Masked Symptoms: Mid-life Women, Health, and Work*

Zelda Abramson
Department of Sociology, Acadia University

RÉSUMÉ

Les données du Sondage sur la population active du Canada (1997) révèlent que relativement peu de femmes ayant atteint la ménopause donnent comme raison la mauvaise santé pour quitter leur emploi ou revenir à un emploi à temps partiel, ce qui suggère que le rôle de la mauvaise santé peut être négligeable dans les changements constatés dans les activités des femmes à la ménopause sur le marché du travail. Par contre, des entrevues auprès de 30 femmes à la ménopause (40 à 54 ans) illustrent que, bien qu'elles ne déclarent pas la maladie comme la principale raison les ayant incitées à quitter leur emploi ou à travailler à temps partiel, la santé est un facteur déterminant. Cette recherche trace aussi la relation complexe entre le travail et la mauvaise santé et indique que le stress lié au travail (en raison des baisses de financement et des changements de politique) a eu une incidence sur la santé mentale et physique de ce groupe de femmes à la ménopause, ce qui, à son tour, a influencé leur décision de modifier leurs activités sur le marché du travail. L'auteur conclut que les décideurs doivent reconnaître que la mauvaise santé peut être sous-déclarée par les femmes à la ménopause comme motif lors des sondages importants, et qu'il faut procéder à une recherche qui examine précisément les conditions de travail des femmes en ce qui a trait à leur santé. Une telle recherche ne devrait pas être basée uniquement sur les sondages importants, mais doit aussi comprendre des études qualitatives englobant les expériences des femmes.

ABSTRACT

Data from the Canadian Labour Force Survey (1997) reveal that relatively few mid-life women offer ill health as a reason for leaving their job or downshifting to part-time employment, implying that the role of ill health may be inconsequential in effecting changing patterns in mid-life women's labour force activity. In contrast, interviews with 30 mid-life women (aged 40 to 54 years) illustrate that, although they do not offer illness as their main reason for leaving their job or working part-time, health is a determining factor. This research also maps the complex relationship between work and ill health, showing that stressful working conditions (due to funding cuts and policy changes) affected the mental and physical health of this group of mid-life women, which, in turn, influenced their decision to change their labour force activity. The author concludes that policy makers must recognize that ill health may be under-reported among mid-life women in large surveys and that research is needed that specifically examines women's working conditions as they relate to health. Such research should not be based solely on large surveys but must also include qualitative studies that capture women's experiences.

* The author thanks the reviewers for their helpful comments.

Manuscript received: / manuscrit reçu : 17/08/05

Manuscript accepted: / manuscrit accepté : 25/07/07

Mots clés : vieillissement, femmes, ménopause, santé, emploi, méthodologie

Keywords: aging, women, mid-life, health, employment, methodology

Requests for offprints should be sent to: / Les demandes de tirés-à-part doivent être adressées à :
Zelda Abramson, Ph.D.
Department of Sociology
Acadia University
Wolfville, NS B4P 2R6
(zelda.abramson@acadiau.ca)

In this article, I examine the relationship between mid-life women's deciding about their continued labour force activity, on the one hand, and ill health, on the other. Data from the Canadian Labour Force Survey (LFS)[1] reveal that, in 1997, relatively few mid-life women (7.4% of women between the ages of 40 and 54) offer illness as their reason for job leaving. However, survey data may not fully capture the

extent and complexity of the way health influences women's decisions about their continued labour force participation. How do women interpret and answer fixed-category survey questions when their reasons for job leaving are multidimensional and interrelated? Using quantitative and qualitative data, I explore the role health plays in mid-life women's decisions either to exit the labour force or to downshift to part-time employment and the way they account for decisions about their labour-force participation. My overall purpose is to explore whether research that relies solely on survey data leads to under-reporting of the effects of ill health on mid-life women's labour-force participation.

Women, Work, and Health

Few studies examine the relationship between women's employment status and the effect of work on women's health, and even fewer examine the relationship between women's health, labour force activity, and age. One early study from Britain found that there was "no clear selectivity in labour force participation according to health status" for women who were younger than 40, but for women older than 40, health had a significant "impact on women's decisions" whether "to seek or leave a job and their ability to find or retain employment" (Arber, Gilbert, & Dale, 1985, p. 385).

