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An examination of selected characteristics contributing to well-being among married women at midlife and married younger adult women

by

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A dissertation submitted to the graduate faculty
in partial fulfillment of the requirements for the degree of
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For the Graduate College
DEDICATION

This paper is dedicated to the late Alyce Bachman. In many ways, she is THE woman at midlife in the 1990s. She was a friend, confidante, wife, mother, grandmother, a college graduate, successful businesswoman, community leader, pillar of her church, avid boater and sailing mate, and cancer survivor for the past nine years. Besides me, no one waited longer and had such faith in my ability to finish this journey through graduate school than she did. I truly could not have come to this point without her.
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CHAPTER 1. INTRODUCTION

Until the late 1980s, research on women's lives typically offered a rather dark portrait of the middle years by focusing on medical descriptions of the deterioration of one's reproductive capacity, the loss of physical beauty, and decreased well-being (Gergen, 1990). Such assessments had the effect of reinforcing the cultural norm that, especially for women, usefulness and productivity are linked inexorably to youth and beauty, and that only old age and death follow young adulthood (Gergen, 1990; Mitchell and Helson, 1990). In terms of well-being among women at midlife, the tendency had been to relate all issues of health and wellness to the menopause, as if women suffered from "estrogen-deficiency disease" (Jacobson, 1995, p. 54), certainly a sign of increasingly diminished well-being.

The "biologizing" of the life course presents a regressive view of women's lives that appears to be in stark contrast with the perceptions reported by many women at midlife today (Gergen, 1990). Not only can women at midlife today expect to live another 40 years after their last child leaves home, but many claim they have never felt so healthy or so full of energy in their lives, and that they are just reaching their prime (Pogrebin, 1996; Jacobson, 1995; Sobel, 1994; McGrath, 1992; Mitchell and Helson, 1990; Smith and Moen, 1988; Elder, 1987; Clausen, 1986; Rossi, 1980; Rubin, 1979). These claims raise the question of just what is it that explains this difference in understandings about the years between young adulthood and old age. If women's lives are to be explained only in terms of hormones, PMS, and ticking biological clocks, why are more women at midlife feeling so optimistic and enthusiastic -- why are they feeling so well -- in the face of such a depressing future? It might be possible that women's lives are explained by a broader range of more positive
variables, such as achievements in the workplace, relationship satisfaction, self-efficacy, and self esteem.

Statement of the Problem

The purpose of this study was to expand previous understandings of women's lives by meeting two objectives. The first objective was to describe married women at midlife using a broad range of selected variables that have increasingly come to be used in sociological and psychological literature to define well-being. The second objective was to compare married women at midlife with married younger adult women using the same range of variables.

It is proposed that for married women at midlife, a wide range of psychosocial factors contributes positively to their well-being. This is not to say that the previously emphasized biomedical factors such as pregnancy, the menopause and aging, are no longer important, but rather, that both biomedical and psychosocial factors need to be considered together in order to understand the many dimensions of women's lives.

Women at Midlife in the 1990s

The segment of the population on which this paper focuses makes up a major portion of the population of the United States. Beginning January 1, 1997, and continuing through the year 2014, the 76 million Americans born between 1946 and 1964 will reach age 50, and over one-half will be women. These Americans came of age in a fast-paced, exciting, and unsettling social, economic, political, and cultural era. Women at midlife today more than likely were raised by parents who had survived the Great Depression and the Great War, and who wanted to give their children better lives and brighter futures than they had experienced. Women at midlife today grew up with television, Viet Nam, the women's movement, the drug and rock cultures, the Pill, and microwave ovens. They experienced greater
educational and career opportunities, as well as greater sexual freedoms than ever imagined by their mothers and grandmothers (McGrath, 1992).

Largely as a part of their extraordinary life experience, women of this generation have also redefined "middle age," or "midlife," not as a specific chronological age, but rather, as a state of mind based ultimately on the degree to which they value their physical condition, health, life accomplishments, and hope for the future (Jacobson, 1995; Costello, 1991; Mitchell and Helson, 1990; Smith and Moen, 1988; Elder, 1987; Clausen, 1986; Marini, 1984; Rossi, 1980, Rubin, 1979). Many women at midlife resist being defined as middle-aged because they consider themselves to be not at all like they remember their mothers looking, dressing, and behaving at age forty or fifty. Extending midlife to age 65 is not the immediate problem for these women; it is defining the beginning of midlife that is the concern. Pogrebin (1996) summarizes this point from research conducted by the American Board of Family Practice that asked a random sampling of 1200 Americans when they thought middle age began:

... [th]e most popular answers were: when you worry about having enough money for health care; when your last child moves out; and when you don't recognize the names of music groups on the radio anymore (Pogrebin, 1996, p. 14).

Defining women at midlife in terms of what they can no longer do (as with bearing children) is also problematic. American culture has typically responded to older women in terms of the "motherhood myth": women are old when they can no longer perform their "primary role" of producing children, leading to the perception that they are nonpersons who have no desires or values of their own (Macdonald, 1989). It is not uncommon for older women to feel the disparity between how they perceive themselves and how they are perceived by others (Barker, 1983). It is largely because of the emphasis health and medical models place on childbearing and the menopause that the rest of women's lives has been misunderstood.
More recent scholarship (Jacobson, 1995; Auburdene and Naisbitt, 1992; Costello, 1991; Sloane, 1985) reveals that indeed, women’s lives are not entirely dominated by health and illness. Rather, especially for women at midlife, there is a wide range of psychosocial factors that contributes to their well-being and to their adjustment to aging that has not been fully explored. Psychosocial variables represent the intersection of biomedical, social, and environmental elements that define an individual. Rodin (1985) defines them as situational variables that result in, maintain, and direct behavior. These are broad, multi-faceted, and multi-dimensional variables, including:

- environmental variables
- person-situation interaction
- social influence
- social support
- attribution
- information processing and decision making
- control
- self-esteem
- and physiological consequences of social psychological processes (Rodin, 1985, p. 808).

While psychosocial variables serve to broaden understandings of human interaction in social settings, these variables are complexly and inevitably interrelated. For example, consider the psychosocial variables in this brief description of women at midlife: In the 1990s, women at midlife expect paid work to be a central feature of their lives, along with increased competition for employment (self-efficacy, economic and political environments, gender role definitions). More than likely, they have borne and raised fewer children than they might have in previous generations (gender roles, economic variables), which now raises questions about how they will be able to afford life after retirement (economic, political, person-situation, social support variables). Furthermore, the structure of families has evolved into variations of cohabitation, never-married women with dependent children, domestic partnerships, as well as marriage, reconstituted families, blended families, and singlehood (environmental variables, person-situation variables, social influence, social support variables, attribution, information processing and decision making processes, control, and self-esteem variables) (Jacobson, 1995; Easterlin

It is evident that there is no single characteristic, such as age, social class or marital status that completely identifies women at midlife today (Jacobson, 1995; Easterlin et al., 1993; House et al., 1992; Fodor and Franks, 1990; Mitchell and Helson, 1990; Adelmann et al., 1989; Smith and Moen, 1988; Wattenberg, 1986; Kettle, 1981; Rossi, 1980; Rubin, 1979): some are new parents, others are new grandparents; some are ready for retirement; some are going back to college; some are divorced and/or remarried; and some are preparing to start new businesses. Still others find themselves with dependent offspring and elderly parents to support at the same time (Dufour et al., 1994; Popenoe, 1992).

