

Topic 5. Gender and Work in Health Inequalities

Gender Disparities in Health: Strategic Selection, Careers, and Cycles of Control

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This article proposes a dynamic model of the intersections between gender, health, and the life course incorporating processes of strategic selection—of roles, relationships, and behavior. Men and women make decisions within a tangled web of multilayered, often contradictory, and frequently outdated institutional contexts of opportunity and constraint. Both their decisions and the institutions shaping them reflect prior as well as ongoing socialization and allocation mechanisms. These institutionalized scripts and regimes tend to reproduce gendered biographical paths around two central life foci: paid work (or careers) and unpaid family work (or careers). The gendered nature of occupational and family-care paths, in turn, produces patterned disparities in a constellation of health-related resources, relationships, and risks, as well as feelings of mastery and control. We call for research charting alternative constellations of these gendered health careers, their antecedents, temporal patterning, and consequences.

WHEREAS both health and gender depend on biological circumstances, they are also socially constructed (Lorber & Moore, 2002). And each is related to the other, such that women tend to live longer than men (at birth their life expectancy in the United States is 5 years greater; see Kochanek & Smith, 2004) but typically experience more stress, poorer health, and more years with disabilities along the way [see, e.g., Crimmins & Saito, 2001; Jans & Stoddard, 1999; Kessler et al., 1994; Kochanek & Smith, 2004; Lorber & Moore, 2002; Mirowsky, 1996]. Gender disparities in health are more complicated and nuanced than suggested by biological or medical explanations alone.

We develop in this article a model of strategic selection, that is, the ways choice and constraint operate such that the links between health and gender are socially constructed, sustained, and changed. In doing so, we elaborate on key life course concepts and advance others to capture both micro-level and macro-level forces. Specifically, we highlight institutional arrangements (higher education, health care, occupational, and retirement policies and practices) shaping processes of strategic selection, resulting in identifiable patterns of biographical pacing of the adult life course, as well as people's corresponding sense of control over their lives. We invoke the concept of "career" to capture health trajectories and individual biographies as they unfold in dynamic interaction with institutions, relationships, and prior experiences (Aneshensel, 1999; Moen, 2005).

We consider health not in the cross section or as baseline-endpoint relationships, but as gendered health "careers," that is, identifiable trajectories and transitions in health and well-being. Thinking about health "careers" captures continuity and change in life chances and life quality over biographical (and biological) time. But the notion of health careers is a function of historical time as well, pointing to the importance of technological and medical advancements and life style shifts,

as well as social policies and practices allocating health care and health behaviors. The career concept embodies structure as much as process, in terms of the health delivery system, patterned age and gender expectations, and consequent behavior (see Pavalko & Woodbury, 2000). We focus as well on occupational careers and career and retirement mystiques as both metaphors and organizing principles, providing conceptual and methodological guidance to understanding the ways institutions legitimate expected age and gender paths, as well as differences in resources, power, and participation (Moen & Roehling, 2005).

We theorize about the gendered life course (Moen, 2001; Moen & Altobelli, 2005; Moen & Spencer, 2005), that is, the ways that gender plays out (1) in existing, historically established institutional arrangements; (2) in men's and women's strategic selection of roles and relationships over the life course, resulting in gender differences in both biographical pacing and perceived control; and (3) in linked lives, the ways relationships produce interlocking roles and behavior. The resulting constellation of gendered experiences, opportunities, and constraints produces age-related health disparities between men and women.

INSTITUTIONAL FORCES AND LAGS

Mayer (1986, p. 167) describes institutional careers as the orderly flow of persons through segmented institutions. These age and gender segmentations and scripts construct expectations and options throughout the life course. Age-graded policies and practices produced a lock-step occupational career path (first full-time education, then full-time [or more] employment, then full-time retirement; see also Kohli, 1986). Such a framework, based on the notion of an (occupational) status sequence (Merton, 1968), is how sociologists and economists have usually characterized the typical (male)

