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Mid-Age Women's Multiple Life Roles and Associated Health and Well-Being Outcomes: A Systematic Review

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ABSTRACT

Background: Two opposing theories, role enhancement and role scarcity have looked into possible effects of a multiplicity of roles on women's health & well-being. The variations in reporting multiple roles and health outcomes have called upon the need to examine how women with varying contextual variables account for differences in well-being.
Aims: Literature on the dimensionality of multiple roles varying from mere role occupancy to the varied role experiences and the associated wellbeing outcomes were systematically reviewed.
Method: The review used a standardized search strategy along with standardizing the data extraction followed by quality assessment of studies. The systematic search of four databases related to social and health areas for the period 1980-2016 resulted in the inclusion of 28 studies.
Results: In addition to roles-to-outcome relationships, protective factors e.g., sociodemographic factors, job conditions, and psychological resources provided a thorough account of the issue. The review yielded consistent support for role enhancement theory along with a cautionary note to consider contextual factors while interpreting the positive and detrimental health outcomes.
Conclusion: Employed mid-age women in partner and parent roles along with adequate economic and social resources are conducive for improved health. The analysis suggested a framework for offering psychosocial wellness program for women.

Keywords
Multiple roles, role enhancement hypothesis, role scarcity hypothesis, systematic review, well-being, women's health.

Multiples Roles: Context and Theory

Recognition of the importance of social determinants of health bounded within societal roles while understanding the pathway toward women's health and wellbeing has remained an important concern for health professionals. Participation of women in paid work and spending a significant amount of time at workplaces seemingly implies an accumulation of roles for women as an "employee" in addition to the roles of family caretaker and being wife and mother. In that way, the increased responsibilities possibly result in beneficial as well as detrimental consequences. Two opposing theories relating to inhabiting multiple social roles in work and family life domains and subsequent health outcomes are dominant in literature. The 'role enhancement' perspective explains the multiplicity of roles as a means for increased resources and fulfilment of responsibilities results in a betterment to one's life that in turn may buffer against the possible negative outcomes (Thoits, 1983). Whereas, the 'role strain' perspective hypothesizes that the combination of competing demands and expectations related to the roles of mother, partner and employee lead to role strain and role overload resulting in negative effects on health and well-being (Pearlin, 1989).

The effect of multiple roles on women's well-being remains controversial despite an understanding that engagement in multiple roles affects mental health. The question as to whether these role effects are beneficial or detrimental to health is still open for investigation, which is undertaken in this current review. Instead of focusing only upon the number of roles women occupy e.g., being mother, partner, employer or the carer, the present review intends to cover how studies have focused on multiple dimensions of role-related experiences. This helped to assess the nature of psychosocial and behavioural investments in multiple roles and their possible

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consequences for women's health. The varying experiences associated with work conditions and the host of explanatory variables associated with domestic and family care roles may potentially lead to variations in explaining the well-being of women. This further provided the rationale for the current review to focus upon and thoroughly review the conditions that support the role accumulation and wellbeing outcomes. Though multiple roles are associated with different life stages, the current review specifically aims for mid-age women with the assumption that mid-age is considered as the key age for employment and most roles particularly child-rearing and domestic responsibilities markedly define the group. Further to this, it is important to note that mid-age is the peak age for developing depressive and anxiety disorders in women (Stansfeld et al, 2016). Moreover, older women are expected to have reduced their number of roles including the employed and parenting responsibilities.

Maximizing health is an underlying objective of the review which is examining the implications deduced from studies to suggest a possible framework for offering psychosocial interventions. The holistic view of multiple roles and subsequently the potential impact on health and wellbeing may help to derive general principles for structuring a wellness program to enhance the health and wellbeing of women.

The review intends to investigate the following questions:

1. What are the most common aspects of role dimensionality reported in the literature?
2. What are the positive and negative health and well-being related outcomes of multiple life roles most often reported by young to mid-age women?
3. What are the conditions/ protective factors that may support the roles-to-outcome relationships?
4. What directions for implications for a wellness program may be offered?

Method

Literature Search Strategy

The databases specified for literature search include PsycINFO, PsycARTICLES, Social Sciences Citation Index (SSCI), and Medline (PubMed). Each database search was guided by study objectives and study inclusion criteria, the specific search term "multiple life roles" was used as the keyword to retrieve the results. The search strategy was limited to journal articles with a period from 1980-2016. Before specifying the search strategy, other search terms including role burden, work-family conflict, and women's health were used to see what type of articles or either similar articles would come out. The references list in the selected articles was also used as a resource to further retrieve the most relevant studies.

Eligibility Criteria & Validity Process

The standard procedure of the PRISMA statement was followed in the execution and reporting of the current systematic review (Liberati et al., 2009). Based upon the nature of the research question, the criteria for screening the articles focused on the studies with salient emphasis on multiple life roles and the outcomes. Studies on life roles involving women with diagnosed chronic disorders and with critical health conditions were not included in the review. It was specified that studies for inclusion in the review should have addressed at least three major roles of mid-age women which are mother, partner, and paid employment roles. In the case of more than one papers from the same author or either from the same study and data, only the most recent publication was selected. The titles, abstracts, and keywords were examined by one researcher as an initial screening to decide for its inclusion keeping in view the underline research question of the review. Once screened out, the full-length papers were reviewed by one author for inclusion in the review. Full-length papers were reviewed by one author for a decision regarding inclusion in the review as per the criteria.