Based on a sub-sample of the 1990 Ontario Health Survey, Burke, Stevenson, Armstrong, Feldberg, and Rosenberg (1992) concluded that women's pattern of labour-force participation—high rates of part-time employment, low wages, non-unionized jobs, and high unemployment rates—makes them "susceptible" to stress-related health problems. Dahl (1993, p. 1083) used data from a sample of approximately 4,000 Norwegian men and women to describe the triangular relationship among low socio-economic status, poor health, and labour force exit. She found that "mobility *out of* the labour market is health related and . . . employment status is divided along lines of health as well as of class".

Women, in general, are segregated into clerical and service industry jobs (Pierson & Cohen, 1995), which tend to be low paying and have stressful working conditions (Messing, 1998). The cause–effect relationship between stressful work and ill health has been difficult to establish (Kome, 1998), and compensation decisions generally have not favoured women (Messing, 1998). There are at least three possible explanations why linking women's stressful work to ill health is not straightforward. First, women's health problems are largely rendered invisible because workers' compensation systems only recognize health problems associated with men's traditional jobs. As a result, "a vicious circle" is created, "where women's occupational health problems are not taken seriously, therefore not recognized, therefore do not cost enough to matter" (Messing, 1998, p. 13). Second, rather than involving traumatic events, women's work often involves emotional work, exposing them to chronically stressful conditions that are more likely to have health effects in mid-life (Chung, Cole, & Clarke, 2000). Third, there may be a triangular relationship among women's work, home life, and health.

Researchers from Britain believe that, in order "to understand the impact of work and social roles on health, we must also consider social position and [the] level of control over resources that certain positions in society afford women" (Griffin, Fuhrer, Stansfeld, & Marmot, 2002, p. 784). A longitudinal study of British civil servants showed that a low level of control (based on latitude to make decisions) in both home and the workplace can lead to depression and anxiety: women who worked in the lowest grade jobs and also experienced a low level of control in their home lives were at significantly greater risk for depression than men "across all grades and women in higher grades" (Griffin et al., 2002, pp. 796–797). Overall, having little latitude to make decisions in the workplace, regardless of employment grade, can adversely affect health. Thus, the quality of the job experience may be as important as the type or status of a job (see also Reid & Hardy, 2000).

Ill health is a well-documented reason for retirement and is the most common reason for non-voluntary retirement, offered even more frequently than economic factors (McDonald & Donahue, 2000, p. 496). One explanation is that retiring for health reasons is socially sanctioned, exaggerating the health/retirement relationship (Laczko et al. as cited in McDonald, Donahue, & Moore, 1998; Ruhm as cited in McDonald et al., 1998). Yet, McDonald and Donahue (2000, p. 496) caution "that health limitations increase exits from labour force for other reasons, even for those who do not cite health as their reason for retirement". Overall, the literature on mid-life women's labour-force inactivity reveals that work can cause ill health and that the overriding reason for voluntary retirement is ill health. What continues to be unclear is the complex relationship between mid-life women's work, ill health, and the process of decision making regarding future labour force (in)activity.

Methodology

Some feminist theorists and researchers (Flax, 1987; Harding, 1987, 1991; Smith, 1987) are critical of

https://doi.org/10.3138/cja.26.4.295 Published online by Cambridge University Press

quantitative research for its gender bias and promotion of patriarchy. They argue, instead, for a qualitative method that focuses on the lives of individual women. For example, Smith (1987) posits that knowledge needs to be situated in women's experiences. She argues that the starting point of social inquiry is the exploration of the dailiness of women's lives in relation to their social, political, economic, and historical context.

Other feminist researchers recognize the biases associated with quantitative research but, in calling for diversity in feminist methodology, include quantitative methods (McCormack, 1994; McDonald, 1994; Reinharz, 1992). Bischoping (1993) believes that quantitative and qualitative methods, when used together, can enhance research analysis.

Rank (2004) similarly argues that there are numerous benefits to ''blending'' quantitative and qualitative methods, particularly in research that examines social and family experiences. Because it assigns numerical values to events, quantitative research on its own is seldom able ''to capture the overall context and underlying mechanisms behind predicted events'' (p. 92). While quantitative data offer generalizability and reliability, qualitative data provide ''richness and depth'' (p. 92).

In this article, I employ both quantitative and qualitative data to explore the effect of health on mid-life women's labour-force activity. First, I analyse a series of cross-tabulation tables based on data from the LFS—a household survey of members over the age of 15 that collects information on labour-market trends, including reasons for working part-time and for leaving last job. Respondents are able to check only one category for each variable.

