

Physical and Mental Health Consequences of Work-Related Stress: A Comparative Study of Women and Men

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Abstract: Work-related stress is a leading occupational health concern, and a substantial literature suggests its consequences differ between women and men. Most of that literature, however, establishes that a difference exists without identifying the mechanism responsible. This study examined the physical and mental health consequences of work-related stress among employed women and men, and tested whether differences persisted after psychosocial working conditions were controlled. A comparative cross-sectional design was adopted. Data were collected from 101 full-time employees aged 25-50 in Bengaluru, India; the analytical sample comprised 100 participants (50 women, 50 men). A 50-item instrument assessed perceived stress, working conditions, physical symptoms, emotional wellbeing and coping. Physical health and emotional wellbeing scales showed good reliability ($\alpha = .83$ and $.86$). Five of six hypotheses were unsupported: women and men did not differ in perceived stress ($p = .584$, $d = -0.11$), physical symptoms ($p = .986$, $d = 0.004$) or emotional wellbeing ($p = .575$, $d = 0.11$), and gender did not moderate the stress-health relationship. One significant difference emerged: men reported greater problem-focused coping ($p < .001$, $d = -0.73$), although the predicted difference in emotion-focused coping did not appear. Perceived stress correlated strongly with physical symptoms ($r = .55$) and emotional wellbeing ($r = .62$), explaining 30% and 39% of variance. Findings are consistent with a differential-exposure account: where working conditions were comparable, health consequences were comparable.

Keywords: work-related stress, gender differences, occupational health, coping strategies, employee wellbeing

1. Introduction

Paid employment occupies a substantial proportion of adult waking life, and the conditions under which it is performed have measurable consequences for health. The World Health Organization defines work-related stress as the response people may have when presented with work demands and pressures not matched to their knowledge and abilities [1]. The definition is deliberately relational: stress is located neither wholly in the individual nor wholly in the job, but in the fit between them.

Chronic occupational stress has been associated with cardiovascular disease, disturbed sleep, impaired immune function, depressive and anxiety disorders, and burnout [2], [3]. In 2019 the World Health Organization classified burnout in ICD-11 as an occupational phenomenon arising from chronic workplace stress that has not been successfully managed [4], a classification locating the problem in the working environment rather than in individual pathology. Although exposure is widespread, research reports that its expression varies by gender, with women more often reporting emotional exhaustion and men reporting comparable or greater somatic complaint [5], [6]. Three explanations compete. Differential exposure holds that women and men encounter different stressors because they occupy different roles. Differential vulnerability holds that the same exposure produces different responses. Differential reporting holds that masculinity norms suppress male disclosure, producing an apparent difference that is partly an artefact [7].

These explanations carry different practical implications. If the difference is one of exposure, the remedy is structural; if of vulnerability, the remedy is individual support; if of reporting, the remedy is reducing stigma. Most research cannot distinguish them. The present study measured psychosocial working conditions alongside outcomes, permitting a partial test between the exposure and vulnerability accounts.

A further limitation of the existing evidence is its origin. The majority derives from North American and European samples, and transferability to Indian workplaces cannot be assumed, given differences in labour force participation, domestic role expectations, working-hour cultures and mental health stigma.

2. Review of Literature

Karasek [8] proposed that strain arises from high psychological demand combined with low decision latitude rather than from demand alone; Karasek and Theorell later added workplace support, producing the demand-control-support model. Siegrist [9] located strain in the imbalance between effort invested and reward returned. Demerouti et al. [10] generalised these in the job demands-resources model, in which demands drive an energy-depletion pathway and resources a motivational one. Lazarus and Folkman [11] supplied the individual-level complement, conceptualising stress as the product of primary and secondary appraisal, with coping classified as problem-focused or emotion-focused.

On physical outcomes, Ganster and Rosen [2] identified cardiovascular, metabolic and immune pathways. Kivimäki et al. [12] reported that long working hours were associated with increased stroke and coronary heart disease risk. Nixon et al. [13] meta-analysed work stressors and physical symptoms, finding consistent associations with headache, gastrointestinal complaint, sleep disturbance and fatigue.

On mental health, Melchior et al. [14] found in a longitudinal cohort that high job demand predicted new-onset depression and anxiety after adjustment for prior psychiatric history. Maslach et al. [3] reviewed burnout as a three-dimensional syndrome with workload and control as its most consistent antecedents. Purvanova and Muros [5] meta-analysed gender differences in burnout and found women higher on emotional exhaustion but men higher on depersonalisation, indicating that aggregate scores may conceal opposing subscale patterns.