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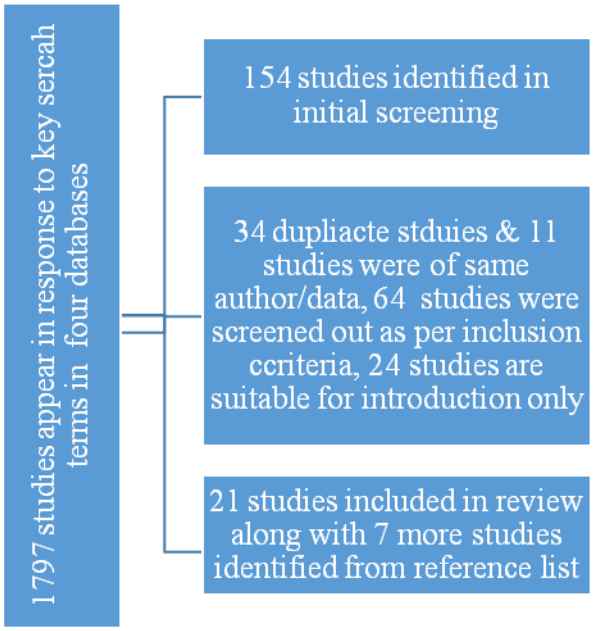
Figure 1



Materials

Data Extraction Sheet

Initial mapping of the literature on multiple life roles guided the process to specify the indicators e.g., study design, terms used to describe multiple roles, measurement indicators, outcome variables, sample characteristics, adjustments (confounding and control measures), outcomes, the direction of implications, and comments on methodology, limitations, & generalizability for inclusion in the data extraction sheet. An independent review by a subject expert was undertaken to evaluate the face validity of the data extraction sheet. A pilot test involving five studies was undertaken followed by evaluating the feasibility of the proforma through a "committee approach" involving two subject experts.

Study Quality Scoring Form

To assess the relative strength or quality of studies to be included in the review, a six-item "Quality Score Form" was developed. The indicators assess studies on dimensions of operationalization of construct, measurement issues, sample representation and size, and control variables. The form comprises 6 items with a maximum score of 10 and 5 as median score. A score above median indicates fairly good methodological quality studies and below-median may be taken as lacking in certain quality checks.

Results

Many studies included in the review are based on secondary analysis extracting from large scale community and nationwide longitudinal and cross-sectional studies. One important consideration for confidence in statistical inferences relates to large sample sizes ranging from a minimum of 1294 to a maximum of 61,383 e.g., the study of Cannuscio et al., (2004) did analysis on a large sample of 61,383 USA women. Lee and Powers (2002) analyzed 28879 Australian women. The comparative study of Lahelma et al., (2002) used data of 4,818 British women and 2334 Finland women. Janzen and Muhajarine's study (2003) used 3129 data of Canadian women. Plaisier et al., (2008) used 3857 data from Netherland. Waldron et al., (1998) used data of 3,331 White and Black women. Lanza di Scalea et al., (2012) used a sample of 2549 USA women. McMunn et al., (2006) used a sample of 1294 British women. Schoon, Hansson, and Salmela-Aro (2013) used comparative data of Estonia, Finland, the UK with Estonian 657 women, Finish 943 women and 5346 UK women. Glaser et al., (2006) used data of 1,181 UK couples. Ahrens and Ryff's study (2006) used 1335 data of USA

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women. Kostiainen, et al., (2009) used 1613 data of Finish women.

Studies based on secondary analysis of large data have extracted small sample sizes below 1000 (Martire, Stephens, & Townsend, 2000; Mellner, Krantz, & Lundberg, 2006; Nyman, Spak, & Hensing, 2012; Perrig-Chiello, Hutchison, & Hoepflinger, 2008; Turner, Killian, & Cain, 2004). The survey study of Ahmad-Nia, (2002) has used a sample size greater than 1000. Studies with a small sample size of less than 1000 are mostly of survey research design e.g., Bull's comparative study (2009) did analysis on 461 Southern women and 505 Scandinavian women. Using Canadian women sample, Hecht's study (2001) was on 279 data and Glynn, Maclean, Forte and Marsha (2009) used 716 data. A study by Tang, Lee, Tang, Cheung, & Chan (2002) used data of 897 Chinese women. Survey studies involving a sample of USA women have used a sample size of less than 310 (Greenberger & O'Neil, 1993; Ruderman et al., 2002; Sumra & Schillaci, 2015; Tiedje et al., 1990; Zambrana & Frith, 1988). Despite the small sample size, it is worth noting that a host of control variables ranging from job characteristics to work-family conflict and social context were considered (see e.g., Baruch & Barnett, 1986; Bull, 2009; Glynn et al., 2009; Hecht, 2001).