**Women's Well-Being at Midlife**

The very idea that women today are categorized as "middle-aged" at all implies that they have undergone at least a chronological transition from one age to another. In the research literature, midlife is defined as that portion of the life cycle between ages 45 and 64. Researchers of adult development do not agree about the chronological parameters of this portion of the life cycle. Generally, the concept of midlife has been built around the woman's reproductive years, and that one is certainly middle-aged by age 50 (Jacobson, 1995; McGrath, 1992; Ackerman, 1990; Dan et al., 1990; Fodor and Franks, 1990; Gergen, 1990; Mitchell and Helson, 1990; Adelmann et al., 1989; Rackley, et al., 1988; Clausen, 1986). Neugarten (1968), who defines midlife for women as between ages 35 and 65, assigns the following characteristics, which have typically been used in the areas of health and medicine to estimate parameters for midlife:

In this study, "younger adult women" are between the ages of 18 and 44, and "women at midlife" are between the ages of 45 and 64.
(a) emptying the nest; (b) peaking in one’s occupation; (c) menopause (usually around age 45 or 50); (d) becoming a grandparent; (e) retirement; (f) onset of chronic illness; and (g) widowhood. Other research suggests that the relationship between a person’s health and the effects of psychosocial variables might grow stronger with age (Kasl and Berkman, 1981).

The transition from one’s reproductive years to the menopause is not the single variable defining midlife, however. Although “midlife” may represent a different set of chronological years in the life course than a set of chronologically “younger” years, it does not follow that either well-being or quality of life will necessarily decrease as one’s age increases. Numerous empirical studies suggest that responses to life transitions and the definition of the quality of one’s life are made in terms of personal history, time, context and individual agency, as well as how one is stratified according to racial, ethnic, gender, and socioeconomic status (Wheaton, 1990; McLeod and Kessler, 1990; White and Edwards 1990; McLanahan and Adams, 1987; Menaghan, 1985). For women at midlife, there is a wide range of responses to emptying the nest, depending on prior personal and family characteristics, such as whether they work, whether they are married, whether they have a college education, and their age when the last child leaves home. Indeed, write Kessler et al. (1995), “social transitions have no a priori status . . . when they are embedded in individual role histories” (Kessler et al., 1995. p. 460).

Clearly, an understanding of women at midlife requires expanding the dimensions on which to evaluate their well-being beyond one dimension. To achieve this goal, this study focuses on social psychological indicators that have been used in the psychology, sociology, medicine, and social psychology literature that discusses health, stress, self and identity, and the life course to evaluate quality of life and well-being. Three sets of indicators of well-being are emphasized here:
interactional indicators: marital satisfaction, income satisfaction, role agreement;

self-appraisal indicators: reflected appraisals, perceived role performance, self-esteem, self-efficacy;

health indicators of well-being: perceived threats to one's health, psychological well-being, diet efficacy.

The Importance of This Study

On the basis of this more positive, multi-dimensional definition of midlife, it is assumed that well-being involves the intersection of biological, psychological, historical and social processes that shape the stages, transitions, sequences of social roles, and sense of purpose and identity that go to make up people's lifetimes. This assumption mirrors the fundamental argument of life course sociology; that people live individual and interdependent lives, and, within the social constraints and options of each situation, they make choices and take action in ways that shape their individual lives (Elder and O'Rand, 1985; Sampson and Laub, 1993; Herzog, 1989; Clausen, 1986; Cohler, 1982; Neugarten and Gutmann, 1958).

Given these assumptions, there are several reasons to examine characteristics contributing to well-being among women at midlife. First, most research on midlife and beyond has been focused on men by male researchers, who have defined midlife in terms of achievement in careers and public life for men, and in terms of relationships or the deterioration of one's reproductive roles for women (Fodor and Franks 1990). Until the mid-1980s, scholars gave less serious attention to understanding the

For purposes of this paper, income satisfaction is an interactional indicator because it is assumed that income satisfaction affects the relative power of husbands and wives in the family (see discussion, pages 16-17).
development of midlife and maturing women largely because women tended to react toward aging with fear and disgust (Gergen, 1990).

Second, what research has been done about women has usually been oriented toward comparing women at midlife with their mothers in terms of medical models that center on the menopause. Several researchers have noted that there has been little attention paid in these discussions to differences between younger adult women and women at midlife (Jacobson, 1995; Hunter and Sundel, 1994; McGrath, 1992; Fodor and Franks, 1990; Gergen, 1990; Mitchell and Belson, 1990; O’Rand and Henretta, 1982; Neugarten, 1968). In this study, married women at midlife are compared with married younger adult women in to detect any significant differences in the interactional indicators, self-appraisal indicators and health indicators that affect their quality of life.

A third reason for examining women’s lives at midlife is that such an examination provides information about women’s well-being in the face of the great technological, historical, and cultural redefinitions of health, illness, and aging. It is becoming increasingly more difficult to generalize about women (or men) at any age, and about women at midlife, in particular. It is argued that it is no longer appropriate to define women at midlife in terms of the menopause, which has been blamed for everything from anxiety to stress and guilt because of role strain or role conflict. If we are to understand that women are agents of their own life course and development on the one hand, then we must also understand that their well-being depends on a wide range of psychosocial factors on the other hand.

Fourth, this study considers married women at midlife and compares them to married younger adult women. This comparison is appropriate because marriage provides an established and understandable context in which to examine interactional indicators such as marital satisfaction, role agreement, and income satisfaction, as well as indicators that measure self perceptions of quality of life and psychological and physical well-being. It is argued that to have a marital status other than married (that
is, divorced, separated, widowed, never married, single) presents far too many additional complications for this discussion.

Finally, if it is true, as we have already noted, that women are redefining what it is to be at midlife, the examination of the relationship of psychosocial variables and well-being is especially important for health care practitioners and educators, as well as others who deal with issues of women's health and well-being. It is no longer appropriate to describe women's lives solely in terms of the menopause and aging; it is more appropriate to place them within a psychosocial context and to consider the intersection of this context with their biomedical histories and characteristics.

The Research Plan

In Chapter 2, three sets of psychosocial indicators are identified from the research literature as important to the study of well-being: (1) interactional indicators, (2) self-appraisal indicators, and (3) indicators of health and well-being. These indicators are used to test ten hypotheses that married women at midlife and married younger adult women do not differ in their perceptions of health, living conditions, and life accomplishments.

In Chapter 3, the methods used to describe married women at midlife and to compare them with married younger adult women are outlined. Scales are developed for each of the items that define each indicator, and mean scores on these scales are used for both describing married women at midlife and for comparing midlife women with married younger adult women. In Chapter 4, the results of this analysis are discussed. In Chapter 5, the implications of this study are addressed, along with suggestions for further research.
CHAPTER 2. REVIEW OF THE LITERATURE

Introduction

The two objectives of this study are (1) to present a description of women at midlife on a broad range of selected variables that have increasingly come to be used in social psychology, health psychology, sociology, medicine, and health services literature to define well-being, and (2) to compare married women at midlife with married younger adult women on the same range of variables in order to challenge previous negative assumptions about women at midlife. Three sets of variables are considered in this analysis: (1) interactional indicators, (2) indicators relating to the self, and (3) health and well-being indicators. As individual concepts, these indicators are not new to sociological and psychological research; indeed, many have stood alone as important singular concepts and measures. What gives them value to a study of women at midlife is that, examined together with biomedical variables such as physiological aging. They add dimension and depth to our understandings of women's lives.