On mechanisms, Kudielka and Kirschbaum [15] reported that sex differences in HPA axis reactivity exist but vary by stressor type and cycle phase, cautioning against simple claims of greater reactivity. Ptacek et al. [16] found women used more emotion-focused and men more problem-focused coping even where stressor and appraisal did not differ, a pattern replicated by Matud [17]. Courtenay [7] argued that masculinity norms discourage help-seeking, producing under-reporting among men.

Hochschild [18] introduced emotional labour, noting its concentration in service roles disproportionately occupied by women. Emslie and Hunt [19] found that women described permanent dual accountability across work and home where men described the domains as sequentially separable. Richardson and Rothstein [20] meta-analysed stress management interventions, noting that most target individual coping despite a largely organisational aetiology. Two gaps follow. First, exposure is rarely controlled statistically, leaving it unclear whether differences reflect gender or the jobs women and men occupy. Second, physical and psychological outcomes are usually examined separately, preventing direct test of the somatisation hypothesis. The present study addresses both.

3. Methodology

3.1 Research Design

A quantitative, comparative, cross-sectional survey design was adopted. The design is comparative because two naturally occurring groups defined by gender were contrasted, cross-sectional because data were gathered at a single point in time, and quantitative because constructs were measured on rating scales yielding interval-level data suitable for parametric analysis. The design permits examination of group differences but cannot establish temporal precedence, a limitation addressed in Section 7.

3.2 Participants and Sampling

Purposive sampling with snowball referral was used to recruit full-time employees aged 25-50 from the information technology, healthcare, education, banking and government

sectors in Bengaluru, India. Non-probability sampling was adopted because the design required balanced gender cells and defined employment criteria. Inclusion required at least 35 working hours per week and a minimum of twelve months with the current employer. Participants on long-term medical leave, under notice of termination, or receiving active treatment for severe mental illness were excluded.

Blanket exclusion of participants reporting any history of psychological difficulty was deliberately avoided, since depression and anxiety are precisely the outcomes under study and excluding affected individuals would bias results toward the null.

A total of 101 responses were received between 16 September and 10 October 2026. One participant identified outside the gender binary and, since a single case cannot constitute a comparison group, was reported descriptively but excluded from between-group tests. The analytical sample was therefore $N = 100$, comprising 50 women and 50 men.

Table 1: Demographic and occupational profile of the sample ($N = 100$)

Characteristic	Women	Men	Total
Age 25-30	10	17	27
Age 31-35	12	12	24
Age 36-40	13	3	16
Age 41-45	8	14	22
Age 46-50	7	4	11
Undergraduate	6	14	20
Postgraduate	28	24	52
Professional / doctoral	12	10	22
Other qualification	4	2	6
Junior level	8	5	13
Mid-level	26	15	41
Managerial	12	16	28
Senior management	4	14	18
Works 40 hrs or fewer	21	13	34
Works 41-50 hrs	21	25	46
Works over 50 hrs	8	12	20
On-site	30	25	55
Hybrid	14	16	30
Fully remote	6	9	15
Primary caregiving role	47	37	84
Household work under 5 hrs	14	2	16
Household work over 30 hrs	12	15	27

Two features of the profile merit comment. The sample was highly educated, with 74% holding a postgraduate or higher qualification, and relatively senior, with 46% in managerial or senior roles. Designation level also differed by gender, with 14 men and 4 women in senior management against 26 women and 15 men at mid-level. Since seniority is associated with both autonomy and workload, this imbalance is relevant to interpretation and is revisited in Section 7.

3.3 Sample Size and Statistical Power

An a priori power analysis indicated that detecting a medium effect ($d = 0.50$) at $\alpha = .05$, two-tailed, with power of .80 would require 64 participants per group. The achieved sample of 50 per group yields the power profile shown in Table 2.

Table 2: Achieved statistical power (n = 50 per group)

Effect size (d)	Achieved power	Interpretation
0.30 (small)	.318	Underpowered
0.50 (medium)	.697	Below .80 threshold
0.57	.806	Minimum adequately detectable
0.73 (observed)	.951	Well powered
0.80 (large)	.977	Well powered

The study was therefore adequately powered for medium-to-large effects but underpowered for small effects. Non-significant findings should accordingly be read as the absence of detectable medium-to-large differences rather than as proof that no difference of any size exists.