The studies with quality scores laying at the bottom level of point 6 on a scale of 1-10 are lacking in certain quality indicators e.g., ignoring to report the sample response rate, gaps in reporting the psychometric indices of the measures on the current sample, and limiting the confounding variables only to basic demographics (see e.g., Schoon et al., 2005; Zambrana & Frith, 1988). It is important to note that the biases induced in the study related to sample, other control measures and the lack of statistical power were beyond the control for the current review.

Review of Multiple Roles Research

Women engaged in major roles e.g., living with a partner, bringing up children and doing paid jobs are regarded as "Double-track women" (Perrig-Chiello et al., 2008). The popular notion of 'superwoman' has been used for women who are engaged in multiple roles of wife/mother/worker/homemaker (Sumra & Schillaci, 2015). Additionally, family caregiving for a parent, parent in-laws, or spouse has emerged as an important part of women's lives.

Studies have provided partial support for scarcity and enhancement hypotheses particularly when role relevant experiences and contextual conditions were considered (Ahmad-Nia, 2002; Hecht, 2001). Janzen and Muhajarine's (2003) study representing Statistics Canada's National Population Health Survey (NPHS) of young and mid-age women suggested multiple role occupancy as health-enhancing because of boost in positive self-image, greater access to social support and added income. Later on, Glynn et al., (2009) suggested that greater overload is associated with the poor mental health of Canadian women. Data from British studies suggested support for role enhancement (Glaser, Evandrou, & Tomassini, 2006; McMunn et al., 2006). Ahrens and Ryff's (2006) study on 1,335 US women suggested support for role enhancement perspective. Findings from many other studies have suggested support for the scarcity hypothesis (Baruch & Barnett, 1986; Cannuscio et al., 2004; Greenberger & O'Neil, 1993; Lanza di Scalea et al., 2012; Martire, Stephens, &Townsend, 2000; Mellner et al., 2006; Plaisier, et al., 2008; Waldron et al., 1998).

Role Dimensionality

The experiences associated with roles support the argument that positive and detrimental effects of several roles can best be examined in the context of role demands and satisfaction experiences instead of mere occupancy of roles. The importance that individuals attribute to their investments in performing roles provides a meaningful understanding of the resultant feelings of stress or satisfaction (Ruderman et al., 2002). The extent of engagement in given roles is strongly associated with better wellbeing (Ahrens & Ryff, 2006). Commitment to one's role particularly the married role showed a negative

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association with role strain and anxiety (Greenberger & O'Neil, 2002).

Linking role quality as a result of role overload, Glynn et al., (2009) suggested that greater overload was associated with poor mental health; whereas, better mental health was associated with high marital role quality, high role quality as a single person, high job quality among employed women, high homemaking quality score among unemployed women, and high scores on parental quality. Tang et al., (2002) suggested that mental health may potentially emerge as a function of the reward and distressing aspects of the role balance. Feelings of role conflict decrease well-being (Hecht, 2001) and increase the odds of poor health (Ahmad-Nia, 2002). Whereas, high reward across roles moderated the negative impact of role stress on social functioning (Lanza di Scalea et al., 2012).

Martire et al., (2000) highlighted that individual's role evaluation and satisfaction explains the role strain and resultant anxiety and depression one experiences (Greenberger & O'Neil, 2002). Role satisfaction across roles is potentially linked to psychological well-being. Average role satisfaction across multiple roles well associates with psychological well-being when double-track women and homemakers showed highest role satisfaction and better psychological well-being and satisfaction with partnership compared to other groups i.e., single mothers (Perrig-Chiello, 2008). The satisfaction received in a role increases life satisfaction and henceforth decreases psychological stress (Sumra & Schillaci, 2015).

Beneficial and Hampering effects of Marriage, Parenthood, and Employment

The debate that each social role carries in itself both beneficial and detrimental aspects led to the realization to expect variations in positive as well as negative role outcomes. The detrimental effects of engagement in multiple roles are more evident in mid-age women who had their first child at a young age and particularly their experiences when examined in the combination of employment and motherhood (Plaisier et al., 2008; Waldron, Weiss, & Hughes, 1998). The double burden due to unpaid household work along with paid job engagement particularly if psychosocial conditions of work are poor is associated with poor self-reported health (Mellner et al., 2006).

The beneficial role of intimate relationships provides an understanding of how marriage can bring a positive impact to women (Schoon et al., 2005). Marital status as an important contributor in one's life satisfaction was supported when data from British General Household Survey (GHS) and the Finnish Government survey on Living Conditions (SLC) suggested that British and Finish women who are lone, single or divorced mothers have higher odds for poor health and long-standing illness compared to couples with children and single with no child. Comparing 'British Couples with no child' also showed higher odds for long term illness (Lahelma et al., 2002). Further to this, divorced women with dependent children from Estonia, Finland, and the UK are less satisfied (Schoon et al., 2005).