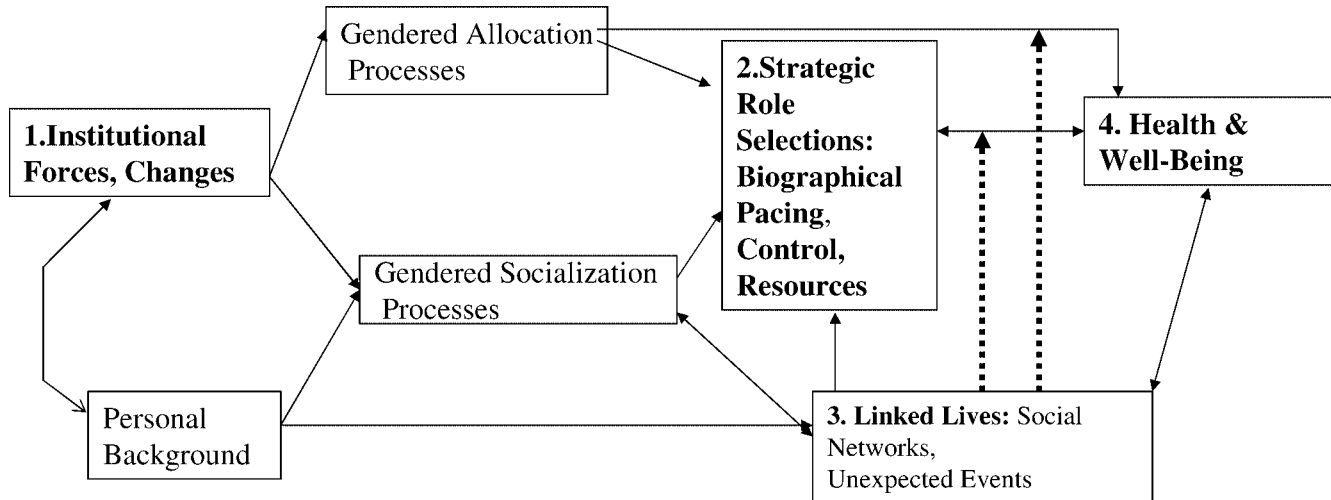


Figure 1. Strategic selections: gendered occupational and health careers.

biography in the post-World War II economy. But women's life paths tend to be neither orderly nor neatly segmented. Rather, women have always tended to move in and out of education, employment, and community roles, often in conjunction with changing family-care obligations and/or accommodating their husbands' job-related moves.

Women's and men's roles and resources are socially constructed as a consequence of a number of institutionalized cultural frames: the feminine mystique, assuming that the roles (and responsibilities) of being wives and mothers are key to women's fulfillment (Friedan, 1963); the career mystique, assuming that the roles (responsibilities) of employee and breadwinner are key to men's fulfillment; and the retirement mystique, assuming that the role (without responsibilities) of retiree comes with economic security and full-time leisure, a well-deserved reward for a lifetime of paid work (Moen & Roehling, 2005). Although the women's movement showed the feminine mystique to be a false myth, its vestiges remain in cultural scripts and institutional arrangements assigning women primacy in family care work. The career mystique is a false myth as well, never a reality except for mostly middle class, mostly White, men in the middle of the 20th century. The career mystique and the retirement mystique are based on the lock-step notion of paid work and one-way, irreversible retirement, but with the backup of full-time homemakers who never "retire." Still, these myths remain part of the cultural landscape, now pursued by women as well as men, in addition to their family responsibilities. But these cultural schemas are being challenged by the uncertainties and ambiguities produced by a competitive information economy with a global work force, wherein seniority no longer means job (or financial) security, health care and pensions are being scaled back, employees are expected to work harder, and concerns about social security occupy center stage in domestic policy debates.

These taken-for-granted gendered scripts and stereotypes may be out of date but nevertheless continue to shape contemporary society in the form of institutionalized rules, regulations, and expectations (Lorber & Moore, 2002; Moen & Roehling, 2005). A number of life course scholars (e.g., Chudacoff & Hareven,

1979; Kohli, 1986; Mayer, 1986; Moen, 1998, 2003; Moen & Roehling, 2005; Riley, 1987; Riley & Riley, 1994) have pointed to occupational careers as providing the organizational blueprint for the life course. Although these are now outdated blueprints, cultural relics of a very different work force, a very different economy of the 1950s and 1960s, and very different gender expectations, the rules and routines they spawned are still in force. One consequence is a hurried society with too much to do and too little time. Today, all "prime age" adults in the household—men and women—are increasingly in the work force, with few men and virtually no women having the backup of a full-time homemaker. Contrast this with a "retired" force that may be busy but with little meaningful to do and no culturally defined obligations and expectations. Both the work force and the retired force are impacted by today's global information economy that makes jobs more demanding, retirement increasingly a result of corporate restructuring, and both paid work and retirement less secure.

These macro-level forces have important implications for health (see "1" in Figure 1). Consider the transformation of the work force and of families, such that now most employees are members of two-earner households. Studies show that engaging in employment can be a source of health and well-being for women as well as men (Barnett, 1995; Barnett & Brennan, 1997; Barnett, Raudenbush, Brenna, & Pleck, 1995). But it also creates strains and overloads, especially for women, given their additional responsibilities for family care (see Hochschild, 1989; Menaghan, 1989; Moen, 2003; Roxburgh, 1996; Simon, 1995; Thoits, 1986).