Then I analyse in-depth interviews with 30 mid-life women—15 women who exited the labour force and 15 who shifted to part-time. They were interviewed in 1999 and 2000 and ranged in age from 40 to 59 (in all instances, these women had exited the labour force before they turned 56). The interview sample was drawn through a variety of methods. I posted fliers in social service agencies, hospitals, and community health centres. Fliers also were included in mailings of a newsletter of the Toronto Women's Health Network. I also posted notices on Web pages of the Toronto Women' s Health Network, *A Friend Indeed* (a newsletter for menopausal women), and an older women's network. Overall, the response to these postings was small; only three women contacted me. The most effective method was word of mouth or a snowball sampling. I chose a diverse group of women, representing various backgrounds, occupations, and socio-economic positions. No two women had the same employer. The interviews were either conducted face-to-face (1/3) or over the telephone (2/3), according to the personal preference of the interviewees. Initially, I was concerned about interviewing by telephone, fearing I would be unable to pick up on the body language of the interviewees and that the interview itself would be qualitatively poorer. These concerns proved to be unfounded. I did not notice any qualitative difference between the telephone and the face-to-face interviews, as the telephone interviews elicited rich and detailed information. The length of the interviews ranged from 30 to 60 minutes, with an average of 40 minutes.

The interview questions were open-ended and were designed to capture the complexity of the decision-making process. Because they focused on the decision-making process itself, the questions were more or less similar for exiters and women who had shifted to part-time. All interviews began with the question, ''If you were to respond to the LFS question 'reason for leaving last job' or 'reason for part-time', how would you answer this question?'' I read out the categories and asked them to choose *one* only. From there, the interviews followed a semi-structured format, insofar as questions were more open-ended and often went beyond those I had prepared. This approach allowed the interviewees to ''go with the material'' (Cockburn, 1991, p. 6). All interviews were tape-recorded, transcribed, and then read. The data were coded line by line, grouped by themes, and then filed into categories for analysis (Kirby & McKenna, 1989).

At the end of the interview, each woman was asked to fill out a brief questionnaire on personal characteristics such as age, marital status, and education. On the questionnaire, exiters were also asked to give the reason why they exited the labour force. This time they were able to choose more than one category. If more than one reason was offered, they were then asked to rank the reasons according to their relative importance.

Sample Description of In-Depth Interviews

Of the women interviewed who had exited the labour force, the majority were married (10) and had either older children (6) or no children living at home (5). Half were of British/Canadian origin, three were of Jewish origin, and two each were of European and of Black/Caribbean origins. Generally, these women were highly educated, lived in higher-income households, and had been employed in professional or managerial jobs. The sample, however, also included women who worked in clerical positions (5) and service industry jobs (1).

https://doi.org/10.3138/cja.26.4.295 Published online by Cambridge University Press

The sample of 15 women who had shifted to part-time employment differed considerably from the exiter sample. Two-thirds lived alone (4 had never been married and 6 had previously been married). As with the exiters, fewer than one third (4) had children under the age of 14. However, more than half (9) of the part-timers had no children living at home (compared with one third [5] of exiters).

The education level of part-timers was even higher than that of exiters. All but one had more than 14 years of education; of those, two thirds (10) had continued their education after they completed their undergraduate degrees. Also, the occupational distribution of part-timers was skewed toward higher-income jobs (10). Over half (8) lived in households with no other income (either they were single or they were the sole earners) and one fifth (3) lived in upper-income households (over $70,000). The part-time sample included mostly women of British/Canadian origin (11). The two other ethnic groups equally represented were women of Jewish and of Black/Caribbean origins (2 each, respectively). Finally, the mean age of the part-time women, like that of those who had exited, was 50 years.

Results

The Labour Force Survey—Exiters

The reasons women across all age groups offered for leaving their last jobs are presented in Table 1. Although job loss was common for all women, it was most prevalent for women aged 35–49 (51.4–51.7% by 5-year cohort). With increasing age, retirement was more prevalent (29.2%: 50–54 cohort; 42.5%: 55–59 cohort). Data from the 1997 LFS showed that relatively few mid-life women chose illness as their reason for leaving their jobs but proportionately more than for women in their thirties. The presence of illness as a reason for leaving the labour force did not increase with age,[2] but rather peaked in the 40–44 age group (10.7%)[3] and steadily decreased thereafter.