It has already been stated that, typically, women's lives have been viewed narrowly in terms of the medical models, largely because society's expectations were that women's importance was in their ability to bear and raise children. This view of women's lives was reinforced by an understanding that the difference between "wellness" and "illness" was simply a matter of "normal" and "not normal" health; that is, illness occurred as the result of culpable biological agents that needed to be treated with vaccinations, medications, and/or strict medical regimens. The beginning of the menopause was seen to signal the beginning of a steady decline in well-being for women that would end, ultimately, in the total state of being "not normal," or death. At the same time, for men's health,
medical models seemed less pessimistic. Men's usefulness has typically been seen in their ability to earn a living or to achieve great public recognition for their achievements in the extra-domestic arena (Rodin, 1985; Kahn, 1981; Taylor, 1978; Moscovici, 1972; Zimbardo, 1969; Milgram 1965).

The earliest studies on midlife were conducted by men on women who were defined as "dysfunctional," using Freudian theory (Freud, 1933) to support the notion that because women were not men, they were pathological and/or neurotic (Jacobson, 1995). This theme persisted into the 1980s when researchers began to look for repetitive patterns of midlife development to explain women's transitions from childbearing years to old age. Scholars noted distinctions between men and women on the basis of the division of labor between women and men primarily in the childbearing phase of the life cycle (Chodorow, 1978), or in terms of psychological differences (for example, women are less war-like than men, they do not play to win, and they become more inhibited as they age) (Gilligan, 1982). However, most agree that it is not possible to generalize these differences to all women all of the time along the entire life course.

At the same time, as medicine and health technology advanced in the second half of the twentieth century, more cures for acute disease began to be discovered, and there was a shifting interest in health issues to the areas of good health and chronic disease. By the 1960s, researchers on disease and health had begun to argue that it was not the state of having a disease that was not normal, but rather, disease was a normal response to abnormal environmental demands. Kessler et al. (1995) write that this argument represented a significant shift away from attributing causes of death to acute diseases to looking instead at how one's physical environment influences one's health, as well as how one learns to live with disease. This shift, coupled with the increasing number of people in the population who are at or are approaching midlife, has turned the social
psychology of health and medicine toward the following three important assumptions:

(1) that illness has multiple determinants, both biomedical and psychosocial;

(2) that what is seen as a disease is not invariant over time but changes based on sociocultural and biological definitions; and

(3) that the medical profession is a social institution that shapes its members' views based on broad sociocultural considerations that go beyond scientific concerns (Kessler et al., p. 548).

Also, at the same time as this shift from biomedical to psychosocial models was occurring in research, women at midlife were beginning to report that they did not see their lives totally in terms of either the reproductive capacities of their youth or the biological deterioration that is supposed to come with aging. Instead, they were describing themselves in more positive terms that implied that there is life after childbearing, and that they are more than capable of accepting their age, affirming their ability to continue to lead fulfilling lives, accepting new challenges, and maintaining a positive outlook on life (Jacobson, 1995; McGrath, 1992; Smith and Moen, 1988; Elder, 1987; Clausen, 1986; Rossi, 1980; Rubin, 1979).

The suggestion that women's lives need to be examined across a wider range of variables than simply those that define their reproductive capacities assumes that health is a state of both physical and mental well-being, not simply the absence of disease. In short, to enjoy physical well-being is to feel fit and able, and to enjoy psychological well-being is to feel happy, hopeful, and energetic. This assumption expands our understanding of women's lives to include many more positive dimensions that serve to define one's quality of life, and that empower the individual to enjoy a lifestyle that promotes wellness, as opposed to passively accepting sickness as one grows older (Rodin and Salovey, 1989; Ross et al., 1991).
Selected Characteristics Contributing to Well-Being Among Married Women at Midlife and Married Younger Adult Women

In this study, three sets of indicators are hypothesized to contribute to women's perceptions of health and well-being: (1) interactional indicators, (2) self-appraisal indicators, and (3) health indicators.

**Interactional indicators of well-being**

Interactional psychosocial indicators are defined as indicators that measure how respondents evaluate their relationships with others along specified dimensions, for example, in the context of marriage. Although there is a strong consensus in the literature that married people report being healthier and happier than unmarried people (Rodin, 1985), there is also considerable research that demonstrates the relationship between the chronic stressors of everyday behaviors and depression (Schafer and Keith, 1997; Kiecolt, 1994; Avison and Turner, 1988; Pearlin, et al., 1981; Ross and Huber, 1985; Liem and Liem, 1978).

Rubin (1983) suggests that women at midlife find themselves turning away from involvement in the various childhood/adolescent/young adult stages of their children to the search for new directions in life. If women have stayed married through the child-raising years, psychological wellness is promoted as they begin to renegotiate their marriages in order to have a relationship that now reflects the couple's development of shared interests. For women who have not stayed married, been married, or had children, the transitions into midlife also represent the opportunity to redirect their lives away from what they have been to what else they can be. Because the married woman who has never divorced is likely to have the role of spouse longer than she will have the role of mother to children who are at home, she may link her contentment with the extent to which
household duties and responsibilities are shared with her husband, as well as to resources and power strategies (Aida and Falbo, 1991). People who see themselves as equal partners in the marriage are more satisfied with their relationship than more traditional (that is, less egalitarian) couples. Further, women who work outside the home report greater marriage satisfaction than do wives who do not work outside the home (Zammichelli, et al., 1988; Dion, 1985; Locksley et al., 1980; Gray-Little and Burks, 1983).

**Marital satisfaction**

Marital satisfaction indicates respondents' assessment of how their spouses would assess the companionship, cooperation, life events, and happiness in the marriage. (Andersen, 1995; Jacobson, 1995; Kiecolt, 1994; Rosenstock, 1990; Rodin and Salovey, 1989; Clausen, 1986). With the exception perhaps of the parent-child relationship, the presence or absence of a marriage relationship is the most important intimate factor in a person's life. In terms of depression, significantly higher incidences of psychological distress for women have been associated with a wide variety of marital/relational psychosocial factors, including physical and sexual abuse, poverty, bias that persists in forms like lower wages than those paid to men, and unhappy marriages. Unhappy marriages lead to depression in women more often than in men, and depression is three times higher among married professional women than all others because the increased income and status do not necessarily protect women from the pressures of role overload (Goleman, 1985).

Change is highly associated with psychological distress. Over the life cycle, marital satisfaction follows a U-shaped curve that shows higher satisfaction during the initial stages of marriage, then a decline during the next ten years of marriage or longer, and then an increase in the later years (Glenn, 1991, 1989; McHale and Huston, 1985; Rollins and Cannon, 1974).
Changes in marital satisfaction have been explained by the presence of children. Although there is a great deal of difficulty and pain for some in raising children, many couples work to balance marital satisfaction with family satisfaction, often enduring situational conflict for the sake of the children. If couples survive these years, many find that their marriage is even more solid than in previous years. Another explanation for changes in marital satisfaction is the duration-of-marriage effect, that is, how well a couple handles such cumulative problem-solving skills as resolving conflict, communication, grievances, role overload, heavy work schedules, and child-rearing over the course of the marriage (Glenn, 1991; White and Booth, 1991). Marital satisfaction is linked to companionship, marriage as a sacred long-term commitment, a shared philosophy of life, pride in one another's achievements, and one's ability to confide in one's partner (Lauer and Lauer, 1985). More than two-fifths (41%) of couples married over ten years rate their marriages as very good, and 34% rate theirs as good (Glenn, 1989; Bell, 1983).