3.4 Instrument

A 50-item self-administered questionnaire was constructed for this study and delivered online. It comprised an informed consent item, 12 demographic and work-profile items, and five rating scales: perceived work-related stress (8 items), psychosocial working conditions (6 items), physical health symptoms (7 items), emotional wellbeing (8 items) and coping strategies (8 items). All items used five-point scales with identical response wording within each scale type, and all were compulsory, eliminating missing data. Three items were positively worded and intended for reverse scoring.

The instrument was self-constructed rather than adopted from published validated scales. This permitted tailoring to the research questions and kept completion time within fifteen minutes, but means no prior psychometric evidence was available. Reliability was therefore established on the present sample and is reported in full in Section 4.1.

3.5 Procedure and Ethical Considerations

Participants received an information sheet describing the purpose, procedure, voluntary nature and confidentiality arrangements of the study, and provided explicit consent before viewing any item. Consent was configured with conditional branching so that participants who declined proceeded directly to submission without seeing any question. No name, employee number or contact detail was collected and email collection was disabled, rendering responses untraceable. It was stated explicitly that no individual-level data would be shared with any employer and that only aggregate findings would be reported.

Because the questionnaire concerned stress, mood and physical symptoms, the information sheet stated clearly that the measures were research instruments and not diagnostic tools, and provided the contact number of a national mental health helpline. The same information appeared on the confirmation page following submission. All data have been reported as obtained; no case was excluded to obtain a significant result and no hypothesis was altered after the data were examined.

3.6 Statistical Analysis

Analysis used Python 3.14 with the NumPy, pandas, SciPy and statsmodels libraries, which implement the same procedures as SPSS. Welch t-tests were used for group comparisons in preference to Student t-tests, since Welch

does not assume equal variances and performs at least as well when variances are equal. Pearson correlation was used for associations, chi-square for categorical association, and moderated and hierarchical regression for Hypotheses 5 and 6. Effect sizes are reported alongside every significance test and alpha was set at .05, two-tailed.

4. Results

4.1 Data Screening

Because every item was compulsory, no missing values were present and no case required deletion or imputation. Three screening checks were applied. All 101 response patterns were compared for exact duplication across the 50 substantive items; no two records were identical. Records were examined for straight-lining, the selection of an identical option across all 37 rating items; no case displayed this pattern. Submission timestamps were inspected for implausible clustering; responses were distributed across 21 days with a median interval of approximately 41 minutes on the busiest day.

4.2 Reliability Analysis

Table 3: Internal consistency of scales

Scale	Items	Alpha	Verdict
Perceived stress (as built)	8	.441	Unacceptable
Perceived stress (revised)	6	.787	Acceptable
Physical health symptoms	7	.834	Good
Emotional wellbeing	8	.863	Good
Problem-focused coping	3	.584	Modest
Emotion-focused coping	3	.609	Modest
Avoidant coping	2	.516	Modest

The two scales central to the research question, physical health symptoms and emotional wellbeing, demonstrated good internal consistency and required no modification. Corrected item-total correlations for these scales are reported in Table 4.

Table 4: Corrected item-total correlations for the two primary scales

Item	Physical health r	Emotional wellbeing r
Item 1	.593 (headaches)	.523 (low mood)
Item 2	.651 (sleep onset)	.567 (anhedonia)
Item 3	.585 (unrefreshing sleep)	.719 (anxiety)
Item 4	.611 (gastrointestinal)	.713 (difficulty relaxing)
Item 5	.572 (musculoskeletal)	.617 (emotionally drained)
Item 6	.570 (cardiac sensations)	.570 (used up)
Item 7	.524 (fatigue)	.549 (irritability)
Item 8	-	.633 (concentration)

4.3 Failure of the Reverse-Worded Items

Examination of corrected item-total correlations for the perceived stress scale revealed that both reverse-worded items correlated negatively with the remainder of the scale after reversal ($r = -.317$ and $r = -.280$). When the same items were correlated with the six-item core in their original unreversed form, both correlations were substantial and positive: $r = +.440$ for "I have felt confident about my ability to handle problems at work" and $r = +.418$ for "I have felt that things at work were going my way".

Participants reporting higher stress therefore also endorsed feeling confident and feeling that things were going their way. Read literally these responses are contradictory, and the pattern is the recognised signature of acquiescence bias, the tendency to agree with statements irrespective of content. Following standard psychometric practice both items were removed and the scale rescored from the remaining six, raising alpha from .441 to .787. This decision was taken on psychometric grounds before any hypothesis was tested.