Reasons for working part-time were notably different for women in their forties than for those in their thirties (Table 2). Overall, the data conveyed that part-time work was an option preferred more by older rather than by younger women.[4] After the age of 40, the most prevalent reasons offered for part-time employment were *personal preference* and *business conditions* that led to job loss. *Personal or family responsibilities* (other than caring for children) were reported more frequently in the three age groups between 40 and 54 as compared to the other age groups. However, this never reached 10 per cent for any age group. Proportionately, few women in all age groups offered illness as their reason for part-time employment; however, with age, the percentages steadily increased, from 1.1 in the 30–34 age group to 4.5 in the 50–54 age group. In the oldest age group (55–59 years), the rate dropped slightly to 4.

The Interviewees

As in the results of the LFS data, only 1 of the women interviewed offered *illness* as her reason for leaving the labour force when only one reason could be offered. In this case, the woman was forced to leave her job and the labour force due to a late-onset, severe physical disability. But when interviewees were asked during the interview and in the questionnaire at the end of the interview what other factors had influenced their decisions to stop working, illness was not

Table 1: Reasons for leaving last job (for women who are out of the labour force) by age group (%)

Reason for Labour Force Exit	Age Groups					
	30–34	35–39	40–44	45–49	50–54	55–59
Other	7.0	7.6	7.1	6.1	2.9	2.5
Illness/Disability	4.9	6.1	10.7	8.3	7.8	7.7
Taking Care of Own Child	13.4	7.8	2.6	1.6	0.0	0.0
Pregnancy	7.6	4.2	1.2	0.1	0.0	0.0
Personal/Family Responsibilities	6.0	5.8	6.2	7.6	4.9	3.6
School	6.7	4.6	4.0	1.4	0.7	0.7
Job Dissatisfaction	4.4	5.3	6.1	6.2	3.5	3.2
Retired	0.6	0.2	1.4	6.2	29.2	42.5
Business Closed or Sold (Self-employed)	6.6	7.0	9.0	10.7	7.8	6.3
Lost Job	42.8	51.4	51.7	51.7	43.2	33.6
Total ($N = 13,786$)	100.0	100.0	100.0	100.0	100.0	100.0

Source: Labour Force Survey, 1997
$\chi^2 = 5,382.8$
$p < 0.000$

https://doi.org/10.3138/cja.26.4.295 Published online by Cambridge University Press

Table 2: Reasons for part-time employment by age group (%)

Reasons for Part-Time	Age Groups					
	30–34	35–39	40–44	45–49	50–54	55–59
Other	1.6	1.5	1.6	2.2	2.5	1.6
Illness/Disability	1.1	1.6	1.9	2.9	4.5	4.0
Caring for Own Children	42.2	35.3	19.6	7.1	2.0	0.5
Personal or Family Responsibilities	5.7	6.7	9.8	9.3	9.6	8.5
Going to School	2.8	1.7	1.0	0.9	0.5	0.3
Personal Preference	15.6	21.3	30.0	43.6	51.3	62.6
Business Conditions (Lost Job)	30.9	31.9	36.0	34.1	29.6	22.5
Total ($N = 57,463$)	100.0	100.0	100.0	100.0	100.0	100.0

negligible; 6 other women reported that concerns about their deteriorating health had shaped their decisions to leave their jobs and stop working altogether. The effect of illness was even more pronounced (7 of 10) if the 5 women who exited the labour force involuntarily (because of job loss) were excluded; none of them included illness as a factor. The reader might ask, ''Why interview?'' when multi-answer surveys can accomplish the same as interviews. But surveys only offer fixed categories that researchers construct. They are not always successful at capturing the range of responses or complexities that explain, in this instance, decision making.

The reports of interviewed part-timers are similar to those of exiters. When asked why they downshifted to part-time employment, no one offered illness as a reason. However, in response to further questions, many of the women indicated that ill health was an important factor influencing their decisions to reduce work hours.

Interviewees often attributed their ill health to the highly stressful work environment caused by workplace restructuring. Many reported that, at one time, they had flourished in their jobs, personally, intellectually, and politically. However, the changing provincial political climate of the 1990s, which brought deep financial cuts to social services, made working conditions intolerable for many of them (22/30). As agencies were reorganized, they found that they were no longer able to do their work in a meaningful way. For example, Betty (aged 45),[5] a senior manager, reported that jobs that once defined her and made her feel ''so positive and wonderful as if I were part of something that was creating world change'' became a source of never-ending stress at work and at home:

> I started to see what an effect it was having on the rest of my life. For so many years, I didn't feel there was a distinction between my work life and my personal life. One kind of flowed in a nice way into the other. I just started to notice how [the stress and the aggravation] was affecting my other life. I'm a fairly light person, lots of laughter, joy in my life. I would get into bad moods. I would snap at my husband. I would snap at my kid. I almost avoided some of my friends. So I started to get quite concerned about that.