One's spouse and family are regarded in the research as the most significant source of social support, and the loss of this support as with the death of a spouse, for example, is a significant stressor (Rodin and Salovey, 1989). Poor marital quality has been linked with poorer immune function (Kiecolt-Glaser et al., 1987), and people with chronic illness who have better support from their spouses and enjoy the participation of their spouses in their treatment may show better adjustment and faster recovery (Taylor et al., 1985).

**Role agreement**

Wheaton (1983) suggests that role agreement becomes a stressor when couples become frustrated about role expectations and interpersonal difficulties within their relationship. Role agreement is closely related to marital satisfaction because one's feelings of satisfaction can be based on perceptions of how often the woman disagrees with her spouse about
cooking, housekeeping, earning the family income, being a friend and companion, sex, and caring for and training children. The importance of this indicator as a distinct measure lies in its usefulness in predicting how a woman's various roles intersect with her most intimate relationships. Further, the degree to which the husband assists with housework and childcare largely determines the extent of the wife's role overload. Dual-career couples report that husbands perform from 19% to 23% of the housework (Kalleberg and Rosenfeld, 1990; Barnett and Baruch, 1987). One of the reasons that women, more than men, find balancing work and family stressful is that, even though women may reallocate some traditional responsibilities, many men tend to be more egalitarian in word than in deed (Barnett and Baruch, 1987; see also Jacobson, 1995).

**Income satisfaction**

Survey results reported in *Public Opinion* in 1986 show that 41% of respondents said that having enough money was very important for a marriage. Because employment decreases economic hardship, it also relieves stress and concern, not only for the woman, but for other family members. While economic necessity (that is, supplementing their husband's loss in earning power) is often cited as the primary factor that places women in the labor force (Menaghan and Parcel, 1991), researchers have also found that employment raises a woman's self-esteem and sense of control. In addition, working women are physically healthier than unemployed women (Gecas and Seff, 1989; Ross, et al., 1991). Ross et al. (1991), found that an employed woman receives greater domestic support from her partner: the more she earns in contrast to her partner, the more likely he is to share in the housework and child care. Other researchers have found that money is the most common source of marital arguments, and economic strains are often involved in spousal abuse. Some speculate that income satisfaction affects the relative power of husbands and wives in the family
Indicators of well-being relating to the self

Mead (1934) defined the self as a social construction based on ongoing processes between the individual’s spontaneous impulse to act and the set of organized perspectives that she has learned from others, depending on the definition of the situation. The self normally maintains a certain degree of stability and consistency, while at the same time it is subject to modification to the ever-changing social environment. Through social interaction, the self undergoes constant comparison, assessment and reinterpretation as the individual’s roles and statuses change. Given this, it can be seen that such variables as role performance (how well she perceives she is carrying out her various roles), self-esteem (how she perceives others think of her), and self-efficacy (how she perceives herself as a causal agent in her environment) are important to her psychological and physical well-being.

Reflected appraisals

The reflected appraisals indicator is based on Mead’s (1934) premise that responses of others shape the self. Schafer and Keith (1997) report that one immediate consequence of role disagreement is unfavorable reflected appraisal. Reflected appraisals reflect social approval inferred from others’ behavior, especially when those behaviors do not agree with the individual’s own identity standards or the meanings that she applies to herself in a given role or situation (Mettee and Aronson, 1974). Burke (1991) argues that any change in reflected appraisals that takes place will be resisted by the individual, who will take action to alter others’ perceptions and to bring them back in line with her own self-appraisals. If she cannot bring about such a change of others’ appraisals, the result
is distress, anxiety or depression (Swann, 1990). Gecas and Burke (1995) suggest that "people work hard to verify and maintain the self-concepts or identities they already hold, and do not easily change them" (Gecas and Burke, 1995, pp. 51-52; see also Andersen, 1995; Jacobson, 1995; Kiecolt, 1994).

**Role performance**

In this study, role performance is an indicator of respondents' assessment of the extent to which they disagree with their partners about household tasks. Research by Heise (1977, 1979) and Smith-Lovin and Heise (1988) suggests that certain emotional reactions accompany adequate and inadequate role performances. Expectations for responses to one's role performances are generated by meanings given to the identities and actions in a particular situation. One's perception of self, others, behaviors, and settings depend on her emotional reaction to events, and is a way to gauge the centrality of an identity in the self structure. For example, a mother's depression at leaving her child to return to work indicates the importance of her role as parent, as compared to her role as worker. Heise (1979) suggests that perceptions of role performance depend on culturally defined fundamental sentiments that serve to evaluate, show potency, and to show the activity of the role, as in the case of the working mother, whose identity as a mother is essentially a nicer, more powerful, and more lively identity than that as a worker (See also Andersen, 1995; Jacobson, 1995; Kiecolt, 1994; Rodin and Salovey, 1989).

**Self-efficacy**

This term is used to describe how individuals see themselves as having control over their own outcomes. Kobasa (1982) defines control as "the tendency to believe and act as if one can influence the course of events" (Kobasa, 1982, p. 7). People who describe themselves as having self-efficacy view explanations for why things happen not only in terms of
others' actions, but also in terms of their own responsibility for that event happening. A woman has reduced self-efficacy if she feels that she has reduced effectiveness in dealing with information and making decisions for herself (Brown and McGill, 1989; see also Andersen, 1995; Jacobson, 1995; Kiecolt, 1994; Rosenstock, 1990; Rodin and Salovey, 1989). Reduced self-efficacy is strongly associated with reflected appraisals. If a marital partner perceives that her spouse has a negative assessment of her, she comes to see herself as incompetent and inadequate, which leads to less confidence in her ability to perform her social roles, and she may even adjust her behavior to bring these negative appraisals in line with her identity (Schafer and Keith, 1997; Burke, 1991).

**Self-esteem**

Self-esteem refers to the sense of self-worth (Rosenberg, 1965, 1979), that is, confidence and satisfaction in oneself. Feelings of incompetence in one's perceptions of her role performance can lead to reduced self-esteem (Schwalbe and Staples, 1991; Thoits, 1991). Rosenberg et al. (1995) say that there are two dimensions to self-esteem: "global self-esteem" is more relevant to depression, and "specific self-esteem" is more relevant to behavior. The authors assert that the two types of self-esteem are neither the same nor are they interchangeable, and one cannot automatically serve as a surrogate for the other. Further, global self-esteem appears to be heavily affective in nature, and specific self-esteem is more judgmental and evaluative. The effect of global self-esteem on behavioral outcomes is mediated by its effect on specific self-esteem. The Rosenberg group concludes that "the effect of specific self-esteem on global self-esteem is affected by the degree to which the relevant role or behavior is personally valued" (Rosenberg et al., 1995, p. 153; see also Andersen, 1995; Jacobson, 1995; Kiecolt, 1994; Rodin and Salovey, 1989).
Indicators of physical and psychological well-being

The growth of scholarship on women and aging has been influenced by demographic changes toward greater longevity that leave women as the majority among older age groupings. However, even though women live longer in America today, they do not necessarily enjoy longer periods of good health because they tend to have more chronic diseases and disabilities than men, due in part to their longevity (Jacobson, 1995; Hagestad, 1990; Mayer and Tuma, 1990; Streib and Binstock, 1990; Rodin and Salovey, 1989; Kertzer and Keith, 1984; Elder and O’Rand, 1985; Elder, 1985). This finding has implications for understanding their lives in terms of a broader range of variables than those defined in biomedical models. Of particular concern to women across the life course are issues involving the menopause and HRT, diet efficacy and exercise, and food safety, as well as the occurrence of cancer, cardiovascular disease, and depression.