The stresses built into particular role combinations, such as simultaneously managing paid work and unpaid care work, reflect time and effort demands. But paid work is also a source of resources. A growing body of research points to the positive physical and psychological impacts, for women as well as men, of employment. Paid work provides a sense of routine, purpose, and identity; it is also a source of capital (human, social, economic). Some jobs provide as well a wide degree of decision latitude (autonomy and control on the job). The positive aspects of employment are especially evident under

working conditions that promote such a sense of control (e.g., Adelman, Antonucci, Crohan, & Coleman, 1990; House, Stecher, Metzner, & Robbins, 1986; Lennon, 1994; Ross & Mirowsky, 1995; Sorenson & Verbrugge, 1987). By contrast, unstable work conditions are related to poor health (Hibbard & Pope, 1993; Jahn, Becker, Jöckel, & Pohlabein, 1995). Men are more apt than women to be in jobs with greater degrees of discretion and flexibility. And men tend to plan more for the future and to have a higher sense of personal control, both of which have been linked to emotional well-being (Prenda & Lachman, 2001).

Thus, one way that gender “matters” for health is in men’s and women’s different locations in the social fabric of institutionalized roles, resources, relationships, and risks. Clearly, gender has direct effects on the incidence, timing, and duration of roles, as well as the combination of roles (role constellations) people hold, with corollary health implications. For example, homemaking is invariably a role occupied by women. Studies show that women who are homemakers tend to have higher depressive symptoms than women (or men) engaged in paid work (Repetti, 1998).

Men and women can experience distinctive health impacts even when occupying the same roles or role constellations. This role context approach (Moen, Dempster-McClain, & Williams, 1989; Musick, Herzog, & House, 1999; Spitze, Logan, Joseph, & Lee, 1994) suggests that particular roles may have beneficial or detrimental effects depending on other circumstances (such as the gendered experiences and expectations men and women bring to them and the match or mismatch between demands and resources at various stages of their lives). For example, employed women are more apt than employed men to feel overworked and overwhelmed by the amount of work they have to do, to be working more hours than they prefer, to work on too many tasks at the same time, and to be interrupted often at work (Galinsky, Kim, & Bond, 2001). Thoits (1986) attributes women’s greater psychological distress to their combining employment with other obligations.

Studies by Rosenfield (1989) show how mental health differences between men and women can be explained by women’s typically higher role overload and lower relative earnings (power), operating through women’s lower sense of mastery and personal control. Lennon (1989) also discusses how men’s and women’s biographical experiences and cultural scripts shape norms that regulate responses to stressors, with women more likely to become depressed and men more likely to express stress outwardly, such as engaging in deviant behavior. These differences help to develop gender-typical responses to stress.

Ross and Bird (1994) also find gender differences in the life styles of men and women, differences that affect health (in their study of a representative sample of 2,031 individuals aged 18–90 years in 1990). Based on a multitude of life style indicators (income level, work status, work rewards, sense of control over life decisions, and general distress) [health was assessed by self-report on a 4-point scale; psychological distress was measured based on anxiety levels and an absence of positive emotions], Ross and Bird conclude that there are significant differences in lifestyle practices and that this does, in fact, affect health outcomes. For instance, men generally report their work as being more rewarding, having more time to exercise, and

having greater incomes. Men also are more apt to report being in better health than women. Ross and Bird suggest that gender inequalities in the workplace, along with corresponding social psychological distress, explain part of men’s health advantage over the life course.

Retirement from the paid labor force is often a consequence of poor health, but retirement itself is not necessarily linked to subsequent poor physical or emotional health—for either men or women (Bossé, Aldwin, Levenson, & Ekerdt, 1987; Ekerdt, Baden, Bossé, & Dibbs, 1983; Moen, Fields, Quick, & Hofmeister, 2000). In their survey of individuals aged 50–70 years, Herzog, House, and Morgan (1991) found that both men and women who stopped work and felt they had little or no choice (28% of those not working) reported lower levels of health and well-being compared with both those voluntarily retired and those working the amount of time they would like.

We argue that the occupational career and the family-care career constitute institutional arrangements that perpetuate gendered disparities in stress but also in access to “good” jobs (those with decision latitude, for example) and health resources (health insurance, adequate income, a sense of well-being) and “good” retirements (by choice, having economic security and opportunities for social participation). These factors can contribute to a lifetime of cumulative advantage for some (often men) and a lifetime of cumulative disadvantage for others (often women, as well as men not able to sustain employment in the primary work force; e.g., Hardy & Shuey, 2000; Heath, Ciscel, & Sharp, 1998; Lopata, 1994; Moen, 1996a,b, 1998; O’Rand, 1996).