Assessing the partner vs. parent role, anxiety and depressive disorder symptomatology explained decreased risk for partner role but not for parent role (Plaisier, et al., 2008). Mother role concerns have shown a positive association with distress feelings (Tang et al., (2002). The intensive parental role alone explains the decrease in social participation (Glaser et al., 2006). With a sample of 600 Swedish women, Nyman et al., (2012) reported that partner role was associated with lower odds for a psychiatric disorder, while a parental role (children <14 years) was associated with higher odds for sickness absence. Whereas, having an occupational role was associated with lower odds for poor self-rated physical health and sickness absence. Parental role with children <14 years was associated with higher odds for sickness absence.

The balancing aspect of the employed mother role has been linked with psychological distress (Tang et al., 2002). Because of spillover effects of work and parental role (Zambrana & Frith, 1988), work and parenthood were associated with anxiety and depressive disorder symptomatology (Plaisier, et

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al., 2008). Longitudinal panel data from the National Longitudinal Surveys of Labor Market Experience involving 3,331 White and Black women aged 24-34 (Waldron et al., 1998) supported that employed and married role contribute to worsening the health problems with a strong increase in health problems later on. Nyman's study (2012) suggested that combining occupational and partner role associates with lower odds for poor self-health, psychiatric disorder and sickness absence.

The status of working women may worsen mental health as reported in Iranian women (Ahmad-Nia, 2002). Despite the varying experiences associated with work roles, studies have emphasized the benefits the work role provides. Employment, irrespective of gender, particularly in professional jobs is associated with better life satisfaction (Schoon et al., 2005). Interaction of employed and married role demonstrated that employment had beneficial health effects for unmarried women and marriage had a little beneficial impact among employed women (Waldron et al., 1998). When assessed for effect across roles, synergistic effects were demonstrated e.g., Swedish women with high domestic work burden and who were also high in job strain experienced an increased risk of common symptoms and poor health (Mellner et al., 2006).

Multiple Roles and Well-being Outcomes

Table 1.
Summary of the Role-to-Outcome Variables and Associative Variables

Role Variables	Health & Well-Being Outcomes	Conditions under which role and outcome relationship occurs
Role Occupancy/ Role combinations *Role Experiences* (Quality, Commitment, Overload, Strain, Conflict, Overload, Balance, Reward, Satisfaction)	Mental health functioning, Physical health, Self- rated health, Positive affect, Anxiety Depression, Stress, Psychological distress, Symptomatology of psychiatric disorders, Long-standing illness, Social functioning, Self-acceptance, Life satisfaction,	*Sociodemographics/ Psychographics* Age, education, social class, economic factors, spouse' education, spouse' characteristics, household size, age of the youngest child, family type, network diversity, social life entertainment *Health Status* Diagnosed health conditions *Job Conditions* Employment status, occupational positions, job strain, job characteristics, working hours, years of experience, work-family conflict, psychosocial work conditions, husband's consent for paid work, career goals, work flexibility *Psychological Resources* Commitment to role, agency, role reward, perceived control, role balance, role rewards, social support, division of responsibilities, State welfare policies

A summary of multiple roles and well-being outcomes presented in table 1 yielded well-being outcomes ranged from physical and mental health to various indicators of social health.

Physical & Mental Health: Lee and Powers (2002) analyzed a survey of age cohorts of 41,818 Australian women suggesting that multiple roles (3-5) are related to higher stress after controlling for confounders including qualifications, income,

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health habits - smoking, and chronic illness. Three or more roles are associated with the best health among the mid-age group compared to young and older groups. A longitudinal study of 3129 young and mid-age Canadian women reported that life stage and role occupancy were significantly associated with self-rated health e.g., double role (vs. triple role) women showed higher odds for better self-rated health compared to a single role (vs. triple) (Janzen & Muhajarine, 2003).

Multiple role occupancy is associated with good self-rated health. Being unemployed is associated with high odds for poor self-reported health and psychological distress after controlling for age, education, and income. Being in no partnership status is linked with high odds for poor self-rated health and psychological distress while adjusted for age, education and income (Kostiainen et al., 2009). Ahrens and Ryff's (2006) study on 1,335 US women suggested that women with multiple roles have lower odds for poor health compared to those with the limited role of domestic work only. Data of 1294 women with age bracket 26-53 years from a British Birth Cohort study suggested that women with multiple roles have lower odds for poor health when compared with a limited role as homemakers. The same pattern has been observed with stronger effects for homemakers when controlled for the agency (quality of paid and unpaid work quality and family stress) and social class of head of household. A slight decrease in poor health has observed in homemakers when controlled for work quality at age 36 (McMunn et al., 2006).

Considering caregiving as an additional role, a longitudinal study of 296 middle-generation American women engaged in parent care reported heightened depression (Martire et al., 2000). The longitudinal data of the Nurses' Health Study of 61,383 American women (Cannuscio et al., 2004) suggested that intensive time spent in caregiving heightened depressive symptoms regardless of employment status, partial support for scarcity hypothesis. The study suggested that spousal care relates more strongly to depressive symptoms than parent care. However, social ties help to decrease depressive symptoms.