The stress manifested itself in physical symptoms such as being ''sick all the time'' with colds, flu, ''anything going around''. Sleep disruptions meant chronic fatigue and, consequently, she ''kept eating and eating'' for energy and self-nurturing. After she gained forty pounds and began to fear that serious illness was around the corner, her husband encouraged her to leave her job. Initially, she resented and resisted his suggestion but eventually, she realized she had to leave.

A similar example is found in the story of Edna, a 54-year-old woman who retired early from her community-college teaching job because the work environment proved to be too taxing. Ultimately, she was ''forced to retire'' because of poor health, which she directly attributes to the restructuring of the college's work environment from an educative to a managerial model. The ensuing changes led to ''unremitting stress'': departmental meetings were hostile, teachers were becoming increasingly pressured and competitive, the departmental chair was demanding more work from the teachers, and the students were unappreciative. ''The manager became more important than teachers [and] students''. Under these deteriorating conditions, many factors converged at one time and place:

> My ninety factor came up . . . My mother was scheduled for her operation . . . Everything [in my body] was breaking down . . . I don't need this anymore. My mother needs me more than I need to take this crap. It was like everything was time for me to get out of there. I used the remaining sick leave I had and just said I'm leaving . . .

https://doi.org/10.3138/cja.26.4.295 Published online by Cambridge University Press

Edna's case is a good example of the triangular relationship among a woman's work, her home life (elder caregiving), and her health. The changing demographics of longevity, together with deep cuts to health care services, have shifted the burden of responsibility for managing care from the state to the family (Armstrong & Armstrong, 1996). Although, in recent years, men have participated more in caregiving, women (mostly at mid-life) provide the bulk of care (Zukewich, 2003). Edna's choice of retirement, however, occurred within the context of economic affordability. Given that she was entitled to her full pension in combination with other savings, retirement was an option. Without this financial cushion, other options might have been considered, such as looking for a new job or downshifting to part-time employment.

Indeed, a key factor in deciding whether to exit the labour force or shift to part-time employment is financial affordability, illustrating the triangular relationship among ill health, exiting, and part-time employment. Many of the part-timers also experienced the incessant stress of a politically charged work environment. Harriet (aged 51 years) explains,

> [T]here was a lot of people with a lot of anxiety and I think that anxiety was directed agency against agency or individual against individual. That's because the problem was so huge and unresolvable so it became non-healthy to work within that environment. I've always enjoyed the work that I've done so this was feeling different so I thought that it was a mental health issue. I just don't need this.

But, exiting was not an option as she had never worked in a job that offered pension benefits:

> So I'll need to do something that will generate income until either I get married, the dreadful prospect, or collect Canadian pension.

Carmen, a 52-year-old nurse who downshifted from full-time to part-time, explained that her decision to cut back on her hours of work was based on many factors: a long work history of being "badly treated", physically strenuous work, and the restructuring of the health care system:

> . . . because of the cut backs . . . some were forced to leave; some left because they found it too difficult to keep working. When all the staffing was cut and more responsibilities fell on their shoulders, their work load got heavier . . . I think it [is] worse [with] age because you start to have wear and tear at an earlier age than you might otherwise. I'm definitely finding it harder and harder as I'm aging to accommodate myself to the physical aspect of the work place . . . My joints aren't really holding up to the battering they take at work.

Carmen did not "foresee" ever working full-time again. But not living with a partner meant that her only "worry" was "how much longer I'm going to have to work to maximize my pension benefits".

The majority of part-timers interviewed were single (either never married or previously married) and would have preferred to stop working if they had had the financial means (age 55):

> I can't afford not to work. The joys of community jobs are no pension. Most of my working career was at or below the poverty line . . .

The compensation for a (financially) lower standard of living was living a more peaceful and meaningful life, in good health:

> I guess money's not the most important thing to me: quality of life is. And in the last several years I've been sick a lot, just colds and run down. I think it's stress related . . . I'd rather live on less money and be more relaxed and enjoy my life more and not be so stressed out all the time . . .

