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Tina Hallman, Helene Thomsson, Gunilla Burell, Jan Lisspers and Sven Setterlind

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Stress, Burnout and Coping: Differences between Women with Coronary Heart Disease and Healthy Matched Women

TINA HALLMAN

Department of Clinical Neuroscience, Section for Personal Injury Prevention, Karolinska Institutet, Stockholm, Sweden

HELENE THOMSSON

Department of Psychology, Division of Work and Organizational Psychology, Stockholm University, Stockholm, Sweden

GUNILLA BURELL

Department of Public Health and Caring Sciences, Uppsala University and Division of Behavioral Medicine, University Hospital of Northern Sweden in Umeå, Sweden

JAN LISSPERS

Department of Human Resources, Management and Environment, MidSweden University at Östersund, Sweden

SVEN SETTERLIND

Department of Education, University of Gothenburg, Sweden

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ADDRESS. Correspondence should be directed to:
TINA HALLMAN, Department of Clinical Neuroscience, Section for Personal Injury Prevention, Karolinska Institutet, Box 12718, SE-112 94 Stockholm, Sweden. [email: Tina.Hallman@cns.ki.se]

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Abstract

Stress is becoming more significant for women, along with the increasing number of women in the workforce. The present study compared women with respect to burnout and coping abilities, and related to the impact of educational level on differences in coping strategies. Women with coronary heart disease reported a higher level of burnout and had the highest scores demonstrating lack of coping, which indicates lesser coping abilities. Differences concerning strain reduction, self-control and emotional distancing are discussed in terms of living conditions. We also discuss that in order to optimize the outcome of rehabilitation and prevention we need more research on women, of women and especially from women's point of view.

Keywords

CHD, coping, diversity, education, gender, psychosocial stress

Introduction

DURING THE last two decades, psychosocial risk factors have come into focus as being important for the development of coronary heart disease (CHD). Psychosocial risk factors and stress are perhaps becoming more significant for women, with the increasing number of women in the workforce (in Sweden, 78 percent in 1999) along with all other responsibilities in modern society. Most women still carry the main responsibility for household chores, which adds to the risk of exhaustion (Edlund, Johansson, Linderöth, & Ståhl, 2001; Murray, Neij, & Lindblom, 2000; Perrons, 1999). CHD alone is the most common cause of death in Europe, accounting for nearly two million deaths each year. More than one in five women (22%) and men (21%) die from CHD (*European cardiovascular disease statistics, 2000 edition*) and several are disabled for a long time (SCB, 2000). Contrary to popular perceptions, CHD is a serious and extensive problem also among American women. Public education, preventive interventions and improved data on CHD risk and prevention in women are needed (Wenger, 1998).

In the present study we will focus on exhaustion and coping strategies in women with CHD. Due to the methodology used, we will use the term 'burnout' for the experience of exhaustion that might be a consequence of long-term stress. In order to clarify our frame of reference, we need to discuss some related and overlapping concepts referring to exhaustion.

The burnout syndrome has been in focus since the 1970s, due to the increasing number of cases of stress-related work disability. This syndrome can be defined as a state of physical, mental and emotional exhaustion, sense of loss of competence and empathy and mental alienation (Schaufeli & Peeters, 2000). Symptoms of long-term stress and the burnout syndrome exhibit many overlapping characteristics. However, one distinguishing dimension seems to be mental alienation, which is a key characteristic of burnout. Burnout has been associated with a variety of job stressors, and is sometimes integrated into larger conceptual frameworks, such as general stress theory and occupational stress theory (Cox, Kuk, & Leiter, 1993). Most researchers relate burnout syndrome to

prolonged job stress; however, stress and burnout cannot be distinguished on the basis of symptoms, only in terms of process (Schaufeli, Maslach, & Marek, 1993). It is suggested that the primary sources of burnout are related to both organizational conditions and the personal characteristics of the individual (Richardson & Burke, 1991). Several measures of quantitative workload have been related to burnout, and burnout scores are always higher in work settings characterized by overload (Burke & Richardson, 1996). Six areas of working life are important determinants of burnout risk: workload, both physical and psychological; control, that is having power; reward balanced with effort; community, meaning fellowship and social network; fairness, as in righteousness; and values, referring to morals and ethics (Leiter & Maslach, 1999). Role conflict and role ambiguities have also been identified as important contributors to the development of burnout, as well as lack of social support (Jackson, Schwab, & Schuler, 1986). Studies have also found relationships between various stress outcomes and type A personality characteristics, and some studies have indicated that a high anxiety trait may make a person more susceptible to burnout (Farber, 1983; Richardson & Burke, 1993).