To summarize, despite remarkable advances in gender equality, the life courses of men and women remain distinctly different, multilevel phenomena, both shaping and shaped by a number of institutional forces and processes: large-scale public policies; cultural, economic, medical, and demographic trends and lags; organizational practices and policies; family exigencies and resources; individual circumstances, abilities, and dispositions. Societal norms and practices remain grounded in the breadwinner/homemaker bifurcation of paid and unpaid work and in the lock-step tripartite division of education, employment, and retirement (Moen & Roehling, 2005; Riley & Riley, 1994). The inherent multiplexity of women’s life courses poses a challenge to conventional conceptualizations of links between health and life pathways, as institutional arrangements around paid work (and work characteristics) and retirement are grounded in the typical (and for most, outdated) mid-20th century male life path. This sustains a complex web of gendered and age-related opportunity structures, networks, and identities, producing and perpetuating differences between men and women in health, health-related behaviors, and well-being.

STRATEGIC SELECTION, BIOGRAPHICAL PACING, AND CONTROL

Women’s and men’s life courses are products of individual action as well as institutional and historical forces. Thus, a second process careers, including health careers, reflects changing mechanisms and pathways of attainment. Careers are what Pearlin (1988, p. 259) describes as “durable arrangements that serve to organize experience over time.” It is

precisely this organized experience that affects how individuals see and define their circumstances and act to preserve or change them. Women and men, as purposive actors, make strategic choices about role and relationship involvement as well as using formal and informal health care and other health-related behaviors. These, along with other decisions, directly and indirectly shape the gendered health course. We term these decisions processes of strategic selection (see “2” in Figure 1), in that people make adaptations to meet their goals or needs in the face of a moving platform of multilayered change (in the economy, in the labor market, in gender expectations), and outmoded cultural and institutional arrangements (the career mystique and the retirement mystique) out of step with life in the 21st century. Strategies may be conscious choices, but they invariably reflect a lifetime of socialization about taken-for-granted aspects of living; the cultural scripts that perpetuate gender and occupational expectations for men and women (e.g., Moen & Orrange, 2002; Moen & Wethington, 1992; Pavalko & Woodbury, 2000). There are as well (often unrecognized) allocation mechanisms (recruitment, hiring, retention, discrimination) that channel men and women into distinctive jobs. These processes—socialization, allocation, and strategic selection—produce a distinctive biographical pacing of roles and routines over the life course. The concept of biographical pacing combines both macro and micro forces shaping lives. It also incorporates the notion of timing: When a particular transition (e.g., parenthood, retirement, a major illness) occurs has major implications for the subsequent life course (Elder, 1998; Elder, George, & Shanahan, 1996).

What scholars increasingly find in both men’s and women’s biographies are more discontinuities than continuities—in families, in paid work, across the generations, and in personal experience and development (Elder & O’Rand, 1995; Han & Moen, 1999a,b; Moen & Han, 2001a,b; Pavalko & Smith, 1999; Rindfus, Swicegood, & Rosenfeld, 1987; Settersten & Mayer, 1997). Women—and growing numbers of men as well—are moving in and out of roles—in families, in the workplace, and in educational institutions—at unprecedented rates. Both women and men are increasingly likely at some stage of their lives to experience the dislocations of divorce, single parenthood, unemployment, and geographic mobility as well as the time squeeze and psychic strains of two-job families and/or the caregiving of young children as well as aged or infirm relatives.

A focus on biography points to the importance of individual differences in both genetic endowments and early experiences that play out throughout the life course. Our life course theory of strategic selection also incorporates social time, that is, the socially constructed and institutionalized entry and exit portals into and out of various roles and relationships at various ages and stages, and for particular subgroups of the population. This is what Riley, Johnson, and Foner (1972) refer to as the age stratification system.

We believe that strategic selection processes involve a gender stratification system as well. Men’s and women’s strategic selections of roles and relationships produce distinctive life courses, including differences in resources and risks at all life stages (see Moen, Fields, Quick, & Hofmeister, 2000; Moen & Wethington, 1999; O’Rand & Henretta, 1999; Settersten & Mayer, 1997). This is especially evident in the incidence,

timing, and duration of paid work and unpaid care work. Men are likely to follow the conventional career mystique (Moen & Roehling, 2005) of long-hour, paid work from the time they complete their schooling until the time they retire. Women also follow gendered scripts, typically as the major care providers of children as well as ailing or infirm spouses, parents, and other relatives. These care responsibilities constrain their occupational career possibilities as well as their retirement paths (Bianchi & Spain, 1996; Moen, 2003; Pavalko & Artis, 1997; Pavalko & Woodbury, 2000; Swisher, Sweet, & Moen, 2004).