Perceived health threats

Perceived health threats are considered to be important indicators of well-being because the imminence of illness is constantly being assessed by the individual woman against what she hears from health care practitioners, the media, and what she already knows. The association of perceptions of threats to physiological symptoms has been addressed by the stress and adaptation model, itself based on the work of Cannon (1932) and Selye (1956). This perspective argues that “characteristics of situations and individuals combine to create perceptions of stress or threat, which ideally elicit responses that reduce stress and protect health” (Kessler, et al., 1995, p. 549). Threats to one’s health can include threat of illness, or ill health due to food content, including fats, cholesterol, sugar, salt, bacteria, chemical residues and additives (see also Andersen, 1995; Jacobson, 1995; Rosenstock, 1990; Rodin and Salovey, 1989).
Specifically, food safety is an integral part of concerns about diet efficacy and good health. Diet-conscious women at midlife report being aware of the harmful effects of fats, cholesterol, sugar, and salt on good health, as well as the effects of bacteria and viruses, chemical residues, additives that improve the product appearance or shelf life, and drug residues in milk and meat. In a public opinion survey of adult Texans in 1994, respondents were assessed on their knowledge and concern over food safety issues related to undercooked hamburger. Only about half had such concerns, and where a majority could identify at least one foodborne pathogen, far fewer were aware of the potential dangers of eating undercooked meat. Respondents identified the mass media, especially print media, as their chief source of information. Women were more aware of food hazards than men; persons with more education and income were also more aware of food hazards (McIntosh, et al., 1994).

Diet efficacy

Diet efficacy is based on how empowered the individual feels with regard to developing a lifestyle that emphasizes wellness (Lazarus and Folkman, 1984). This concept is closely related to the concept of self-efficacy, how individuals see themselves as having control over their dietary habits. Given that depression and physical well-being are associated with health and wellness, this indicator specifically addresses an important aspect of physical health. Perceptions of control over one's diet habits can involve issues of weight gain, age-related changes in blood pressure and muscle strength, and exercise.

One area of importance to the concept of diet efficacy is weight gain, which in turn is related to lifestyle. Weight gain at midlife is closely linked to heart disease, stroke, high blood pressure, and many other illnesses, including cancer. Both men and women tend to put on

\footnote{Recall McGrath, 1970.}
weight during the years between 40 and 55, but this phenomenon is not inevitable (Bresnick, 1994). The popular wisdom is that hormones cause middle-aged weight gain, but experts say that the gain is more likely due to the slowing down in metabolism, mainly because of lowered activity levels as one gets older. In the Nurses' Health Study conducted by researchers at Brigham and Women's Hospital and the Harvard School of Public Health in Boston, it was found that women who start out slim at age 18 but gain 11 to 18 pounds during middle age, increase their heart attack risk by 25%, while those who put on 18 to 24 pounds raise their chances by 60%. If a woman gained 20 or more pounds or more in her middle years, she should start losing weight or at least exercise regularly (including resistance training) and monitor her diet in order to decrease these risks (Griffin, 1995; Derrow, 1995).

Another issue for researchers with regard to diet efficacy involves age-related changes like increased blood pressure and waning muscle strength, which are common among women at midlife. A 1993 study published in The American Journal of Health Promotion (Tucker and Mortell, 1993), however, suggested that among middle-aged women, a comparison of pre-/postprogram scores in a test for the benefits of weight training versus exercise walking revealed that weightlifters showed greater improvements in body image and muscular strength than walkers, but that walkers showed increased cardiovascular endurance relative to the weightlifters.

A third area of importance with regard to diet efficacy is exercise. Women have been found to experience a drop in physical activity levels after age 39 (Dan, et al., 1990). As a result, the level of cardiorespiratory fitness showed a drop among subjects ages 45-49. Among women respondents in a study conducted by Johnson et al. (1990), 13.9% felt they were already in good shape, 69.6% perceived themselves to be in "adequate" physical condition, and only 16.1% characterized themselves as being in less than adequate physical condition. Less than 3% felt that exercise was not very important, 23.6% endorsed modest exercise, and 74%
said it was very important. Ninety-four percent indicated that they enjoyed physical activity (Johnson et al., 1990). Many women said that lack of time was the most notable limitation to the amount of exercise, and that the lack of willpower and time constraints kept them from weight management behaviors. Other barriers to exercise that women listed were the lack of money, lack of facilities, lack of an exercise partner, that exercise is boring, health problems, and a loss of interest in exercising.

**Depression**

Depression is defined as the overwhelming sense of distress, often associated with physiological symptoms, that is caused by the perception of being unable to cope. Kobasa (1982) identifies several psychosocial mediators that link stress to illness including perceived social supports, early childhood experiences, and norms governing illness behavior (Andersen, 1995; Jacobson, 1995; Kiecolt, 1994; Rosenstock, 1990; Rodin and Salovey, 1989; Cobb, 1976; Luborsky, Todd, & Katchen, 1973; Mechanic and Volkart, 1961). Psychological distress can arise from a wide range of interactional risk factors, such as coping with change, communication, the distribution of power in making decisions, financial difficulties, parental roles and hardships, the death of family members, substance abuse, changing jobs, pregnancy, personal achievement, going back to school and holidays (Boss, 1987; Lavee, et al., 1983; Holmes and Rahe, 1967; see also House et al., 1992; Cohen and Williamson, 1991; Mirowski and Ross, 1989; Marmot, Kogevinas and Elston, 1987; Kessler, Turner, and House, 1987; Crockerham, 1986; House and Cottington, 1986; Rodin, 1986; Jemmott and Locke, 1984; Lazarus and Folkman, 1984; House, 1981; Krantz et al., 1981; Pearlin et al., 1981; Brown and Harris, 1978; Langer and Rodin, 1976; Friedman and Rosenman, 1974; McGrath, 1970; Selye, 1956; Cannon, 1932.). It follows then, that diet efficacy, perceived health threats and depression are intricately interrelated with other psychosocial variables, such as marital
satisfaction, income satisfaction, role agreement, reflected appraisals, role performance, self-esteem, and self-efficacy.

Hypotheses

Clearly, it is appropriate to study the life course along a range of indicators (including interactional indicators, indicators relating to the self, and health indicators) beyond those offered by biomedical models. In this study, it is hypothesized that (1) for nine of the ten indicators, the mean scores for married women at midlife will be above the midpoint of their respective scale means, and for the tenth indicator, depression, the mean score will be below the midpoint of its respective scale; (2) that for all ten indicators, there will be no significant differences in mean scores between married women at midlife and married younger adult women; that (3) correlation analysis will show an inverse relationship between self-efficacy and diet efficacy for both married women at midlife and for married younger adult women.