Pines and Aronson (1988) present a broader definition of burnout and describe it as a state of physical, emotional and mental exhaustion caused by long-term involvement in situations that are emotionally demanding. Appels and Schouten (1993) describe one of the dimensions of vital exhaustion as 'demoralization'. Maslach and Leiter (1997) talk about 'the erosion of the soul' and Schaufeli and Enzmann (1998, p. 35) cite Etzion (1987, pp. 16–17) when writing as follows:

In burnout, I propose that continuous, barely recognisable, and for the most part denied misfits between personal and environmental characteristics are the source of a slow and hidden process of psychological erosion. Unlike other stressful phenomena, the mini-stressors of misfit do not cause alarm and are rarely subject to any coping efforts. Thus the process of erosion can go on for a long time without being detected.

These thoughts are noteworthy when discussing women's situations and the damage and illness it

might lead to. There are parallels to the slow and silent progression of coronary heart disease.

'Vital exhaustion' is a concept originally used by Appels and co-workers (Appels et al., 1993). It is described as a syndrome of mental and physical exhaustion, sense of loss of competence, and 'demoralization' (development of hostile attitudes)—thus, a description very similar to the burnout syndrome. Vital exhaustion has been shown to predict first myocardial infarction, as well as recurrence. Since burnout is defined very similarly to vital exhaustion it is also likely that it may be related to CHD. It has been suggested that the burnout syndrome could be a predictor of cardiovascular morbidity and mortality (Melamed, Kushnir, & Shirom, 1992). In order fully to understand sources and consequences of burnout we have to include cognitive variables, such as how work environments are appraised, and how coping resources are assessed and used (Burke & Richardsen, 1996).

Lazarus and Folkman (1987) identify two major coping strategies, namely problem-focused (approaching) and emotion-focused (dissociating). The first-mentioned involves an action-oriented overt behaviour, where the individual is trying to do something about the concrete problem causing the stress. Emotion-focused coping is covert, and the primary goal is to restrain the emotions that the situation arouses and to maintain emotional balance. Coping is defined as the individual's effort to manage external and/or internal demands that are estimated to exceed the individual's assets of behavioural and cognitive ability. The estimation of the situation and the choice of coping strategy depend on earlier experiences of similar situations, conceptions of the self and the environment and access to resources (Lazarus & Folkman, 1984). Both strategies are applied in most stress situations. However, problem-focused coping is more common in situations that the individual perceives as modifiable and thereby under control, while emotion-focused coping is more common in situations that are judged to be difficult to change. Interaction between external factors, the individual's disposition, skills and habits results in the specific coping pattern. Thus, greater attention must be paid to the particular demands on people, and the resources that they have at their disposal

(Steptoe, 1991), in order to understand the specific stress response in an individual.

There are few studies of coping that focus on women, and most studies which include women are confined in a comparison with men, often finding women's skills to be inferior to a normative (male) model of coping (Banyard & Graham-Bermann, 1993). Likewise occupational stress research is mostly based upon male or predominantly male populations and does not necessarily apply to women (Gross, 1997). Attention is rarely given to gender as an influencing or mediating factor in the research on coping with stress. Coping is treated as a general concept that is untouched by such individualizing characteristics as gender, race or class. Differences in the lives of women and men are often discussed as though both (all) gender roles are valued and treated equally in society, with little emphasis on the fact that women and men are given access to different amounts of power (Aldwin, 2000). In the same way as other structural factors, gender is of great relevance in every study of human life. However, as, for example, Wilkinson (1996) points out, gender also has to be a topic in its own right, questioning what it means to be a woman or a man in each specific situation. Acts and experiences of women and men, working in occupational segregation and living in gender-segregated family life and society, become central issues when examining coping, and investigating what factors are stress-producing (Aldwin, 2000; Crawford & Unger, 2000; LaCroix, 1994). Yet coping skills are often attributed to individual personality characteristics rather than viewed as the product of access to and control over resources in a broader context. Apparent gender-neutral theories are packaged as universal explanations of behaviour, in spite of being based on the experiences of those in the more privileged strata of society: white working men (Banyard & Graham-Bermann, 1993). There is a need for reformulated theories of coping by including power, resources and gender positions as analytical tools. Furthermore, as feminist theory points out, we need more studies of women's and men's lives, and fewer studies of how women differ from men.