Social Indicators of Health: Life satisfaction as an important dimension of well-being about women's multiple role engagements has been widely studied. Bull's study (2009) involving a sample age 45 or younger from South European countries (Greece, Portugal, Spain; n = 461) reported that women in parent and partner roles had a better positive affect and life satisfaction when compared with single mothers. In a similar direction, coupled mothers from Scandinavian countries (Denmark, Norway, Sweden; n = 505) reported better life satisfaction compared to Scandinavian single mothers. Ruderman et al's., (2002) study on USA women with 177 samples reported that commitment to multiple life roles predicts variance though minimal in life satisfaction up to 3% only and 8% in explaining association with self-acceptance. Stress in parental and wife roles are negative predictors of life satisfaction (Martire, et al., 2000). A sample from North America involving 308 women with varied education reported role satisfaction as a positive predictor explaining 22% variation in life satisfaction. Moreover, higher stress was reported by single mothers, employed, and also by homemaker women (Sumra & Schillaci, 2015). Employed women as partner and parent have shown a positive association with life satisfaction in samples from UK, Estonia, and Finland when controlled for occupational status (Schoon et al., 2005).

Data from British Household Panel Study (BHPS) involving 1, 181 couples (Glaser et al., 2006) suggested that employment as a full-time role along with intensive elderly carer role do not decrease the participation in social and leisure activities. Whereas, an intensive parental role decreases social participation of women whilst their husbands' involvement in parental role provides a boost to women's social participation.

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Conditions that Contribute to the Multiple Roles and Outcomes Relationships

Several correlates and protective factors contribute to the relationship between multiple roles and health outcomes. Personality as a covariate provides a possible understanding of the influence on perceptions of enhancement and conflict (Tiedje et al., 1990). Considering the developmental context of life roles, age and role tenure explains variations in health outcomes (Greenberger & O'Neil, 1993). An increase in age and year of schooling has shown modest effects on depressive symptoms (Reid & Hardy, 1999). Age as a predictor negatively correlates with stress outcome (Sumra & Schillaci, 2015). Ahmad-Nia (2002) suggested that age is strongly related with odds of poor health increasing by a factor of 1.05 for each additional year of age. Education as a negative predictor explains depression (Greenberger & O'Neil, 1993). Women's less education and poor health, husbands' poor health and social class explain a decrease in social participation among women with multiple roles (Glaser et al., 2006).

A strong effect of the socio-economic class has been seen on women's health (Ahmad-Nia, 2002; Baruch & Barnett, 1986; Martire et al., 2000). Unemployment and low income in less-educated women are significantly associated with poor self-rated health because of material deprivation and lack of resources associated with low income (Mellner et al., 2006). Ethnicity stands out as an important demographic factor in shaping women's role experiences (Lanza di Scalea et al., 2012; Lee & Powers, 2002; Reid & Hardy, 1999).

While explaining the processes that contribute to roles and outcome relationships, role characteristics have been explored as mediating variables (Waldron et al., 1998). Importance associated with roles assessed through role centrality e.g, mother role centrality buffered women from the negative effects of mother role stress on depressive symptoms. Wife role centrality exacerbated the effects of stress on life satisfaction and employee role centrality exacerbated the effects of employee stress on depression (Martire et al., 2000). Rewards associated with roles particularly high reward across roles moderates the negative impact of role stress on depression and social functioning (Lanza di Scalea et al., 2012).

Among job-related conditions, Mellner et al., (2006) suggested that more control over work conditions and financial control along with better sharing of responsibilities at home are protective factors when assessed for physical and mental symptoms and self-rated health. Increased work hours showed a positive association with role strain (Greenberger & O'Neil, 1993). Occupational status e.g., professional, skilled and semiskilled jobs (Schoon et al., 2005) and flexibility in work schedules and higher income relate to greater well-being (Hecht, 2001). Working women in higher occupational job classes characterized by better physical job conditions with at least average psychosocial job conditions, economic independence, and low pressure from work and family domains reduces the odds for reporting poor health (Ahmad-Nia, 2002).

The role of unique psychological resources and the importance of supportive interpersonal relationships over the life course need to be considered to explain variations in well-being. Spouse's social support is negatively associated with all forms of well-being compared to other sources of support (Greenberger & O'Neil, 1993). The ongoing life events and associated stress worsen the general health (Ahmad-Nia, 2002). As social context variables, marital support, companionship and self-esteem improve mental health (Ahmad-Nia, 2002). Perceived control taken as personal mastery and perceived constraints compensates for low education status and low role involvement (Ahrens & Ryff, 2006).