Strategic selection and biographical pacing also capture perceptions of control (see “2” in Figure 1). This is key, given the vast literature showing a sense of personal mastery or control as a key moderator of stress and facilitator of psychological well-being (Bandura, 1989; Gecas, 2003; Mirowsky & Ross, 1986, 1989; Peterson, 1999). Pearlin, Menaghan, Lieberman, and Mullan (1981, p. 340) define personal control or mastery as “the extent to which people see themselves as being in control of the forces that importantly affect their lives” (also Pearlin & Schooler, 1978). In part, a subjective sense of mastery reflects persons’ resources as sufficient to their needs or the demands in their lives. Our control cycles approach (Elder, 1985; Moen & Yu, 2000) charts the distribution of claims (demands, needs, risks) and resources over the life course (Figure 2). One way that the occupational career as an organizational blueprint has contributed to gender disparities is in the differential power, status, earnings, and other resources men and women accrue. For example, health insurance, pensions, unemployment insurance, disability insurance, and Social Security all rest on the edifice of the (male) lock-step life course. [Consider the fact that women in the United States are smoking at a much greater rate, almost catching up to women in Europe. Comparative analysis is instructive as to the cultural complexities around gendered behaviors. For example, in Vietnam, 50% of men smoke, but only 3.4% of Vietnamese women do so (World Health Organization, 2003). The World Health Organization notes that this reflects socially constructed gender norms and social disapproval of Vietnamese women as smokers, not health concerns.]

The notions of control cycles (Elder, 1985; Karasek & Theorell, 1990; Moen & Yu, 2000) and capital (human, cultural, social, economic) are important factors in understanding the distribution of health and well-being by gender and age. Gaps between resources and needs (or expectations) occur both on home and on job fronts, with individuals and families at more or less risk at various life stages. “Needs” or “demands” at home include both time requirements (for caregiving of older relatives and children) as well as income requirements (for housing, health care, food, and other costs of living) and a sense of security. “Needs” or “demands” at work include the requirements of long hours, shift work, frequent travel, and arduous (physical or mental) job conditions. Resources can include human/cultural capital (education, autonomy and perceived control, information, workplace flexibility, initiative), social capital (family, friends, community ties, coworker relationships, supportive supervisors), and economic capital (income, pensions, job security). Individuals feel they are in charge of their lives (what is termed a sense of mastery or perceived control) when resources are adequate to meet needs or demands.

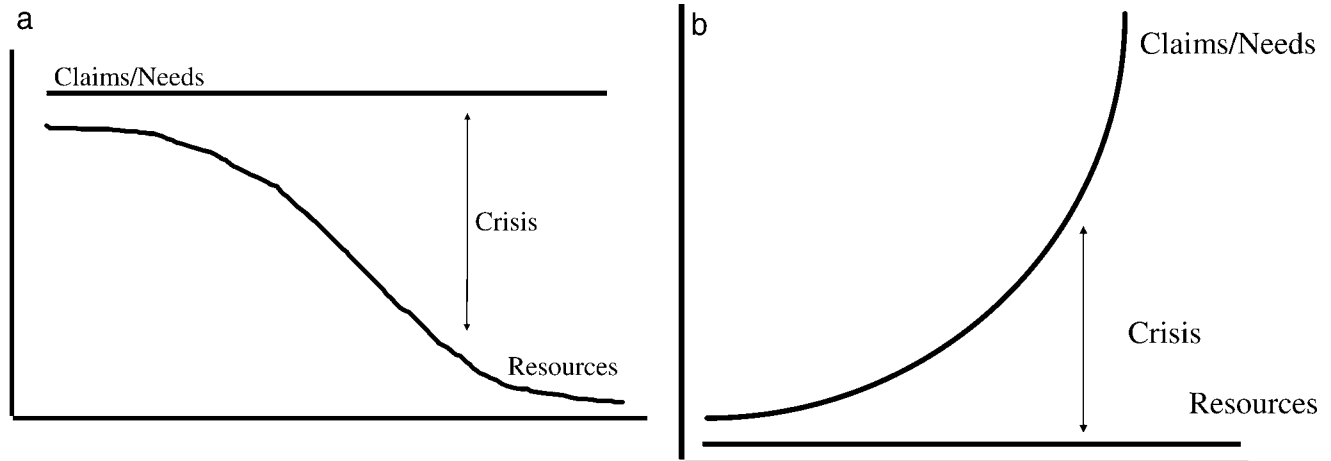


Figure 2. Strategic selections and cycles of control. **A**, Spiraling claims. **B**, Declining resources.