We have previously (Hallman, Perski, Burell, Lisspers, & Setterlind, 2002) found interesting patterns of differences between educational

backgrounds for women and men with regard to stress. When analysing differences regarding external stress between the educational groups, mean values are significantly higher mostly for those with nine years of education or less. But when analysing women and men separately, women with upper secondary school and university education report significantly higher levels of external stress than men in the respective groups. In the present study we want to investigate how differences in coping skills are related to educational level, within a group of women with CHD, within a group of healthy women, and also between the groups.

The aim of this study is to compare a group of women with CHD with a healthy matched group of women, with respect to burnout and coping strategies. We will also investigate differences in coping strategies between women with different levels of education.

Methods

Participants

The study sample comprised Swedish patients consecutively referred to a programme for rehabilitation and secondary prevention of CHD previously described (Lisspers, Hofman-Bang, Nordlander, Ryden, Sundin, Öhman, & Nygren, 1999). Participants in the present analysis participated in the rehabilitation programme sometime between January 1992 and 1995.

The present patient group consisted of 97 women (aged between 40–65 years). All of them participated in the rehabilitation programme and answered the 224 questions in the 'Stress Profile—instrument' (Setterlind & Larson, 1995). Healthy matched control women were selected from a reference group containing more than 10,000 persons (5308 women), all working in various occupations in more than 200 companies and organizations in different parts of Sweden, who answered the same 224 questions in the 'Stress Profile—instrument' sometime between 1992 and 1996. Age group and educational level were used for matching because of their importance on how individuals appraise and deal with various things in their lives. Table 1 shows demographic data for the patient group and the healthy matched group.

Measurement

The Stress Profile is a psychosocial instrument for measuring stress at work, during leisure and in private life. It was developed over a period of five years and is derived from different areas of current stress research. It has been inspired by original scales and adjusted to Swedish conditions and has earlier been described in detail (Setterlind & Larson, 1995). During the development process several validity tests have been made (i.e. content, criterion-related and construct) using Antonovsky's Sense of Coherence (SOC) (Antonovsky, 1987), the Social Readjustment Rating Scale (SRRS) (Holmes & Rahe, 1967), items concerning daily hassles and satisfactions (DeLongis, Coyne, Dakog, Folkman, & Lazarus, 1982; Kanner, Coyne, Schaefer, & Lazarus, 1981; Lazarus, 1984), type A-behaviour (Friedman & Rosenman, 1959; Rosenman, 1983), items concerning coping (Lazarus & Folkman, 1984, 1987), items concerning psychosocial work conditions (Siegrist, 1996; Theorell, 1991), items concerning social support (Johnson & Hall, 1988), items concerning burnout (Hallsten, 1993; Maslach & Jackson, 1981; Melamed et al., 1992; Pines, 1993). Face-validity has also been high during use of the Stress Profile in recent years by the health care professionals and organizations. The Stress Profile consists of 224 questions, 20 of which concern background variables and 10 criteria for testing internal validity. It has been tested and standardized on over 3000 women and men in different companies and organizations, and has also been tested for validity and reliability in relation to criteria questions. The reliability of the instrument was tested in four ways: test-retest, Cronbach's Alpha, Spearman-Brown Split-half and Maximum Likelihood. In each test the reliability coefficients measured over .80 (Setterlind & Larson, 1995). The Stress Profile assessment has been used in various studies (Edvardsson, Larsson, & Setterlind, 1997; Grossi, Theorell, Jurisoo, & Setterlind, 1999; Hallman, Burell, Setterlind, Oden, & Lisspers, 2001; Hallman et al., 2002; Hofman-Bang, Lisspers, Nordlander, Nygren, Sundin, Öhman, & Ryden, 1999; Kabbe, Setterlind, & Svensson, 1996; Larsson, Kallenberg, Setterlind, & Starrin, 1994; Larsson & Setterlind, 1990, 1991; Larsson, Setterlind, & Starrin, 1990; Lindberg, Larsson, Setterlind, & Rastam, 1994;

Table 1. Demographic data for patients and healthy matches (%)