Indeed, for many, health improved dramatically once they stopped working. But the trek to good health, according to Betty (age 45), was not an easy one:

> I felt like I was being born again or born back into something I remembered . . . It was just amazing. Staying tired or staying sick, the physical stuff took years to recover from. I still feel some things are not quite right, but . . . [I now] have so much more to give everyone, to give my dog, to give my husband, to give my neighbour next door who is fairly elderly and can't shovel her snow. I don't think I noticed how much I had tunnelled my vision and cut off my world just to be able to cope in that environment. I just felt like I was waking up again . . .

Edna believes that if she had not retired, "I would have probably been dead by now because I was really in a bad state". Currently, however,

> I have won my energy back. That's it. I have returned to my own imagination . . . At this point in my life I feel that I'm the healthiest I've ever been and that I have more options if I so choose . . . I'm a new person.

The interviews illustrate that the decision to change labour-force activity at mid-life is not one-dimensional, and large surveys do not always capture the complexity of the decision-making process. From the onset of each interview with exiters—when women were asked their reason for leaving their last job—it was apparent that explanations could not easily or effectively be reduced to a single reason:

> It's a mix of several but I'll say the "personal and family" one . . . Partly for my own health and the

https://doi.org/10.3138/cja.26.4.295 Published online by Cambridge University Press

> amount of stress that I can or cannot manage. Partly, I just made the decision to not do as much paid work and do more volunteer work and that had to do with that kind of work appealing to me more and it just gave me a better sense of myself and my place in my life. (52-year-old married woman working as freelance writer)
>
> I was burned out. I mean, perhaps illness, but if it was illness, it was illness in direct relation to the job. (45-year-old married woman who worked in senior management and offered ''other'' as her reason for job leaving)
>
> I retired. I could have stayed on. I had an illness/disability. I was quite ill for the last year of work and well into the next few years . . . the fibromyalgia I have now is a product of extra stress. Extreme unremitting stress over a long period of time . . . a lot of work-related stress. (54-year-old divorced woman who had ''retired'' as college teacher)

Women who shifted to part-time employment also, when first asked, wavered at isolating one reason: ''I guess I have to say it's personal preference''; ''Originally, it would have been 'other' and subsequently/partially it becomes caring for family members''; ''It's kind of a mix''; ''personal preference plus also my son is mentally challenged and I choose, actually I prefer to be at home with him''; and ''It's actually a lot of those things''.

Discussion

When compared with the LFS data, the qualitative and quantitative (the end-of-interview questionnaire) data obtained from 30 mid-life women reveal that health is quite often a major contributing factor in decisions to change labour-force activity. The interviews and questionnaire, which offered the opportunity to give more than one reason, extended our understanding of labour-force exit and decreasing hours of work. Responses to the end-of-interview questionnaire could have been influenced by the interview process, but I would argue that this was not the case, as, from the onset, when women were asked to give only one response, many immediately said that it was difficult to reduce reasons that were complex to one answer. Although a multi-answer approach could be incorporated into larger social surveys, qualitative data from interviews allow a deeper exploration of the decision-making process and the ways that reasons are linked to one another.

Health is a factor that women must assess and weigh against other concerns, such as difficult working conditions, financial affordability, and, where relevant, the needs of their family. If exiting is unaffordable, part-time employment is one way to balance health concerns and household economics. One way of accounting for the labour-force participation decisions made by these women is that part-time employment may become more viable during the mid-life years because household dynamics have changed and economic burdens have been reduced now that the children are no longer living at home. Consequently, working women may be able to exercise agency in the health–work trade-off in ways they were unable to even a decade earlier. A second possibility is that the expansion of part-time employment in the job market in the late 1980s and early 1990s[6] provided labour-market options unavailable in earlier time periods. Depending on the severity of the illness, some women could accommodate working reduced hours. In this way, part-time employment provided a balance between caring for their health and financially contributing to their families. However, should part-time work not be an option, there may be no choice but to stop working altogether.

The stories shared by these women illustrate the adverse effects that their work has had on their health. Yet, they were reluctant to categorize their reasons for changing their labour-force activity as *illness* and instead chose *retirement* or *other* as their reason. Perhaps mid-life women are inclined to choose an umbrella category, such as other or retirement, over illness because it captures an array of reasons. Alternatively, they may perceive retirement as a more palatable choice than illness (McDonald & Donahue, 2000). Possibly, they associate illness with hegemonic medical beliefs that historically have constructed them as weak and unhealthy (see Coney, 1994; Cobb, 1993; Ehrenreich & English, 1978; Gullette, 1997; McCrea, 1983; McKinlay & McKinlay, 1986; Mitchinson, 1991; Tilt, 1857), and mid-life women may reject any label that implies they are weak and disadvantaged.