* See APPENDIX B
CHAPTER 3. METHODS

The Sample

The cross-sectional sample used for this study was drawn from 155 married couples who were studied in 1992 using the "Couples' Health, Food and Relationship Study" developed by the Departments of Sociology, Food Science Health and Nutrition and the Statistical Laboratory at Iowa State University at Ames, Iowa. Respondents were selected using a state-wide, multi-stage area sample that was designed so that all housing units in Iowa had an equal chance of being selected. Respondents were selected to represent different life stages ranging from younger families with one child less than six years of age and wife under age 45, families with children in school (ages six through 18) with no child less than six years of age and wife under age 45, empty nest families with no children in the home where the wife was between ages 45 and 59, and older families with no children in the home, and with wife age 60 or older. Originally, one hundred ninety eight married couples were contacted in their homes, of which 155, or 78%, agreed to participate in the study. Respondents were paid $25 per couple for their participation. Wives ranged in age from 23 to 82 years with a mean age of 47.3 years. Trained interviewers administered the interview in the home to husbands and wives separately. Information reported in this analysis is part of a larger investigation of family interaction and change and food related behavior. The average length of marriage was 25 years.

The current study uses a sample of married women up to and including age 64. Subsamples were selected to represent the two cohorts studied in this paper: married women up to and including age 44, who are identified as "married younger adult women," and women between the ages of 45 and 64, who are identified as "married women at midlife." There are a total of 130
respondents, 73 of whom belong to the group of married young adult women, and 57 of whom belong to the married women at midlife group. Table 3.1 compares the two groups according to mean values for age, years married, annual family income before taxes, level of education, presence of children in the home, current employment, and current health status.

Table 3.1. Mean values for age, years married, annual family income, education, number of children living at home, and employment for married women at midlife and married younger adult women.

<table>
<thead>
<tr>
<th></th>
<th>Married women at midlife (N=57)</th>
<th>Married younger adult women (N=73)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Age</td>
<td>53.2</td>
<td>35</td>
</tr>
<tr>
<td>2. Years married</td>
<td>31</td>
<td>13</td>
</tr>
<tr>
<td>3. Annual family income</td>
<td>$25,000 to $34,999</td>
<td>$25,000 to $34,999</td>
</tr>
<tr>
<td>(before taxes)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Years of education</td>
<td>13.7 years</td>
<td>13.5 years</td>
</tr>
<tr>
<td>5. Number of children</td>
<td>0 or 1 child</td>
<td>2 children</td>
</tr>
<tr>
<td>living at home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Currently employed</td>
<td>71.9%</td>
<td>71.2%</td>
</tr>
<tr>
<td>7. Employment</td>
<td>32.4 hrs/wk</td>
<td>34 hrs/wk</td>
</tr>
</tbody>
</table>

According to the data, there appear to be few differences between the two groups of married women, except, of course, for subjects' ages, the number of years married, and the number of children at home. The difference in the number of children presumably can be attributed to the fact that the married women at midlife who have children may now have children who no longer live at home.

Income before taxes was measured using categories arranged in ascending order from less than $5,000 (1), to $100,000 or more (9). For both groups of the sample, the means fell within the income same category, $35,000 to $49,999.
Measures

Three sets of psychosocial indicators of well-being were developed from items from the "Couples' Health, Food and Relationship Study." For all indicators, the number of cases was 130.¹

Interactional indicators of well-being

Marital satisfaction

The three items that measure marital satisfaction were adapted from Spanier's "Dyadic Adjustment Scale" (1976). Items were recoded so that respondents could indicate their evaluation of their marriage by using a 5-point Likert scale, ranging from extremely dissatisfied (1) to extremely satisfied (5). The items were summed and a mean was calculated to get a single measure for marital satisfaction. The higher numerical value of the mean score, the more satisfied the respondent is with her marriage. Factor analysis indicated that this scale is unidimensional. The marital satisfaction scale has an alpha reliability of .86.

Role agreement

The six items for this indicator were developed to focus on the respondent's perception of how often she and her spouse agree about certain household activities. Responses to these items were recoded to form a 5-point Likert scale ranging from agree very often (5) to never agree (1) for all items. The items were summed and a mean was calculated to get a single measure for role agreement. A higher mean score indicates that the partners agree very often; a lower score indicates that they never agree. Factor analysis indicated that this scale is unidimensional. The scale has an alpha coefficient of .56.

¹ See Appendix A for the item content for all measures.
Income satisfaction

A single item with four responses about respondents’ perceptions of their family’s ability to get along on their income was used to measure income satisfaction. Respondents were asked to mark the statement that best described their situation. The closer this is to 4, the more satisfied respondents are with their income.

Indicators of well-being relating to the self

Reflected appraisals

The seven items that measure reflected appraisals are adapted from Sherwood’s (1970) self-actualization and self-identity theory. Items were recoded so that the most positive appraisal had the highest numerical value along a 5-point Likert scale. The items were summed and a mean was calculated to get a single measure. The higher the numerical value of the mean, the more positively the respondent thinks her spouse thinks of her. Factor analysis indicated that this scale is unidimensional. The scale has an alpha coefficient of .80.

Role performance

This measure assesses how well the respondent thinks she performs her roles. Responses for the five items relating to role performance form a 5-point Likert scale, ranging from much below average (1) to much above average (5). The items were summed and a mean was calculated to get a single measure. The higher the mean score, the better the respondent thinks that she performed her roles. Factor analysis indicated that this scale is unidimensional. The role performance scale has an alpha equal to .49 (this low reliability will be discussed later).
**Self-efficacy**

The seven items for this indicator were adapted from Pearlin's mastery scale (1980). This scale measures how much control the respondent thinks she has. Items were recoded so that the higher the mean score, the more the control the respondent feels she has in her life. Subjects used a 5-point Likert scale, ranging from *strongly disagree* (1) to *strongly agree* (5). The items were summed and a mean was calculated to get a single measure for self-efficacy. Factor analysis indicated that this scale is unidimensional. This scale has an alpha coefficient of .78.

**Self-esteem**

The ten items that measure self-esteem were adapted from Rosenberg's (1965) scale to measure self-esteem. This is a well-established measure based on 11 items measuring feelings of self-worth, eight of which are used in this paper. Items were recoded to give a higher value to more positive statements. Subjects responded to each statement along a 5-point Likert scale, ranging from *strongly disagree* (1) to *strongly agree* (5). The items were summed and a mean was calculated to get a single measure for self-esteem. Factor analysis indicated that this scale is also unidimensional. Its alpha coefficient is .85.

**Indicators of physical and psychological well-being**

**Depression**

The items used to measure depression were developed to indicate the degree of psychological wellness one feels. The eleven items were drawn from Derogatis, et al.’s (1971) scale of neurotic symptom dimensions. Responses ranged along a 5-point Likert scale, ranging from *never* (1) to *very often* (5), which refer to the frequency which they experience depressive symptoms. A high score on this scale indicates greater
depression (that is, decreased psychological well-being). The items were summed and a mean was calculated to get a single measure for depression. Factor analysis indicated that this scale is unidimensional. The depression scale has an alpha coefficient of .82.

**Perceived health threats**

The items used for this measure concern perceived threats to one’s health based on the contents of foods. Responses to the eight items formed a 5-point Likert scale, ranging from very little (1) to very great (5). The items were summed and a mean was calculated to get a single measure. A higher mean score indicates that the respondent feels there is a greater chance of developing health problems if her food contains the item. Factor analysis indicated that this scale is unidimensional. Its alpha coefficient is .83.