	<i>Patients</i> (<i>n</i> = 97)	<i>Matched</i> (<i>n</i> = 97)		<i>Patients</i> (<i>n</i> = 97)	<i>Matched</i> (<i>n</i> = 97)
<i>Age group:</i>			<i>Type of employer:</i>		
40-49	23	23	local government	27	29
50-59	76	76	national government	20	13
60-69	1	1	county council	12	11
			private	35	45
			self-employed	6	2
<i>Education:</i>			<i>Occupational position:</i>		
grade 9 or less	44	44	manager	19	20
upper sec. school	28	28	white-collar	33	57
university graduate	28	28	blue-collar	48	23
<i>Living with:</i>			<i>Years in the company:</i>		
husband/wife/partner	70	76	0-2	7	6
other	9	8	3-5	16	11
alone	21	16	6-10	21	21
<i>Children:</i>			> 11	56	63
one or more	94	94	<i>Working-hours:</i>		
no children	6	6	part-time	23	34
<i>Living area:</i>			full-time	55	56
metropolitan area	54	43	overtime > 10h/w	22	10
middle-sized city	5	10			
smaller city	18	14			
rural area	23	33			

Lisspers, Hofman-Bang et al., 1999; Lisspers, Sundin, Hofman-Bang, Nordlander, Nygren, Ryden, & Öhman, 1999).

There are 16 main fields in the Stress Profile classifying external and internal causes of stress, stress reactions and behaviours related to coping with stress. Each main field includes a number of statements, which are subdivided into 60 subsidiary fields (for more details see Hallman et al., 2001 or Hallman et al., 2002). Scores on each of the Lickert scales range from 1 to 5, where 1 indicates a low degree of stress and 5 indicates a high degree. All scores are directed, showing heavy odds with high levels for plain identification. In this study we used the index for burnout, containing 18 items, which has been validated with four different burnout inventories: Pines' Burnout Measure (Pines, 1993), Hallsten's Burnout Scale (Hallsten, 1993), Shirom's Burnout Scale (Melamed et al., 1991) and Maslach's Burnout Inventory (Schaufeli et al., 1993). Coping was measured in two main fields, problem-focused and emotion-focused, containing 10 subsidiary fields

calculated from 29 variables, all measuring coping strategies aimed to balance or avoid situations with stress (see Fig. 1 for details).

Statistical methods

Categorical variables were analysed by Chi² test, and relations were calculated using Pearson's product moment correlation. Multiple linear regression analysis (single model) was used to assess the predicting power of burnout and group affiliation (respectively) on coping strategy. For continuous variables, means were compared by Student's t-test or analyses of variance (ANOVA), and post hoc differences were investigated using Bonferroni's test. All tests were performed using SPSS for Windows version 10.1. A *p*-value of .05 was considered significant.

Results

The group of women with CHD reported a significantly higher level of burnout than the healthy matched group (*p* .000). We also found

significant differences between the groups regarding emotion-focused coping ($p .001$) but not regarding problem-focused coping ($p .066$), showing that women with CHD had the highest scores demonstrating lack of coping, which indicated lesser coping abilities (see Table 2). Multifactorial analyses showed that both emotion-focused coping and group affiliation had significant influence on burnout, and that emotion-focused coping (Beta .455) had a greater impact than group affiliation (Beta .196) (see Table 3).

The emotion-focused coping index and the problem-focused index contain 10 subsidiary indexes, each measuring different aspects of coping. Figure 1 shows the differences between the group of women with CHD and the group of healthy matches concerning those 10 indexes. Significant differences appeared concerning *strain reduction* ($p .012$), *self control* ($p .000$) and *emotional distancing* ($p .039$) showing that women with CHD had the highest scores indicating lesser coping abilities.

Table 4 shows differences in coping abilities in each of the three educational levels in the patient group and the healthy matched group respectively. In the patient group *problem-focused coping* ($p .041$) and *problem-solving skills* ($p .017$) differed significantly between those with nine years of education or less, and university graduates. *Social/emotional support* ($p .022$) was significantly different between upper secondary school level and university graduate level. In the healthy matched group, several significant differences emerged.

Problem-focused coping ($p .000$), *initiative* ($p .003$), *problem-solving skills* ($p .000$) and *social/practical support* ($p .000$) differed between those with nine years of education or less, and university graduates. *Problem-focused coping* ($p .019$) also significantly differed between those with nine years of education versus upper secondary school level. *Initiative* ($p .022$) significantly differed between those with upper secondary school versus university graduates. Also *emotion-focused coping* ($p .008$), *social/emotional support* ($p .012$) and *self-control* ($p .017$) significantly differed between those with nine years of education or less and university graduates.