Investigators are continuing to document the complexity of the gendered links between roles, relationships, and well-being as they play out over the life course. For example, the disparities between men and women in mental health problems narrow with age, suggesting that a cycles of control model fits better than a cumulation of advantage one (National Survey on Drug Use and Health, 2002).

Both paid work (as a result of downsizing and restructuring) and parenting (as a result of the push toward intensive mothering and insights from child development) are increasingly “greedy” institutions (see Coser, 1974; Hays, 1996; Moen, 2003; Moen & Roehling, 2005; Townsend, 2001). Tensions play out (in long-term as well as day-to-day strategic adaptations) as women seek to meet—and integrate—their work and family obligations, and men seek to provide economically for their families while also being available to their children.

Relationships between work and health as they develop across occupational careers and health careers are both complex and interdependent. This is especially the case for men approaching retirement. Looking at panel data collected on men around retirement age (55–64 years old), Mutcher, Burr, Massagli, and Pienta (1999) show that (poor) health affects the likelihood of men leaving the work force, especially if their spouses are employed. Poor health also dampens the likelihood they will re-enter the work force.

Studies of locus of control at work as related to health and gender conclude that women experience more job stress and report worse health, even at the same occupational levels (Bosma, Stansfeld, & Marmot, 1998; Muhonen & Torkelson, 2004). (This study used data from 281 women and men at managerial as well as nonmanagerial levels at a Swedish telecom company. Work locus of control was measured by a 16-item survey asking respondents to select one of six assessments of agree or disagree. Stress was measured by an 11-item survey asking how often certain situations occurred at work. Health was defined by the Hopkins Symptom Checklist-25.) One possible explanation for this is the amount of social support that men and women use to moderate occupational stress. Generally, negative interpersonal relationships in the workplace are associated with more mental and physical complaints of illness (Repetti, 1998). From their 2003 study

of 204 male and female Australian managerial-level employees, Bellman, Forster, Still, and Cooper conclude that there is a direct negative link between perceived social support and occupational stress (social support and occupational stress as measured by the Pressure Management Indicator) in the workplace for both men and women (Repetti, 1998). There is, however, a gender difference in how employees perceive and cope with occupational stress. Men typically perceive more of “need for recognition” stress than women, whereas women generally report being in poorer health (Bellman et al., 2003).

To summarize, men and women adopt various strategies of adaptation as they move through and construct their life biographies. Both women’s and men’s family and career paths play out with existing (and frequently outmoded) cultural and institutional contexts, producing constraints on their strategic selections and the resulting biographical pacing of their lives. Taken-for-granted schema and scripts (such as the career and retirement mystiques), combined with prior choices (strategic selections), affect women’s and men’s quest for biographical coherence and a sense of control as they seek to integrate and synchronize the public and private aspects of their lives.

LINKED LIVES AND ROLE CONSTELLATIONS

The notion of linked lives (Elder, 1985) implies (1) interdependence across roles, such that work, family, and other roles are interlocking and interdependent (our concept of role constellations; see also Macmillan & Eliason, 2003, 2005; Moen, 2005; Moen & Roehling, 2005). Equally important are (2) the ways lives are joined—husbands and wives, parents and children, adult children and aging parents, grandparents and grandchildren, workers and coworkers. Consider the social relations that constitute the “convoy” of one’s life course (Antonucci, 1994). Such interlocking life course paths have consequences for power and control disparities between women and men, as well as disparities in their health-related risks, behaviors, and outcomes.

Studies of men’s and women’s biographies underscore how individual lives are embedded in, and mediated through, the lives of others (see, e.g., Burton & Bengtson, 1985; Clausen, 1993; Cooney & Uhlenberg, 1992; Henretta, O’Rand, & Chan,

1993a,b; Lüscher & Pillemer, 1998; Pavalko & Elder, 1993). Marriages by definition are about linked lives, providing supportive relationships conducive to health (Waite & Gallagher, 2000). Being married appears related to better health at all life course stages (Mirowsky & Ross, 2003 [Mirowsky & Ross (2003) draw on data from the Aging, Status, and the Sense Of Control (ASOC) Survey, a 1995 survey of U.S. households; the sample consists of $n = 2,592$ respondents aged 18–95 years; health is based on a subjective assessment of respondent's own health; depression is measured by the frequency and prevalence of depressive symptoms]; Repetti, 1998). Even expectations of support matter: Drawing on data from a nationally representative sample, Ross and Mirowsky (2002) conclude that expecting to have someone to care for you when sick increases subjective life expectancy [they also show that men expect to live 1 year less, on average, than women]. Older men who are married expect to live longer (in other words, they have an increased subjective life expectancy).