**Diet efficacy**

This set of ten statements and responses was adapted from Hollis et al.’s (1986) “Helpless and Unhealthy Scale.” These items measured respondents’ perceptions that what they eat may be unhealthful, but they believed they were unable to change. For this scale, the lower the mean score, the less helpless respondents feel they are about their ability to control their diet. Responses ranged on a 5-point Likert scale from strongly agree (1) to strongly disagree (5). Items were summed and a mean was calculated to get a single measure. Factor analysis indicated that this scale is unidimensional and has an alpha coefficient of .84.

**Data Analysis**

To describe married women at midlife, mean scores were calculated, along with t-ratios to test the hypotheses that mean scores for the ten variables do not differ from the midpoints of their respective measurement scales. Second, to compare married women at midlife with married younger
adult women, mean scores were calculated on each indicator for each group, and t-ratios were calculated to test the hypotheses that there are no differences in mean scores between married women at midlife and married younger adult women. The final step in the analysis was to test differences in mean scores between the two groups in order to identify the presence of any third variable that could explain these differences.
CHAPTER 4. FINDINGS

Married Women at Midlife

It was expected that for married women at midlife on nine of the ten indicators, the scores would be greater than 3.0, the scale midpoint, and for the tenth indicator, depression, the mean would be less than 3.0. To test these ten hypotheses, mean scores were calculated and one-tailed t-ratios were used to compare mean scores with scale midpoints. Table 4.1 reports these findings.

Table 4.1. Comparison of scale midpoints with mean scores on all indicators for married women at midlife (N=57).

<table>
<thead>
<tr>
<th>Interactional indicators</th>
<th>Scale midpoint</th>
<th>Mean score</th>
<th>SD</th>
<th>t-ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital satisfaction</td>
<td>3.0</td>
<td>4.02</td>
<td>.89</td>
<td>8.64**</td>
</tr>
<tr>
<td>Role agreement</td>
<td>3.0</td>
<td>4.43</td>
<td>.42</td>
<td>-25.54**</td>
</tr>
<tr>
<td>Income satisfaction</td>
<td>3.0</td>
<td>3.25</td>
<td>.81</td>
<td>5.64**</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicators relating to the self</th>
<th>Scale midpoint</th>
<th>Mean score</th>
<th>SD</th>
<th>t-ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reflected appraisals</td>
<td>3.0</td>
<td>3.63</td>
<td>.68</td>
<td>7.00**</td>
</tr>
<tr>
<td>Role performance</td>
<td>3.0</td>
<td>3.19</td>
<td>.55</td>
<td>2.71**</td>
</tr>
<tr>
<td>Self-efficacy</td>
<td>3.0</td>
<td>3.63</td>
<td>.68</td>
<td>9.00**</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>3.0</td>
<td>3.98</td>
<td>.58</td>
<td>12.25**</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicators of physical and psychological well-being</th>
<th>Scale midpoint</th>
<th>Mean score</th>
<th>SD</th>
<th>t-ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>3.0</td>
<td>2.39</td>
<td>.45</td>
<td>-10.17**</td>
</tr>
<tr>
<td>Perceived health threats</td>
<td>3.0</td>
<td>3.87</td>
<td>.62</td>
<td>10.88**</td>
</tr>
<tr>
<td>Diet efficacy</td>
<td>3.0</td>
<td>2.86</td>
<td>.83</td>
<td>-1.27</td>
</tr>
</tbody>
</table>

Note: one-tailed t-tests, ** significant at p<.01

· Recall that for the depression indicator, a higher mean score indicates greater depression (that is, decreased psychological well-being).
These data show that nine of the ten hypotheses were supported. In the case of the tenth indicator, diet efficacy, the difference between the mean score and midpoint ($t = -1.27, p < .01$) indicates that the hypothesis was not supported, that is, the mean score was less than 3.0 and there was a significant difference between the scale score and its midpoint.

**Comparing Married Women at Midlife and Married Younger Adult Women**

Mean scores and t-ratios were used to test the next set of ten hypotheses that there are no significant differences in mean scores for married women at midlife and married younger adult women along the same range of measures. Table 4.2 presents these results.

<table>
<thead>
<tr>
<th></th>
<th>Married women at midlife</th>
<th>Married younger adult women</th>
<th>Pooled variance estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interactional indicators</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital satisfaction</td>
<td>4.02</td>
<td>4.06</td>
<td>.24</td>
</tr>
<tr>
<td>Role agreement</td>
<td>4.43</td>
<td>4.13</td>
<td>13.86</td>
</tr>
<tr>
<td>Income satisfaction</td>
<td>3.25</td>
<td>2.82</td>
<td>-2.87</td>
</tr>
<tr>
<td><strong>Indicators relating to the self</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reflected appraisals</td>
<td>3.62</td>
<td>3.53</td>
<td>-.84</td>
</tr>
<tr>
<td>Role performance</td>
<td>3.19</td>
<td>3.70</td>
<td>4.69</td>
</tr>
<tr>
<td>Self-efficacy</td>
<td>3.61</td>
<td>3.82</td>
<td>2.09</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>3.98</td>
<td>3.99</td>
<td>.14</td>
</tr>
<tr>
<td><strong>Indicators of physical and psychological well-being</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>2.39</td>
<td>2.50</td>
<td>1.32</td>
</tr>
<tr>
<td>Perceived health threats</td>
<td>3.87</td>
<td>3.91</td>
<td>.42</td>
</tr>
<tr>
<td>Diet efficacy</td>
<td>2.86</td>
<td>3.36</td>
<td>3.86</td>
</tr>
</tbody>
</table>

* $p < .05$, ** $p < .01$
In the case of five indicators (role agreement, income satisfaction, role performance, self-efficacy, and diet efficacy) mean scores for married women at midlife differed significantly from corresponding mean scores for married younger adult women. There were no significant differences in mean scores for marital satisfaction, reflected appraisals, self-esteem, depression, and perceived health threats. It can be concluded that the hypotheses were supported for five out of the ten psychosocial indicators, and rejected for five indicators.

Tests for Mediating Effect of Household Size on Role Agreement, Role Performance, and Income Satisfaction

Given the difference reported in Table 3.1 of household size (for married younger adult women, 3 or more children living in the home; for married women at midlife, 0 to 2 children living in the home), it was hypothesized that household size would explain the difference in means for role agreement, role performance, and income satisfaction using two-step regression analysis for the entire sample of married women (N=130). Table 4.3 reports the results of the regression analysis of role agreement on age.

Table 4.3. Coefficients from regression of role agreement on age: Married women at midlife and married younger adult women (N=130).

<table>
<thead>
<tr>
<th>Independent variable</th>
<th>Coefficient</th>
<th>(S.E.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>age</td>
<td>.015</td>
<td>.00</td>
</tr>
<tr>
<td>age and number of children living at home</td>
<td>.014</td>
<td>.00</td>
</tr>
</tbody>
</table>
It can be seen that the beta coefficients did not change for either the entire sample or for the individual sub-sample groups; therefore it is concluded that household size does not explain role agreement.

Table 4.4 reports the regression analysis using role performance and the age and household size variables. As with the role agreement variable, the conclusion to be drawn from this analysis is that household size does not explain this variable.

Table 4.4. Coefficients from regression of role performance on age: married women at midlife and married younger adult women (N=130).

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Table 4.5. Coefficients from regression of income satisfaction on age: married women at midlife and married younger adult women (N=130).