Discussion

With the realization that multiple role involvement is beneficial for women in certain respects and carries detrimental consequences as well, the newer trends in the role literature offer quite a diverse analysis. The interrelationships between role occupancy and health among women are complex and depend on a host of

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sociodemographic and contextual factors along with the influential roles played by unique psychological resources and the personal circumstances needed to survive in the social life sphere. The varying experiences corresponding to work conditions and the normative conditions associated with societal roles must need be considered while interpreting the impact women are likely to experience as a result of managing multiple roles. Most studies have debated the independence of enhancement and scarcity hypotheses rather than addressing the interdependence of both dimensions, a question that has received less attention (Tiedje et al., 1990). Despite a handful of studies that provide support for the role enhancement perspective, the complexity of how multiple roles interact and the psychosocial mechanisms that help to balance out the negative effects must need be appreciated.

Women in the employed role and being partner and parent along with the supportive family environment, flexible work conditions, reasonable psychosocial conditions, high-income group, and high education are important determinants of health. Mental health effects of women's multiple roles provide a meaningful explanation when studied in the context of role relevant experiences. The commitment associated with marital roles and the evaluation of role in terms of how well one is performing and the satisfaction emerging out of role performance and the rewards associated with roles are linked to enhanced wellbeing. Whereas, an increase in feelings of role conflict significantly decreases women's well-being.

In understanding the conditions that support role-to-outcome relationships, the review has highlighted the supportive role of social factors. Social resources have emerged as powerful contributory factors both within the family and work-life spheres as well. This complements the resource-oriented model of well-being suggesting that satisfying social resources provide a powerful explanation of well-being enhancement (Perrig-Chiello et al., 2008). Social class as a powerful factor accounts for improving women's health. Being in a greater number of social roles itself is associated with greater financial and psychological resources (Martire et al., 2006) partly because women paid employment provides better resources to couples and families (Glaser et al., 2006)

The socio-economic circumstances mediate the odds for poor health especially in a vulnerable group of lone mothers (McMunn et al., 2006). The variation in well-being concerns of women across different countries partly may be attributed to the economic circumstances. This in turn suggests that a broader context of social and cultural inequalities are needed to consider rather than understanding wellbeing as an individualistic phenomenon (Schoon et al., 2005). Among social context variables, spouse's social support, rewarding marital and parenting role and sharing in family role responsibilities are important protective factors. Women's less education has been linked with poor self-rated health. The review has highlighted certain important dimensions e.g, considering the role played by social role obligations, intimacy, and reciprocity that provide a meaningful understanding of well-being, particularly in the family context. Among unique psychological resource, perceived control and personal mastery, role centrality, sense of agency are buffering factors for improved mental health for women. Among job-related conditions, control over work conditions, level of occupational status, flexibility in work schedules, low work pressure, better physical and psychosocial job conditions are protective factors for women's health.

Overall, it is worth noting that the contextual conditions under which women work e.g., the psychosocial aspects of work and the support mechanism at work along with the influence of one's social class must need be accounted for while understanding the potential outcomes of multiple role engagements. The economic independence of women in paid work and the benefits and resources that come by way of when women are in partner role provides a meaningful understanding of positive well-being benefits of multiple roles rather than being in fewer roles. Parenting and motherhood themselves provide positive benefits protecting one from experiencing

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negative effects in most of the studies. It is interesting to note that health benefits are evident for a group of women who own certain economic, material, and social resources. We just need to consider that the selected group of women tend to have a smooth way towards health benefits out of multiple role engagements. Not everyone is blessed with supporting factors which in turn calls upon the need of health practitioners to address the well-being concerns of women.

Implications for offering a Wellness Program

Despite the increasing attention towards understanding multiple roles as explanatory factors in explaining women's health, there has been relatively little emphasis on policy implications. The relatively neglected area needs to look into more defined ways of health management. Since, employee role has emerged as the one role carrying impeding as well as the beneficial impacts (Glynn et al., 2009; Martire et al., 2000; Nyman et al., 2012; Schoon et al., 2005), the importance of wellness interventions associated with employment role cannot be ignored (Kostiainen, 2009). Synergy across roles and the competition between roles contribute to workplace behaviours and attitudes calling for support mechanism helping to integrate work and off-the-job lives (Ruderman et al., 2002; Nyman et al., 2012).

The variations in social roles profile among subgroups of women themselves call for a comprehensive workplace compensation program conducive to varying needs and preferences. Findings from countries including Britain, Estonia, and Finland suggested the need for policies in employment legislation for providing favourable employees benefit program for women who are divorced and have dependent children (Schoon et al., 2005). Countries with comprehensive State welfare policies are in a better position for promoting the health of a varying group of women including the vulnerable group of single mothers (Bull, 2009). Emphasizing policies that possibly may ease the financial burdens of single and lone mothers must be introduced. The budgeting policy for compensation plan must need to consider the cafeteria-style benefits for employed lone mothers (Lahelma et al., 2002). Considering the added responsibility of elderly care in the family context has stressed the need for policy-driven impact in introducing flexible work hours for individuals who are caring for adult dependents (Glaser et al., 2006).

The considerations for designing interventions by wellness practitioners emerges out of the balancing aspects of managing the multiple life roles. An increased emphasis upon work and personal life boundaries as a mean of maintaining work-life balance may work well (Bulger, Matthews, & Hoffman, 2007). Integrating the job-family trade-off context has called upon an emphasis for understanding the changing pattern of gender role expectations e.g., transforming an attitude of sharing of household responsibilities among spouses (Mellner et al., 2006). An important consideration stressing the need for multiple role planning attitudes (Lopez, McDermott, & Fons-Scheyd, 2014) should ideally address by counselors.