When comparing patients and healthy matches in each educational level with respect to coping abilities, patients with an upper secondary school or university education showed less coping ability compared to healthy matches (see Table 5). *Emotion-focused coping* ($p .008$), *emotional distancing* ($p .007$), *social/emotional support* ($p .032$) and *strain reduction* ($p .013$) differed between patients and healthy matches with an upper secondary school education. *Social/practical support* ($p .036$), *emotion-focused coping* ($p .002$), *avoidance/escape* ($p .029$) and *self-control* ($p .001$) differed between patients and healthy matches who were university graduates.

Discussion

Women with CHD reported a higher degree of burnout compared to women in the healthy

Table 2. Differences between women with CHD and healthy matched women concerning burnout and coping strategies

	Patients		Matched		P
	M	SD	M	SD	
Burnout	2.6	.6	2.2	.6	.000
Problem-focused coping	2.7	.6	2.6	.6	.066
Emotion-focused coping	3.1	.6	2.8	.6	.001

Table 3. Multiple linear regression concerning coping strategies, group affiliation and burnout

	Beta	t value	P	95%CI
Problem-focused coping	.064	.86	.390	-.07-.24
Emotion-focused coping	.455	5.98	.000	.34-.67
Group belonging	-.196	-3.12	.002	-.42-.09

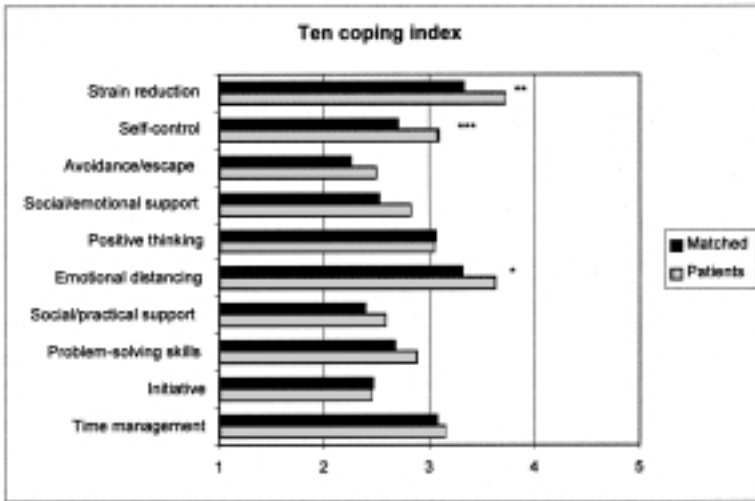


Figure 1. Coping ability. Differences between women with CHD and the healthy matched group * $p < .05$, ** $p < .01$, *** $p < .001$

Table 4. Differences in coping abilities between women in each of the three educational levels, in the patient group and in the healthy matched group respectively

	Patient group			Healthy matched group		
	\leq grade 9 $n = 43$ $M \pm SD$	upper sec. $n = 27$ $M \pm SD$	university $n = 27$ $M \pm SD$	\leq grade 9 $n = 43$ $M \pm SD$	upper sec. $n = 27$ $M \pm SD$	university $n = 27$ $M \pm SD$
<i>Problem-focused coping</i>	2,9 ± 0,5*	2,8 ± 0,6	2,5 ± 0,5	2,9 ± 0,5***	2,5 ± 0,7	2,3 ± 0,4
Time management	3,3 ± 0,6	3,2 ± 0,8	2,9 ± 0,8	3,3 ± 0,7	2,9 ± 1,0	2,9 ± 0,7
Initiative	2,6 ± 0,4	2,4 ± 0,7	2,3 ± 0,6	2,6 ± 0,5**	2,6 ± 0,7*	2,1 ± 0,5
Problem-solving skills	3,1 ± 0,8*	2,9 ± 0,8	2,5 ± 0,6	3,0 ± 0,7**	2,6 ± 0,8	2,2 ± 0,6
Social/practical support	2,6 ± 0,9	2,8 ± 1,0	2,4 ± 0,9	2,7 ± 0,8**	2,3 ± 1,0	1,9 ± 0,7
<i>Emotion-focused coping</i>	3,0 ± 0,5	3,3 ± 0,4	3,1 ± 0,5	3,0 ± 0,4**	2,8 ± 0,6	2,6 ± 0,5
Emotional distancing	3,5 ± 0,9	3,9 ± 0,7	3,6 ± 1,2	3,5 ± 1,0	3,2 ± 1,0	3,2 ± 1,2
Positive thinking	3,0 ± 0,8	3,1 ± 0,9	3,1 ± 1,1	3,2 ± 0,8	3,1 ± 1,1	2,7 ± 1,1
Social/emotional support	2,8 ± 1,0	3,3 ± 1,2*	2,4 ± 1,1	2,8 ± 1,0*	2,6 ± 1,2	2,0 ± 0,8
Avoidance/escape	2,5 ± 0,7	2,5 ± 1,1	2,5 ± 1,1	2,4 ± 1,0	2,4 ± 0,9	1,9 ± 0,5
Self-control	3,0 ± 0,6	3,2 ± 0,8	3,1 ± 0,8	2,9 ± 0,7*	2,8 ± 0,9	2,3 ± 0,6
Strain reduction	3,5 ± 0,9	4,0 ± 1,0	3,8 ± 1,0	3,4 ± 0,9	3,2 ± 1,2	3,4 ± 1,2