The working-conditions items did not cohere as a single scale, which is the expected result for a deliberately multidimensional set assessing job demand, decision latitude and workplace support. These six items were therefore analysed as individual indicators rather than combined, a recognised approach for job-characteristic measures.

4.4 Assumption Checks

Table 5: Normality and homogeneity of variance

Variable	Skew	Kurtosis	Shapiro p	Levene p
Perceived stress	-0.17	-0.34	.011	.670
Physical symptoms	+0.53	+0.21	.029	.401
Emotional wellbeing	+0.14	-0.23	.054	.978
Problem-focused coping	-0.20	-0.61	.013	.787

All skewness values fell between -0.53 and +0.53 and all kurtosis values between -0.61 and +0.21, well within the range of plus or minus two conventionally taken to indicate approximate normality. The Shapiro-Wilk test was significant for three variables, but this test is highly sensitive at moderate sample sizes and detects trivial departures; the skewness and kurtosis statistics provide the more informative assessment. Levene test results were non-significant throughout, indicating homogeneity of variance. Parametric procedures were therefore appropriate, with Welch correction applied as an additional safeguard.

4.5 Descriptive Statistics

Table 6: Descriptive statistics for study variables (N = 100)

Variable	M	SD	Min	Max
Perceived stress	2.53	0.81	1.00	4.83
Physical symptoms	2.35	0.78	1.00	5.00
Emotional wellbeing	2.37	0.77	1.00	4.75
Problem-focused coping	3.39	1.02	1.00	5.00
Emotion-focused coping	3.33	1.06	1.00	5.00
Avoidant coping	2.76	1.15	1.00	5.00

Mean scores on the three difficulty measures clustered between 2.35 and 2.53, corresponding to the region between "rarely" and "sometimes" on the response scale. The sample therefore reported moderate rather than severe occupational strain, with substantial individual variation and the full range of each scale represented.

4.6 Gender Comparisons

Table 7: Gender comparison on all twelve measures (N = 100)

Measure	Women M (SD)	Men M (SD)	t(98)	p	d
Perceived stress	2.49 (0.76)	2.58 (0.88)	-0.55	.584	-0.11
Physical symptoms	2.35 (0.84)	2.35 (0.74)	-0.02	.986	-0.00
Emotional wellbeing	2.42 (0.79)	2.33 (0.76)	0.56	.575	0.11
Problem-focused coping	3.02 (0.99)	3.72 (0.92)	-3.67	.0004	-0.73
Emotion-focused coping	3.27 (1.11)	3.37 (1.02)	-0.44	.662	-0.09
Avoidant coping	2.65 (1.13)	2.84 (1.18)	-0.82	.413	-0.16
Job requires fast work	2.94 (1.28)	3.06 (1.28)	-0.47	.641	-0.09
Insufficient time (R)	2.44 (1.09)	2.28 (1.16)	0.71	.479	0.14
Freedom in how work done	3.78 (1.20)	3.34 (1.29)	1.77	.080	0.35
Say in decisions	3.24 (1.19)	3.10 (1.22)	0.58	.562	0.12
Supervisor support	3.28 (1.09)	3.40 (1.21)	-0.52	.604	-0.10
Colleague support	3.68 (1.24)	3.56 (1.13)	0.51	.613	0.10

Women and men did not differ significantly on perceived stress, physical symptoms or emotional wellbeing, and the observed effects were negligible in magnitude. On physical health the two group means were identical to two decimal places. Men reported significantly greater problem-focused coping, a medium-to-large effect in the predicted direction, but the corresponding prediction for emotion-focused coping was not supported. Critically, none of the six working-condition indicators differed significantly by gender, indicating comparable exposure across the two groups.

4.7 Relationships Among Variables

Table 8: Correlations with perceived work-related stress

Variable	All	Women	Men
Physical symptoms	.548***	.583	.526
Emotional wellbeing	.624***	.678	.591
Problem-focused coping	.044	.149	-.087
Emotion-focused coping	-.105	-.081	-.134
Avoidant coping	.184	.076	.266

Note: *** $p < .001$

Perceived stress correlated strongly and significantly with both health outcomes, and the magnitude of these associations was similar for women and men. Coping strategies showed no significant association with perceived stress in either group, although avoidant coping showed a weak positive association among men that did not reach significance at this sample size.