Thus, the LFS could be improved markedly by including additional work-related health categories, such as *stress* and *burnout* and by allowing respondents to select multiple reasons for their decisions. However, such a survey is unable to capture the complex decision-making processes that respondents assign to their choice of category and that are revealed in qualitative interviews. The conundrum is that policy makers rely on large databases (such as the LFS) to guide program development. If ill health is not identified (or is under-reported) as a reason for leaving the labour force or shifting to part-time work, then the effects of work on health and thus of health on decisions about work are masked, and women's work-related illnesses go unrecognized. The under-reporting of illness contributes to the

https://doi.org/10.3138/cja.26.4.295 Published online by Cambridge University Press

already challenging task of establishing links between women's work and ill health: ''decision-makers are reluctant to believe that women's jobs can make them ill'' (Messing, 1998, p. 17). Women's pattern of labour-force participation—high rates of part-time employment, low wages—differs from that of men and puts them at risk for stress-related health problems (Burke et al., 1992). Because women juggle home and work lives, isolating the source of stress becomes more difficult (Chung et al., 2000). Without such validation, the cause–effect relationship between women's work and health cannot totally be established.

The stories of these women are particularly illuminating because they capture the causal relationships between work and ill health. Initially, doing meaningful work meant feeling healthy. But when funding and policy changes (downsizing) were introduced in their workplaces, work became stressful and, ultimately, had adverse effects on their health. Their poor health became the catalyst that led to changes in labour-force activity. Finally, their health improved once they either stopped working or worked less.

The voices of the women interviewed forewarn that stressful working conditions can seriously affect women's mental and physical health. Their experiences should not go unnoticed. The decision either to leave the labour force or to reduce hours of work can be long and drawn out, often involving a multitude of factors. An abbreviated labour-force history or a reduction of work hours predetermines mid-life women's pension prospects. Some women will not be eligible for any pensions, while others will only qualify for a reduced pension. For these reasons, qualitative research is needed to examine women's working conditions, the relationships of these to health, and the decisions that mid-life women make about work.

Notes

1 Raw data from this survey was made available in an SPSS data file.

2 Data from the 2005 LFS revealed reporting of illness as a reason for leaving last job similar to that of 1997. In fact, proportionately fewer (6.9%) mid-life women—between the ages of 40 and 54—offered illness than in 1997 (7.4%).

3 The striking results of the 40–44 cohort in 1997 continue to be baffling. Although 1997 may very well have been an anomalous year, as this pattern was not replicated in earlier Labour Force Surveys, a similar observation of health-related exits in the 40–44 cohort was observed in Ginn and Arber's (1996) research in Britain. More investigation, therefore, is warranted to determine whether, in recent years, women in their early forties have experienced unusually high levels of ill health and, if so, why.

4 Rates of downshifting to part-time employment due to illness were substantially higher in 2005 than in 1997. The 2005 rates for mid-life women were, for ages 40–44 (3.9%); 45–49 (5.1%); 50–54 (6.0%).

5 Pseudonyms have been used to identify all interviewees.

6 Part-time employment increased by 27% between 1981 and 1989, compared to an 11% increase in full-time employment (Duffy & Pupo, 1992, p. 44).

References

Arber, S., Gilbert, G.N., & Dale, A. (1985). Paid employment and women's health: A benefit or a source of role strain? *Sociology of Health and Illness*, *7*(3), 375–400.

Armstrong, P., & Armstrong, H. (1996). *Wasting away: The undermining of Canadian health care*. Toronto: Oxford University Press.

Bischoping, K. (1993). Integrating qualitative and quantitative methods in a study of knowledge about the holocaust. *American Statistical Association: 1993 proceedings of the section on survey research methods* (Vol. 2, pp. 999–1003) Alexandria, VA: American Statistical Association.

Burke, M., Stevenson, H.M., Armstrong, P., Feldberg, G., & Rosenberg, H. (1992). *Women, work, and health inequalities: An analysis of the 1990 Ontario Health Survey.* (Report to the Ontario Ministry of Health). Toronto: York University Centre for Health Studies.

Chung, J., Cole, D., & Clarke, J. (2000). Women, work and injury. In T. Sullivan (Ed.), *Injury and the New World of Work* (pp. 69–90). Vancouver, BC: UBC Press.

Cobb, J. (1994). *Understanding menopause*. Toronto: Key Porter.