Lennon (1989) describes how marriage can serve as a buffer for stressors but also a source of stress. She warns, "It is misleading to relegate 'social support' to a mediating role because both support and stressors often reside in the same set of interactions" (p. 262). Studies show that both spouses in couples experiencing marital problems typically report greater negative health effects (Repetti, 1998). Conversely, positive and supportive marital relationships have a positive effect on both spouses' mental and physical well-being. The existence of such relationships can help combat and reduce stressors in both men's and women's lives (Repetti, 1998).

The salutary impact of marriage varies by the gendered division of emotional work (Strazdins & Broom, 2004) [based on a 2004 study of 102 couples with young children; division of labor measure by a 7-point scale rating which partner does which tasks; psychological distress measured by Center for Epidemiological Studies Depression Scale depressive symptoms]. When women do considerably more emotional work within the relationship than their husbands, they are at greater risk of depression. However, when the emotional work (such as giving emotional support to partner and children, caring for a partner's or children's emotional needs, helping solve problems, etc.) is shared, both partners tend to report less mental stress (Strazdins & Broom). [Strazdins & Broom (2004) defined emotional work by six items measuring relative involvement in family emotional work such as caring for and understanding partner's or children's emotional needs, helping with problems, giving emotional support to partner and children, doing things to improve or maintain the relationship, and setting and enforcing standards for children's behavior. Strazdins & Broom (2004) also discuss the importance of future research concerning gender and health. Their study did not take into account the effect work hours have on children in the relationship, especially of time. They call for research looking at children's mental health over the life course in conjunction with mothers' and fathers' work hours and gender roles.]

Focusing on women's and men's social relational expectations and experiences reveals the complex and dynamic intersections of paid work, unpaid family care work, and health. For example, Stolzenberg (2001) finds significant but gendered relationships between husbands' and wives' work hours and poor health. Drawing on panel data [data from 3,617

individuals from 1986 and 1989], he shows that when wives work more than 40 hours per week, their husbands report increased health issues [health was measured by a scale of excellent, very good, fair, or poor]. But the obverse is not true: Wives of husbands who work more than 40 hours a week do not subsequently have more health problems. Another example: The stress levels of husbands with demanding work careers are often cushioned (and thus reduced) by having encouraging, supportive wives at home (Repetti, 1998).

The "linked lives" concept also applies across generations. As a case in point, parents' life styles have a huge impact on their children's lives. For example, children's risk of respiratory illness doubles if the child's mother smokes (owing to second-hand smoke inhalation; see Cook & Strachan, 1999). The risk of sudden infant death syndrome increases five times for infants of mothers who smoked during pregnancy (Mitchell & Milerad, 1999; World Health Organization, 1999). [In 2002, the Centers for Disease Control estimated that 2,035 infants died of sudden infant death syndrome, actually a decrease from the 2001 number: 2,234 (Kochanek & Smith, 2004).] Children of parents who smoke are also likely to take up the habit themselves, putting them at an increased risk for cardiovascular disease.

Gender is also a key factor shaping social integration and connectedness to the broader community in the second half of the life course (Pillemer, Moen, Glasgow, & Wethington, 2000). Friends and neighbors are important sources of continuing integration, with older women typically having larger social networks than men (Campbell & Lee, 1992; Wethington & Kavey, 2000). Investigators are also documenting the health and well-being effects of unpaid community engagement. For example, Musick, Herzog, and House (1999) drew on a nationally representative sample to show the longevity effects of volunteering for both men and women (see Moen et al., 1989). Moen and Fields (2002) also find a positive link between formal community participation and a range of measures of well-being.

Women's lives are typically contingent lives, shaped around the experiences of others: their husbands, children, and parents. While this is obvious around parenthood, women of all ages continue to shape their choices (involving retirement, for instance) around those of their husbands and their caregiving of children as well as aging and infirm relatives (see Pixley & Moen, 2003). Men's choices are tied to their roles as family income providers, which is how they show their concern for their wives and children (Townsend, 2002).

Women's taking on the nurturing care work of their families and of society renders them vulnerable to the stresses and tension in others' lives as well as in their own (see review by Rosenfeld, 1999). Simon (1995) draws a similar conclusion. According to her panel study of 40 employed and married parents, differences in men and women's family roles are at least partially responsible for the differences in men and women's mental health.