* $p < .05$, ** $p < .01$, *** $p < .001$. Means in **bold** are significantly different

matched group. Emotion-focused coping abilities were correlated to burnout and were in addition a stronger predictor than group affiliation.

We preferred to measure burnout, which is the result of prolonged stress and is considered to reflect on external, environmental as well as inherently unhealthy pressures. It is impossible to say which came first—coping ability or CHD.

Emotion-focused coping abilities were measured with 16 questions structured in six indexes and the pattern between the healthy group and the patient group shows more unfavourable scores for the patient group. The statistically significant difference concerning *strain reduction* includes questions indicating a crucial difference between the groups in terms of time to relax, or the awareness of how

Table 5. Coping ability: comparison between women with CHD and a healthy matched group in each educational level.

	Grade 9 or less		Upper sec. school		University graduate	
	patients M ± SD	matched M ± SD	patients M ± SD	matched M ± SD	patients M ± SD	matched M ± SD
<i>Problem-focused coping</i>	2,9 ± 0,5	2,9 ± 0,5	2,8 ± 0,6	2,5 ± 0,7	2,5 ± 0,5	2,3 ± 0,4
Time management	3,3 ± 0,6	3,3 ± 0,7	3,2 ± 0,8	2,9 ± 1,0	2,9 ± 0,8	2,9 ± 0,7
Initiative	2,6 ± 0,4	2,6 ± 0,5	2,4 ± 0,7	2,6 ± 0,7	2,3 ± 0,6	2,1 ± 0,5
Problem-solving skills	3,1 ± 0,8	3,0 ± 0,7	2,9 ± 0,8	2,6 ± 0,8	2,5 ± 0,6	2,2 ± 0,6
Social/practical support	2,6 ± 0,9	2,7 ± 0,8	2,8 ± 1,0	2,3 ± 1,0	2,4 ± 0,9	1,9 ± 0,7*
<i>Emotion-focused coping</i>	3,0 ± 0,5	3,0 ± 0,4	3,3 ± 0,4	2,8 ± 0,6**	3,1 ± 0,5	2,6 ± 0,5**
Emotional distancing	3,5 ± 0,9	3,5 ± 1,0	3,9 ± 0,7	3,2 ± 1,0**	3,6 ± 1,2	3,2 ± 1,2
Positive thinking	3,0 ± 0,8	3,2 ± 0,8	3,1 ± 0,9	3,1 ± 1,1	3,1 ± 1,1	2,7 ± 1,1
Social/emotional support	2,8 ± 1,0	2,8 ± 1,0	3,3 ± 1,2	2,6 ± 1,2*	2,4 ± 1,1	2,0 ± 0,8
Avoidance/escape	2,5 ± 0,7	2,4 ± 1,0	2,5 ± 1,1	2,4 ± 0,9	2,5 ± 1,1	1,9 ± 0,5*
Self-control	3,0 ± 0,6	2,9 ± 0,7	3,2 ± 0,8	2,8 ± 0,9	3,1 ± 0,8	2,3 ± 0,6***
Strain reduction	3,5 ± 0,9	3,4 ± 0,9	4,0 ± 1,0	3,2 ± 1,2*	3,8 ± 1,0	3,4 ± 1,2

* $p < .05$, ** $p < .01$, *** $p < .001$

important it is to do so. Women are often in work positions with fewer opportunities to choose when and what to do; and in their private positions, most women have the main responsibilities for children and the household, and are seldom given time or space to take a relaxing break, or time for themselves (Gjerdingen, McGovern, Bekker, Lundberg, & Willemsen, 2000; Lundberg, 1996). Responsibility for the well-being of others presupposes accessibility, and that women do not have any opposing needs of their own (Elvin-Nowak & Thomsson, 2001; Thomsson, 1999).