Cockburn, C. (1991). *In the way of women: Men's resistance to sex equality in organizations*. Basingstoke, UK: Macmillan.

Coney, S. (1994). *The menopause industry: How the medical establishment exploits women*. Emeryville, CA: Hunter House.

Dahl, E. (1993). Social inequality in health: The role of the healthy worker effect. *Social Science and Medicine*, *36*(8), 1077–1086.

Duffy, A., & Pupo, N. (1992). *Part-time paradox: Connecting gender, work and family.* Toronto: McClelland and Stewart.

Ehrenreich, B., & English, D. (1978). *For her own good: 150 years of the experts' advice to women*. New York: Doubleday.

https://doi.org/10.3138/cja.26.4.295 Published online by Cambridge University Press

Flax, J. (1987). Postmodernism and gender relations in feminist theory. *Signs*, *12*(4), 621–643.

Ginn, J., & Arber, S. (1996). Gender, age and attitudes to retirement in midlife. *Ageing and Society*, *16*, 27–55.

Griffin, J., Fuhrer, M.R., Stansfeld, S.A., & Marmot, M. (2002). The importance of low control at work and home on depression and anxiety: Do these effects vary by gender and social class? *Social Science and Medicine*, *54*(5), 783–798.

Gullette, M.M. (1997). Menopause as magic marker: Discursive consolidation in the United States and strategies for cultural combat. In P. Komesaroff, P. Rothfield, & J. Daly (Eds.), *Reinterpreting menopause: Cultural and philosophical issues* (pp. 176–199). New York: Routledge.

Harding, S. (1987). *Feminism and methodology.* Bloomington: Indiana University Press.

Harding, S. (1991). *Whose Science? Whose knowledge? Thinking from women's lives*. Ithaca, NY: Cornell University Press.

Kome, P. (1998). *Wounded workers: The politics of musculoskeletal injuries*. Toronto: University of Toronto Press.

Kirby, S., & McKenna, K. (1989). *Experience research social change: Methods from the margins*. Toronto: Garamond Press.

McCormack, T. (1994). *New faces of science: Post Harding—standpoint theory and the social sciences*. Unpublished manuscript.

McCrea, F.B. (1983). The politics of menopause: The ''discovery'' of a deficiency disease. *Social Problems*, *31*(1), 111–123.

McDonald, L. (1994). *The women founders of the social sciences*. Ottawa: Carleton University Press.

McDonald, L., & Donahue, P. (2000). Poor health and retirement income: The Canadian case. *Ageing and Society, 20*, 493–522.

McDonald, L., Donahue, P., & Moore, B. (1998, April). *The economic consequences of forced retirement due to poor health* (IESOP Research Paper No. 29). Hamilton, ON: McMaster University.

McKinlay, S.M., & McKinlay, J.B. (1986). Aging in a ''healthy'' population. *Social Science and Biosocial Science*, *28*(2), 108–115.

Messing, K. (1998). *One-eyed science: Occupational health and women workers*. Philadelphia, PA: Temple University Press.

Mitchinson, W. (1991). *The nature of their bodies: Women and their doctors in Victorian Canada*. Toronto: University of Toronto Press.

Pierson, R.R., & Cohen, M.G. (1995). *Canadian women's issues: Vol. 2. Bold visions: twenty-five years of women's activism in English Canada*. Toronto: James Lorimer.

Rank, M.R. (2004). The blending of qualitative and quantitative methods in understanding childbearing among welfare recipients. In S.N. Hesse-Biber, & P. Leavy (Eds.), *Approaches to qualitative research: A reader on theory and practice* (pp. 81–96). New York: Oxford University Press.

Reid, J., & Hardy, M.A. (2000). Multiple roles and well-being among midlife women: Testing role strain and role enhancement theories. *Journal of Gerontology: Social Sciences*, *56B*(1), S329–S339.

Reinharz, S. (1992). *Feminist methods in social research*. Oxford: Oxford University Press.

Smith, D. (1987). *The everyday world as problematic: A feminist sociology.* Toronto: University of Toronto Press.

Tilt, E.J. (1857). *The change of life in health and disease: A clinical treatise on the diseases of the ganglionic nervous system incidental to women at the decline of life*. (2nd ed.) London: John Churchill.

Zukewich, N. (2003, Autumn). Unpaid informal caregiving. *Canadian Social Trends*, *70*, 14–18. (Statisitics Canada—Catalogue No. 11–008).

https://doi.org/10.3138/cja.26.4.295 Published online by Cambridge University Press