ideal of "the good mother" as selfless and self-sacrificing remains a powerful influence on women in Western cultures (Villani, 1997). Although family social and public policies in Canada are framed within an individual model of responsibility (Eichler, 1997) that is overtly gender-neutral (i.e., both mothers and fathers are assumed to be responsible for family well-being), the social ideal of motherhood effectively holds women responsible. When faced with inconsistent support from an uninvolved partner, an unreliable adolescent, very young children, or an unsupportive work supervisor, women reasonably rely on individual coping strategies that are under their control.

Unlike most research with employed mothers, this study focused on women in support-staff positions. Their stress increased with inflexibility in working conditions and lack of supervisor support for taking family leave. This finding is consistent with stressors identified in studies with women clerical workers in California (Meleis, Norbeck, Laffrey, Solomon, & Miller, 1989) and Brazil (Meleis, Messias, & Arruda, 1996). From a feminist perspective (Tronto, 1992), women's differential access to power, both in family relationships and in the workplace, is a major constraint on their coping decisions. A lack of power in relations within the workplace makes it difficult to challenge supervisor or co-worker attitudes. Women are expected to work within an employment mentality that centres paid work in employees' lives and marginalizes

family responsibilities (Baker, 1995). Women who are members of support staff may be doubly disadvantaged, since their positions often are structured so that workers are easily replaced and have little job control, inflexible hours, and limited opportunity for promotion (Armstrong & Armstrong, 1994).

Except for shared decision-making, the coping strategies used by the women in this study were individual strategies. These strategies support Antonovsky's (1987) proposed theoretical constructs of instrumental and emotion-focused coping strategies. Asking for help and choosing employment with flexibility and health benefits fit within instrumental focused coping, while emphasizing self-rewards and letting go of expectations and demands are types of emotion-focused coping. In contrast, shared decision-making is a family-level coping strategy, similar to family problem-solving and coping, one of the main concepts identified by McCubbin and colleagues (1996). Shared decision-making occurred within families where women were able to share authority with their partner. Such power-sharing may depend on men seeing themselves as partners in family work, rather than as "helpers" with women's work (Coltrane, 1996; Pyke & Coltrane, 1996). An imbalance of family and job responsibilities between men and women in North American families persists despite a shift towards men making a greater contribution to family work (Duxbury & Higgins, 1991; Higgins et al., 1994; Hochschild, 1997). Women have assumed paid-work and family-provider roles like men, but men have not assumed a proportionate contribution to family caregiving (Eichler, 1997). Disproportionate contributions to family caregiving by men and women are grounded in gender-role ideology and compounded by men's typically higher wages (Pyke & Coltrane; Tiedje & Darling-Fischer, 1993).

Social-ecological influences, including power in family and workplace relationships, have been inadequately examined in stress and coping research. There is a need to examine power differentials in order to extend the relevance of coping theory to women's and family experience in everyday life. Failure to do so may result in support for individual models of stress and coping that inadequately reflect family dynamics and the influences of gender inequities on everyday experience and action.

The focus of this study with mothers employed in support positions extends previous research typically focused on women in professional positions. The study, however, was limited by the exclusion of non-English-speaking women and by recruitment from a large, publicly

funded institution. The demonstrated influences on women's experiences, their sources of stress, and their coping strategies need to be examined under conditions of greater socio-economic and cultural diversity and in other workplace environments. Employed mothers who are immigrants may experience greater stress, as they frequently work in low-paying jobs that are not consistent with their qualifications or experience and may lack the English-language skills needed to access resources (Ng, 1993). Women in low-income circumstances such as those returning to work after receiving social assistance may have limited employment and family resources to support coping with multiple responsibilities (Heymann & Earle, 1998). Mothers employed in smaller organizations or self-employed mothers may have access to fewer workplace resources than women in this study (MacDermid & Williams, 1997). The coping methods of such women warrant examination. Another limitation of the study was the use of only one family member to describe family coping strategies. Although Patterson and Garwick (1998) suggest that one family member can provide insight into family coping, further insight into shared decision-making and family use of supports might be gained if other family members were interviewed.

Nurses have opportunities to explore stress and coping strategies with employed women and their families. Women in the current study found that talking about their everyday experiences promoted reflection on their coping decisions and contributed to their awareness of a wider range of coping and stress-reduction strategies. Encouraging reflection may be an effective intervention to enhance coping skills (Collins & Tiedje, 1988). Nurses, however, should be aware of Denham's (1999) caution about speaking only with women about family issues, as this approach implicitly pressures women to fulfil a primary role as family caregiver. Nurses who work with women and their families also need to help them identify ways to share responsibility within the family, to develop realistic expectations, and to use appropriate support from workplace, health, and social systems as well as their extended families.

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## Authors' Note

This research was supported by an Internal Research Allocation grant from the Faculty of Nursing, University of Alberta, and a National Health Research Development Program PhD Fellowship.

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