The statistically significant difference concerning *self-control* includes questions regarding the ability to control feelings and thoughts, and to look in a matter-of-fact manner at problematic situations. The differences could indicate that women with CHD have to a greater extent given in or lost control because the situation is generally overwhelming. One can argue about what is optimal in problematic situations: a calculated rational behaviour with no emotional components, or a more emotionally involved reaction (Banyard & Graham-Bermann, 1993), since diverse situations demand different actions. Dealing with people or dealing with objects requires, and is more appropriately approached with, different strategies. Dealing with problems at work or in private life has different implications, at least concerning the way in which feelings are

involved (Crawford & Unger, 2000). Problems at home are always personal and it is harder to change the family situation than to quit and change jobs.

The statistically significant difference concerning *emotional distancing* includes questions regarding the ability to take time out, in order to gain different perspectives and some detachment to problems. Again, it is a matter of having opportunities to be able to take a break. Another obstacle may be the unawareness of what can be gained in terms of better problem solving. The female gender role of caring for others entails managing most situations without any prospects of taking a break. Since a majority of women in the western world work in caring or service occupations, the working situations often involve other people who need attention or are in distress (SCB, 2000). Therefore it is hard or even impossible to take a break just to withdraw, or to do something else in order to gain new perspectives and distance—to get away from the job tasks to reflect or do something else. Women's working time, either at work or at home, is often not regulated by the clock (Perrons, 1999). Too often it consists of unlimited duties. Tasks are endless and feelings of guilt are often experienced because 'not enough' has been done, thereby preventing the woman from allowing herself a break. Often her own feelings of inadequacy and guilt, or fear of (real or imagined) social consequences

determine when and if it is possible to even take a lunch break (Elvin-Nowak, 1999). Too often women's unpaid work is measured by what has not been done and extremely seldom by all that really has been done (Thomsson, 1996). Taking a break is regarded as a benefit, and not a right that one is entitled to.

Our findings show that coping strategies (as defined in e.g. Lazarus & Folkman, 1984) are correlated with burnout, and that women with CHD report a higher degree of burnout. As Lazarus and Folkman (1984) point out, the choice of coping strategy depends on earlier experiences and access to resources. The purpose of our discussion is to question what might be behind the women's 'choice' of unhealthy coping strategies, and to point out the need for greater attention to gender systems and power relations. If focus is directed to the demands and resources of women suffering from CHD, not on personality factors, but on resources that are accessible, permitted and possible for women to use, we advance towards what feminist theory calls gender politics (Connell, 1993). Coping behaviour, whether health or unhealthy, is mainly constructed by social opportunities and experiences throughout life and can be influenced by consciousness raising, and learning how and why it is necessary to break unhealthy gender norms.

Patterns in subgroups—diversity

Interesting patterns arise when we compare coping abilities between women in each of the three educational levels, in the healthy group of women and the women with CHD respectively. The healthy group of women with a low level of education showed the highest scores demonstrating lack of coping, which indicated lesser coping abilities, and there were several (seven) statistically significant differences, especially concerning problem-focused coping. In the patient group there were only three statistically significant differences and only two of them showed a worse situation for those with a low level of education. Thus there is a clear pattern in the healthy group but not in the patient group, concerning level of education and coping-strategies.

When comparing healthy women and women with CHD in each educational group, another pattern emerged, and statistically significant

differences were only observed between women in the groups with the higher level of education. There were no differences at all between the mean values when comparing healthy women and women with CHD, with a low level of education; both groups showed similar coping patterns. However, on the high educational level, women with CHD showed lesser coping abilities than healthy women did. This could imply that women with CHD and a higher level of education have higher demands and have experienced fewer resources in life, and therefore apply less healthy coping strategies than women with a lower level of education.

Limitations and considerations

The difference between burnout (which is the focus of the present study) and vital exhaustion in terms of definitions refers to the presumed source of burnout and vital exhaustion respectively. Most researchers relate burnout to work overload, while it has been shown that vital exhaustion is also linked to family and financial stress. However, whichever of the terms is used, inadequate coping strategies and resources can indeed have an influence on health, and make the women more vulnerable for physical and emotional collapse as in CHD.