Considering age as a marker of life stage implies the need to look for coping mechanisms that may have to change or adapt along with changes in life stages (Cannuscio, 2004; Mellner et al., 2006). This explains to introduce wellness training in areas helping role mastery and effective role performance. Generally, efforts have been seen in the context of individuals' personal ability to cope with role demands. Enhancing the problem and emotion-focused coping while embedding the support system may prove useful for women's well-being (Rao, Apte, & Subbakrishna, 2003). An important dimension emerging for offering a wellness program for women may look into enhanced coping through realization about the investments people made and how to do these are linked with desirable outcomes. The cognitive realization that they are contributing successfully and the associated benefits will itself serve as a mechanism to experience life satisfaction and enhanced self-acceptance (Ruderman et al., 2002). The dynamics that underlie the type of cognitive coping strategies should consider the contextual appropriateness and also the attribution style that

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shape women's cognition (as cited in McBride, 1990). A society's socio-cultural climate provide insight while understanding women's coping e.g., factors like gender role ideology, women's traditional roles and socializing pattern of men are important contextual factors to consider. A focus on strengthening the individual based coping to the more specialized support offered at the institutional level stands as the need of time.

Limitations of the Review

The current review has incorporated studies from few relevant databases that may leave the possibilities of exclusion of various studies reported elsewhere. The methodological aspects of the studies were best assessed through quality assessment of the studies. However, the possibility of bias in published studies related to study sample, specification and control of confounding variables and the lack of statistical power was beyond the control of the current review.

Future Focus

Considering the beneficial impact of employment in the context of role enhancement, future research studies need to thoroughly examine the career path and values women endorse as a mean to better understand the importance women attribute to their career or employed role. The opportunities and restrictions that social roles provide to women and how these relate to women's health needs more attention and further testing. The review strongly suggests that future studies should address cross-cultural variations as an account of how being part of the collectivistic and individualistic cultures might put women at risk of ill-health or may offer beneficial outcomes.

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References

[1] Ahmad-Nia, S. (2002). Women's work and health in Iran: a comparison of working and non-working mothers. *Social Science and Medicine*, *54*(5), 753-765.

[2] Ahrens, C. J. C., & Ryff, C. D. (2006). Multiple Roles and Well-being: Sociodemographic and Psychological Moderators. *Sex Roles*, *55*(11-12), 801-815.

[3] Baruch, G. K., & Barnett, R. C. (1986). Role quality, multiple role involvement, and psychological well-being in midlife women. *Journal of Personality and Social Psychology*, *51*(3), 578-585.

[4] Bull, T. (2009). Work-life and mental well-being: single and coupled employed mothers in Southern Europe and Scandinavia. *Glob Health Promot*, *16*(3), 6-16.

[5] Bulger, C. A., Matthews, R. A., & Hoffman, M. E. (2007). Work and personal life boundary management: boundary strength, work/personal life balance, and the segmentation-integration continuum. *Journal of Occupational Health Psychology*, *12*(4), 365-375.

[6] Cannuscio, C. C., Colditz, G. A., Rimm, E. B., Berkman, L. F., Jones, C. P., & Kawachi, I. (2004). Employment status, social ties, and caregivers' mental health. *Social Science and Medicine*, *58*(7), 1247-1256.

[7] Glaser, K., Evandrou, M., & Tomassini, C. (2006). Multiple Role Occupancy and Social Participation among Midlife Wives and Husbands in the United Kingdom. *The International Journal of Aging and Human Development*, *63*(1), 27-47.

[8] Glynn, K., MacLean, H., Forte, T., & Cohen, M. (2009). The Association between Role Overload and Women's Mental Health. *Journal of Women's Health*, *18*(2), 217-223.

[9] Greenberger, E., & O'Neil, R. (1993). Spouse, parent, worker: Role commitments and role-related experiences in the construction of adults' well-being.

Developmental Psychology, 29(2), 181-197.

[10] Hecht, L. M. (2001). Role conflict and role overload: Different concepts, different consequences. *Sociological Inquiry, 71*(1), 111-121.

[11] Janzen, B. L., & Muhajarine, N. (2003). Social role occupancy, gender, income adequacy, life stage and health: a longitudinal study of employed Canadian men and women. *Social Science and Medicine, 57*(8), 1491-1503.

[12] Kostiainen, E., Martelin, T., Kestila, L., Martikainen, P., & Koskinen, S. (2009). Employee, Partner, and Mother Woman's Three Roles and Their Implications for Health. *Journal of Family Issues, 30*(8), 1122-1150.

[13] Lahelma, E., Arber, S., Kivelä, K., & Roos, E. (2002). Multiple roles and health among British and Finnish women: the influence of socioeconomic circumstances. *Social Science and Medicine, 54*(5), 727-740.