4.8 Moderation Analysis

Table 9: Moderated regression with stress x gender interaction

Outcome / Predictor	b	SE	t	p
Physical symptoms (R ² = .312)				
Perceived stress	+0.645	0.125	+5.14	<.001
Gender	-0.046	0.133	-0.35	.729
Stress x Gender	-0.199	0.165	-1.20	.233
Emotional wellbeing (R ² = .408)				
Perceived stress	+0.711	0.115	+6.21	<.001
Gender	-0.143	0.121	-1.18	.243
Stress x Gender	-0.196	0.151	-1.30	.197

Neither interaction term approached significance, indicating that the relationship between work-related stress and health outcomes is of comparable strength for women and men. Perceived stress was, however, a powerful predictor of both outcomes.

4.9 Hierarchical Regression

Table 10: Hierarchical regression predicting health outcomes

Model / Step	R ²	Delta R ²	F	p
Physical symptoms				
1. Perceived stress	.301	+.301	42.11	<.001
2. + Working conditions	.391	+.091	8.44	<.001
3. + Gender	.395	+.003	7.41	ns
Emotional wellbeing				
1. Perceived stress	.389	+.389	62.52	<.001
2. + Working conditions	.451	+.062	10.80	<.001
3. + Gender	.464	+.013	9.83	ns

Gender contributed 0.3% and 1.3% of additional variance respectively, neither significant ($b = -0.094$, $p = .477$ and $b = -0.178$, $p = .148$). By contrast, perceived stress alone accounted for 30.1% of variance in physical symptoms and 38.9% in emotional wellbeing, and working conditions added a further significant increment to both models. Since no unadjusted gender difference was detected, there was no difference available to survive adjustment.

Table 11: Summary of hypothesis testing

H	Prediction	Result	Outcome
1	Stress differs by gender	$p = .584$	Not supported
2	Women higher psychological	$p = .575$	Not supported
3	Men higher physical	$p = .986$	Not supported
4	Gendered coping	$p < .001$ / $p = .662$	Partial
5	Gender moderates	$p = .233$ / $.197$	Not supported
6	Persists after adjustment	ns	Not supported

5. Discussion

5.1 Convergence Rather Than Divergence

The principal outcome of this study is the near-complete absence of gender differences in the health consequences of work-related stress. Five of six hypotheses were unsupported, and the differences observed were not merely non-significant but negligible: $d = -0.11$ for perceived stress, $d = 0.11$ for emotional wellbeing, and $d = 0.004$ for physical symptoms. On the last measure the two group means were identical to two decimal places.

This diverges from a literature reporting that women experience higher emotional exhaustion while men somatise or under-report [5], [7]. Three explanations merit consideration, and the present design permits partial discrimination between them.

The first is that the sample was occupationally atypical. Participants were highly educated, with 74% holding postgraduate or higher qualifications, and relatively senior, with 46% in managerial or senior roles. Where women and men occupy comparable positions with comparable

autonomy, the structural differences in exposure that drive gendered outcomes in broader samples may be substantially reduced. On this reading the convergence is real but conditional, describing professional employees in similar roles rather than the workforce at large.

The second is that the differential-exposure account is correct and exposure did not differ here. None of the six working-condition indicators showed a significant gender difference, including job demand, decision latitude and supervisory support. If women and men in this sample genuinely faced comparable job conditions, then comparable outcomes are precisely what the demand-control-support model predicts [8]. This interpretation is reinforced by the hierarchical regression, in which gender contributed under 1.5% of variance once stress and conditions were accounted for.

The third is insufficient statistical power. The study was powered only for medium-to-large effects, and a genuinely small difference would likely have been missed. This cannot, however, account for effects as small as $d = 0.004$, which is not a true effect obscured by sampling error.

5.2 The Coping Difference

Against this background of null results, one difference emerged clearly. Men reported significantly greater use of problem-focused coping ($M = 3.72$) than women ($M = 3.02$), a medium-to-large effect predicted in advance and consistent with Ptacek et al. [16] and Matud [17].

The finding becomes more informative when read alongside the second half of the same hypothesis, which failed. Women did not report greater use of emotion-focused coping; the two groups were almost identical on that measure. The gendered pattern is therefore asymmetric rather than reciprocal. It is not that women and men adopt opposite strategies in equal measure, but that men additionally employ problem-focused approaches which women use less, while emotion-focused strategies are used comparably by both.