In what way do our questions and coping indexes reflect strategies and attitudes, which are significant in women's lives and for their health development? Current instruments imply that coping is a personality trait which can be assessed in a standardized way, regardless of the complexities of varying social contexts, and regardless of the individual's perception of the social response. Instead of asking *if* women react and/or behave regarding some statement/question, it might be more appropriate to ask *how* they cope, and in what kind of situations they experience problems and need to cope in some specific way. What do we really need to know about women's living conditions, from the women's point of view, in order to assess coping behaviour in a more flexible and dynamic way? Methodologically, coping research has a nomothetic approach and researchers have begun to formulate questions, and procedures for testing them, based on their own notions of what they suppose they are going to find (Unger, 1990). But questionnaires for measuring coping strategies developed by

researchers may be inadequate and not sensitive enough to reflect ways of adapting used by particular groups (Banyard & Graham-Bermann, 1993; Gergen & Davis, 1997). This criticism is of course valid for the instrument used in this study as well. In addition, when designing questionnaires, our comprehensive understanding of the coping process, and more specifically women's coping, has been hindered by the narrow selection of outcome measures. Focus on the context only in terms of the individual excludes the nature of the social environment in which a particular stressor is experienced, with the risk of overlooking essential determinants. Perhaps women report coping with problems in different ways, and use different coping strategies depending on the social context, and also on whether they are coping in the context of other women, or in the presence of men, or when they are alone. Gender norms influence coping by assigning women (and men) to different social roles, and sanction only certain behaviours for each gender. So gender will look different from situation to situation, and operates also in combination with other social structures such as race and class to define the context of the situations. 'Good' or 'bad' coping are also judged differently, but the judgement is often from a perspective which does not take into consideration what could or must be most adequate, being a woman (Banyard & Graham-Bermann, 1993).

Coping theories demonstrate that coping is highly specific to both the individual and the context, but this is seldom taken into account in measurements. Women live in diverse contexts, depending on e.g. race, class, age, history and culture and sexual orientation. Therefore we must study a broad range of situations before we can talk about a general theory of coping, or about which types of coping strategies lead to more favourable psychological outcomes and health for women (Harding, 1991). According to theories about coping, those with more power do better. Yet power, as a determinant of strategies is never talked about per se. It is hidden under the costume of biological or role differences (Hare-Mustin & Marecek, 1990). Without taking power and opportunities into consideration, (rehabilitation) programmes are developed with the intention of analysing and treating the individual rather than examining

the problem of their position and role in the family, at work and in society. Instead it is essential to consider the complex context women find themselves in and then create opportunities to increase the availability of sufficient resources, so that women have, see and, above all, get practical prospects to use them. Coping behaviour may be much more a consequence of social dynamics than of individual characteristics.

Conclusions

Our results showed differences between the group of women with CHD and a healthy matched group of women concerning burnout and coping strategies, although the relation between coping strategies and burnout was stronger than the group affiliation. Our results also emphasize the complexity of assessing coping without a more profound knowledge of the context and situations in which the respondents live. Educational level does not guarantee certain coping strategies, nor does it guarantee empowerment and power for women as a group. As long as women have at least two working arenas, at work and at home, with decreased opportunities to decide and control their time and activities, healthy and functional strategies are harder to apply and measure, unless we learn more about the conditions that govern women's lives and the context of the female gender position. Banyard and Graham-Bermann (1993) suggest that we can initiate more gender-oriented research on coping by using old measurements to raise and answer new questions, while working to develop new tools that are more sensitive to women's experiences. More research must be done concerning coping, with respect to circumstances outside the labour market, and with focus on common and possible coping strategies for women in women's life situations. In our discussion we have tried to describe possible scenarios which could be connected with our results, referring to earlier research and other researcher's knowledge about what could be related to women and women's life situations. We wished to raise thoughts and questions, rather than make conclusive statements. We hope that we have done this in our discussion about how the importance of recognizing, identifying and measuring *women's* coping strategies,

considering the lack of knowledge about the actual situation and experience of women. Our results also provide implications on how to design rehabilitation and prevention programmes. Women's living conditions and our need to pay attention to women call for a more person-centred and multidisciplinary attitude towards programme design and preventive actions. In order to optimize the outcome of rehabilitation and prevention we need more research on women, of women and especially from women's point of view.

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