Women are also more likely than men to serve as caregivers for their spouses. Longitudinal analyses over a 20-year period (1974–1994) provide compelling evidence that providing care to spouses predicts lower psychological well-being (Strawbridge, Wallhagen, Sherma, & Kaplan, 1997). Employment combined with caregiving may either exacerbate or reduce psychological distress, depending on whether it offers an escape or added role strain (Brody, 1990; Moen, Robinson, &

Fields, 1994). Sutor and Pillemer's (1994) study of caregiving daughters (or daughters-in-law) found that whether their husbands felt they (the daughters) were neglecting other roles affected the daughters' marital quality during the first year of caregiving. Caregiving can also produce a sense of entrapment, eliminating other possibilities (Marks, 1998). In a study of 555 caregivers (two thirds of whom were female) to parents or spouses with Alzheimer disease, Aneshensel, Pearlin, and Schuler (1993) conclude that this type of unpaid carework causes increased stress [definitions of stress and physical health rely on self-reported perceptions of the caregivers] for the family member providing the care. As women are disproportionately more likely to become care providers to aged family members (Strawbridge et al., 1997), this means that women are disproportionately more likely to experience this type of stress.

To summarize, the life course concept of "linked lives" reminds us that an individual's biography is always intertwined with the biographies of others (see "3" in Figure 1). This is especially evident in women's lives, given the extent to which their lives revolve around relationships. Linked lives can be both positively and negatively related to health. And there are gendered aspects of the same relationship. For example, considerable evidence suggests that marriage typically has salutary effects for men and women, but men are far more likely to be in another marital relationship after divorce or widowhood than are women.

INTEGRATING INSTITUTIONAL FORCES, STRATEGIC SELECTION PROCESSES, AND RELATIONSHIPS OVER THE GENDERED LIFE COURSE

Disparities in health paths and passages reflect the dynamic interplay between institutions and individual lives. Our approach to health disparities draws on the concepts of careers and control cycles to theorize about the strategic selections of roles and relationships by men and women in light of institutional schema, scripts, and structures that are themselves in flux. We argue that these selections, while pragmatic and reasonable from the point of view of the individuals making them, nevertheless play out in, and reconstruct, distinctively gendered life courses. Space limitations mean that we have not addressed heterogeneity within gender, subgroup variations that certainly exist in men's and women's occupational, family, and health paths. Nevertheless, gender provides one of the most salient—and consequential—comparative frames for assessing "social address" inequities.

We also see the occupational career (and the taken-for-granted career and retirement mystiques related to it) as a fundamental organizing force in contemporary society, shaping gender disparities in men's and women's sense of control over their lives as well as their health-related resources (e.g., health insurance, income, retirement, pensions), risks (layoffs, stress, burnout, injuries), and behaviors (e.g., getting sufficient sleep or scaling back on work to provide care for children and other family members).

Future research can contribute to the understanding of health disparities between men and women by synthesizing and integrating many lines of inquiry. First on the research agenda is the need to capture the nature and range of health pathways (careers) over the life course. How do they differ by gender?

Such basic descriptive work can capture the dynamic interplay between biography, biology, and institutional arrangements in forging health careers as well as the patterned relationships existing between various health outcomes. For example, researchers who study mortality outcomes paint a very different gender picture than those studying mastery or subjective well-being. How are these and other outcomes linked? Do these linkages vary by gender? How do the linkages between various health outcomes change over the life course? The first challenge is to capture men's and women's health careers as they unfold over different ages and stages as well as for different subgroups (such as by race and ethnicity and by socioeconomic status).

Second, how do historical events and institutional "givens" contribute to or narrow health disparities by gender? Our strategic selection model (see Figure 1) suggests the potential fruitfulness of capturing relationships between life choices, life chances, and the institutions shaping them as well as between individual development and social change. Doing so can provide important explanations of the links between gender and health—men's and women's different (and changing) locations in the larger social structure, which, in turn, affects their cycles of control, the sense of mastery emanating from sufficient resources to meet needs at different life stages. How are particular health patterns and paths linked to the ebb and flow of resources, needs, and control? What are the historical, institutional, and relational structures (and changes) that produce such shifts?

All the temporal processes we have discussed—institutional forces, strategic role selections, biographical pacing, and control—and the linked lives of social relationships are themselves interrelated and gendered (see Figure 1). Theoretical and empirical advances necessitate research documenting the ways (1) that institutional arrangements and the uneven processes of social change in them produce gender disparities in roles and resources, (2) that these resource and role disparities play out in subsequent strategic role and relationship selections by men and women at different ages and life stages, along with (3) resultant biographical pacing and interdependent relationships (linked lives), producing (4) corresponding differences in health and well-being. Such a reappraisal of contemporary life patterns can lead to a view of health as both cause and effect in the complex interplay between gender, work, and family over the life course.

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