[14] Lanza di Scalea, T., Matthews, K. A., Avis, N. E., Thurston, R. C., Brown, C., Harlow, S., & Bromberger, J. T. (2012). Role stress, role reward, and mental health in a multiethnic sample of midlife women: results from the Study of Women's Health Across the Nation (SWAN). *Journal of Women's Health, 21*(5), 481-489.

[15] Lee, C., & Powers, J. R. (2002). Number of social roles, health, and well-being in three generations of Australian women. *Int J Behav Med, 9*(3), 195-215.

[16] Liberati, A., Altman, D., Tetzlaff, J., et al. (2009). The PRISMA Statement for Reporting Systematic Reviews and Meta-Analyses of Studies that Evaluate Health Care Interventions: Explanation and Elaboration. *Annals of Internal* Medicine, *151*(4), 65-94.

[17] Lopez, F. G., McDermott, R. C., & Fons-Scheyd, A. L. (2014). Profiling the Multiple Role Planning Attitudes of College Women. *Journal of Career Assessment, 22*(4), 700-714.

[18] Martire, L. M., Stephens, M. A., & Townsend, A. L. (2000). Centrality of women's multiple roles: Beneficial and detrimental consequences for psychological well-being. *Psychology and Aging, 15*(1), 148-156.

[19] McBride, A. B. (1990). Mental health effects of women's multiple roles. *American Psychologist, 45*(3), 381-384.

[20] McMunn, A., Bartley, M., Hardy, R., & Kuh, D. (2006). Life course social roles and women's health in mid-life: causation or selection? *Journal of Epidemiology and Community Health, 60*(6), 484-489.

[21] Mellner, C., Krantz, G., & Lundberg, U. (2006). Symptom reporting and self-rated health among women in mid-life: The role of work characteristics and family responsibilities. *International Journal of Behavioral Medicine, 13*(1), 1-7.

[22] Nyman, C. S., Spak, L., & Hensing, G. (2012). Multiple social roles, health, and sickness absence- A five-year follow-up study of professional women in Sweden. *Women and Health, 52*(4), 336-351.

[23] Perrig-Chiello, P., Hutchison, S., & Hoepflinger, F. (2008). Role Involvement and Well-Being in Middle-Aged Women. *Women and Health, 48*(3), 303-323.

[24] Rao, K., Apte, M., & Subbakrishna, D. K. (2003). Coping and subjective wellbeing in women with multiple roles. *International Journal of Social Psychiatry, 49*(3), 175-184.

[25] Reid, J., & Hardy, M. (1999). Multiple roles and well-being among midlife women: Testing role strain and role enhancement theories. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 54*(6), S329-S338.

[26] Ruderman, M., Ohlott, P., Panzer, K., & King, S. (2002). Benefits of multiple roles for managerial women. *Academy of Management Journal, 45*(2), 369-386.

[27] Schoon, I., Hansson, L., & Salmela-Aro, K. (2005). Combining work and family life - Life satisfaction among married and divorced men and women in Estonia,

Article Received: 08th October, 2020; Article Revised: 15th February, 2021; Article Accepted: 20th March, 2021

Finland, and the UK. *European Psychologist, 10*(4), 309-319.

[28] Sumra, M., & Schillaci, M. A. (2015). Stress and the multiple-role woman: taking a closer look at the "superwoman". *PLoS One, 10*(3), e0120952. doi:10.1371/journal.pone.0120952

[29] Stansfeld, S., Clark C., Bebbington, P., King, M., Jenkins, R., & Hinchcliffe, S. (2016). *Common Mental Disorders. Chapter 2.* Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England 2014. NHS Digital.

[30] Tang, C., Lee, A., Tang, T., Cheung, F., & Chan, C. (2002). Role occupancy, role quality, and psychological distress in Chinese women. *Women and Health, 36*(1), 49-66.

[31] Tiedje, L. B., Wortman, C. B., Downey, G., Emmons, C., Biernat, M., & Lang, E. (1990). Women with multiple roles: Role-compatibility perceptions, satisfaction, and mental health. *Journal of Marriage and the Family, 52*(1), 63-72.

[32] Thoits, P. (1983). Multiple identities and psychological well-being: A reformulation and test of the social isolation hypothesis. *American Sociological Review, 48*, 174–187.

[33] Zambrana, R., & Frith, S. (1988). Mexican-American professional women: Role satisfaction differences in single and multiple role lifestyles. *Journal of Social Behavior and Personality, 3*(4), 347-361.

[34] Pearlin, L. I. (1989). The sociological study of stress. *Journal of Health and Social Behavior, 30*, 241-256.

[35] Plaisier, I., de Bruijn, J. G., Smith, J. H., & dee Graaf, R., et al., (2008). Work and family roles and the association with depressive and anxiety disorders: differences between men and women. *Journal of Affective Disorders, 105*(1), 63-72.

[36] Waldron, I., Weiss, C. C., & Hughes, M. E. (1998). Interacting effects of multiple roles on women's health. *Journal of Health and Social Behaviour*, 216-236.