This asymmetry carries a methodological implication. Studies reporting a composite coping difference, or inferring women's emotion-focus from men's problem-focus, may be overstating a one-sided finding as a reciprocal one.

It is also notable that the coping difference did not translate into any difference in outcome. If problem-focused coping were straightforwardly protective, men's greater use of it should have produced better health outcomes; it did not. Coping showed no significant correlation with perceived stress in either group. Within this sample, how participants coped appeared less consequential for health than how much stress they experienced. This is consistent with the transactional position that neither coping style is inherently superior, its adaptiveness depending on the controllability of the stressor [11].

5.3 The Stress-Health Relationship

While the comparative hypotheses were largely unsupported, the study provides strong confirmation of the premise on which it rests. Perceived stress correlated substantially with physical health symptoms ($r = .548$) and emotional wellbeing difficulties ($r = .624$), both $p < .001$, accounting for 30.1% and 38.9% of variance respectively. Psychosocial working conditions added a further significant increment to both models, supporting the demand-control-support framework.

These associations were of comparable magnitude for women ($r = .583$ and $.678$) and men ($r = .526$ and $.591$), the correlational counterpart of the non-significant moderation. The relationship between occupational stress and health is robust; what this study does not find is that it operates differently by gender.

5.4 A Methodological Observation

The failure of both reverse-worded items constitutes a finding in its own right. Acquiescence bias is well documented but its practical consequence is often underestimated: here it reduced a scale from acceptable to unusable reliability, and would have been invisible had item-level diagnostics not been examined. The episode supports the view that reverse-worded items should be validated in pilot testing before deployment in self-administered online instruments, particularly where respondents are completing the measure quickly and without supervision.

6. Conclusion

Among 100 employed adults in comparable professional roles, work-related stress was substantially associated with both physical and mental health outcomes, but these consequences did not differ by gender. Gender did not moderate the stress-health relationship and contributed under 1.5% of variance once stress and working conditions were accounted for. The single significant gender difference concerned problem-focused coping, which men reported using more, and which did not translate into differential health outcomes.

The pattern is consistent with a differential-exposure account: where working conditions were comparable, health consequences were comparable. For organisational practice this suggests that wellbeing provision in comparable professional settings may be more effectively targeted by exposure, namely workload, autonomy and support, than by demographic category. For counselling practice, the absence of gender differences argues against assuming different presentations by gender at intake, while the strong association between stress and somatic complaint supports routine enquiry into occupational conditions when clients present with headache, disturbed sleep or fatigue.

7. Limitations

The cross-sectional design precludes causal inference; an association between stress and symptoms cannot establish which preceded the other. All variables were self-reported

by the same respondents at a single time using the same response format, raising the possibility of common method variance inflating observed associations. Self-report is also vulnerable to differential disclosure, of particular relevance in a study of gender differences in reporting distress; the inclusion of somatic measures provides only a partial safeguard.

The instrument was self-constructed and lacked prior psychometric validation. Two reverse-worded items failed and were removed, and two-item subscales for job demand and decision latitude did not achieve acceptable internal consistency, requiring those items to be analysed individually. The coping subscales, while usable, achieved only modest reliability. These constraints reduce confidence in the working-conditions and coping findings relative to the physical health and emotional wellbeing findings.

Purposive sampling limits generalisability, and the sample was more educated and senior than the general workforce. Designation level differed by gender, which may itself have influenced results. Statistical power was adequate only for medium-to-large effects. Finally, one gender-diverse participant could not be included in comparative analysis, so the study cannot speak to the experience of gender-diverse employees.

8. Recommendations

Future research should replicate these findings using validated instruments such as the PSS-10, the DASS-21, the Copenhagen Burnout Inventory and the Brief COPE, permitting direct comparison with the wider literature. A sample of approximately 128 participants per group would provide adequate power to detect small-to-medium effects, and stratification by occupational sector would permit separation of gender from job composition. Longitudinal designs would establish temporal precedence.

Caregiving load should be measured with separate items for cognitive responsibility and physical hours, since the present data showed a divergence between the two that a single item could not resolve. Targeted recruitment of gender-diverse participants would allow their experience to be examined rather than excluded. Supplementing self-report with physiological indicators or absence records would reduce common method variance. Finally, since designation level was unevenly distributed by gender in this sample, organisational position merits investigation as a predictor in its own right.

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