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<th>(S.E.)</th>
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Table 4.5 shows the results of regression analysis of income satisfaction on age and household size. Once again, it can be seen that the regression coefficients for age did not significantly change when the household size was introduced into the regression equation. Therefore, household size does help to explain income satisfaction.
Correlation Analysis of Self-Efficacy and Diet Efficacy Indicators

For the two efficacy indicators that were shown to be significant for married women at midlife, it was hypothesized that correlation analysis would show an inverse relationship between the two indicators for both married women at midlife and for married younger adult women. Results of correlation analysis showed that for married women at midlife, there is an inverse association between self-efficacy and diet efficacy \((r = -0.22, \text{ ns})\), and for married younger adult women the relationship is also inverse and significant \((r = -0.40, p<0.01)\).

\[ \text{See APPENDIX B} \]
CHAPTER 5. DISCUSSION

The assumption of this study was that, typically, midlife for women has been viewed narrowly in terms of the menopause and aging, which is in apparent contradiction with what women at midlife actually report about their lives. It was hypothesized that (1) it is appropriate to describe married women at midlife along a broad range of psychosocial indicators, and (2) by comparing women at midlife with their younger counterparts, it can be seen that midlife for married women can be as multi-dimensional and satisfying as it is for younger women.

The findings indicated that, for married women at midlife, there was no significant difference between the mean score on depression and the scale's midpoint. The group's mean score of 2.39 was lower than the scale mean, 2.50. On a scale ranging from never (1) to very often (5), which refers to the frequency which they experience depressive symptoms, the group's mean score was located between the categories, rarely (2) and sometimes (3). This finding is reasonable, given this group's significantly higher-than-average scores on marital satisfaction, income satisfaction, role agreement, reflected appraisals, role performance, self-efficacy, and self-esteem. This finding is supported by the work of McGrath (1992), Norvell et al. (1991) and Costello (1991), all of whom have linked higher levels of education with lower levels of depression, paid employment with decreased levels of depression, and increased depression among women at midlife with traditional roles.

This paper has broadened the range of psychosocial variables that should be considered in studying depression and married women at midlife. One question that needs consideration is whether for this group of women, marriage and childbearing were seen simply as alternatives to success and self-actualization, or whether marriage and parenthood were seen as two
dimensions among many that contribute to psychological and physical well-being along the life course.

While it is true that women at midlife face a variety of health and psychological challenges, for these women the relationship of perceptions of health threats due to the contents of food is complexly related to self-efficacy (for example, if you have more information about threats presented by certain foods, you are likely to be more in control of your choices), depression (note linkage between control and depression noted above), and well-being. For example, if the individual has learned to act as if she is helpless, then she might be more likely to be depressed, and thus, less likely to feel she is efficacious with regard to decisions about the contents of the foods she eats. Further research is needed to fully explore this intersection of biomedical and these psychosocial variables.

Given that the stereotypical view of women focuses on the positive aspects of youth and reproductive capacities, it was important to test for differences between the two groups of women along the same range of indicators. The results of these tests showed that on five indicators (role agreement, income satisfaction, role performance, self-efficacy, and diet efficacy) there were significant differences between the two groups, and on the other five indicators (marital satisfaction, reflected appraisals, self-esteem, depression, and perceived health threats), there were not. In the case of the indicators where the differences between the two groups were significant, it was important to look for alternative ways to explain the findings. The findings that neither household size nor employment status contribute significantly to explain differences between married women at midlife and married younger adult women on the role agreement and role performance indicators are clear indications that to describe women at midlife is a complex and multidimensional task. This paper has simply touched on these complexities.

Based on the data in Table 3.1, where married younger adult women had more children in the home than did married women at midlife, it was
reasonable to expect that a third variable such as household size would explain the significant differences. A case can be made that the larger the household, the more complex the roles for the married woman become, and that she may experience additional stress in terms of agreeing with her spouse about what tasks each partner should perform in the household, and in terms of how well she thinks she performs her roles. However, the finding that household size does not contribute significantly to either role agreement or role performance indicates that the dimensions of a married woman’s life are far more complex than can be measured by these indicators. The close relationship between role performance and role agreement, for example, suggests that one will be unable to satisfactorily carry out her role if she disagrees with her husband about who performs which household tasks (Smith-Lovin and Heise, 1988; Heise, 1979), and role agreement depends on shared understandings between the spouses about role expectations, which in turn contribute to marital satisfaction (Wheaton, 1983). While it was hypothesized that household size was a strong contributing factor to both role agreement and role performance, data from this study do not support these hypotheses.

It is also reasonable to expect that household size would account for income satisfaction. For married women at midlife, one explanation for this could be that by this time of life, women expect to experience a decrease in household size. But given the trends in the 1990s where the nest is never truly empty when the child leaves home the first time, and where women at midlife can also expect to take on the care-taking responsibilities for one’s parents, the relationship between household size and income satisfaction needs further examination.

Another finding that requires further scrutiny is the negative correlation between self-efficacy and diet efficacy that was not significant for married women at midlife, but was significant for married younger adult women. One explanation for why women in this sample reported increasing self-efficacy at the same time as they reported decreasing diet
efficacy could be that they might think of themselves as controlling their environment in most situations, but in terms of diet, they might not see themselves as "perfect" in terms of stereotypes for body size, weight, and beauty. The significant correlation for married younger adult women might be explained by the additional stress of maintaining healthy eating habits and good health compounded by the presence of children in the household, as well as being employed outside the home, all of which might be perceived by the married younger adult woman as being out of control of one's life. Married women at midlife, on the other hand, may feel that such issues as body size, weight, and stereotypical beauty are not as important to their perceptions of self-efficacy and self-esteem. Such questions as gender differences, differences in marital status, differences in levels of education, job prestige, etc., with regard to issues of locus of control (Rotter, 1966) are relevant here, as well.

Conclusion

The assertion that women's lives can be better understood by examining a broad range of psychosocial and biomedical variables is not new with this paper. A number of models have been developed since the mid-1980s that focus on expanding understandings of well-being to include psychosocial variables, including the health belief model (Becker, 1974; Rosenstock, 1974), health psychology models (Rodin and Salovey, 1989), a model for the decision to change oneself (Kiecolt, 1994), research on midlife baby-boom women (Jacobson, 1995), and the behavioral model and access to medical care (Andersen, 1995). In each of these areas of study, researchers are calling for including psychosocial variables in research models.

By far the most important implication of this study is that it is both possible and important to understand women's lives as a complex of multi-dimensional and positive characteristics. Because of the complexity of individual lives across the life course, further research involving
statistical approaches that can handle multiple variables and that can
discern complex interactions needs to be done. For example, using
structural equation modeling, which tests a model with multiple predictors,
each of which have been measured by several methods, and which may include
reciprocal and/or nonlinear relationships with the outcome variables. In
addition, research is also needed to relate individuals’ location in the
social structure (as with gender, and education) to self-esteem, self-
efficacy and diet efficacy. The inclusion of these psychosocial indicators
in stress research models is equally important, as in the case of how and
why some indicators influence coping strategies, and their relationship to
role-related stressors.

Thus, both by describing women at midlife along a broad range of
psychosocial variables and by comparing married women at midlife with their
married younger counterparts, we were able to assess whether the assumption
that younger is better really holds for women. It could very well be that
women at midlife feel liberated from the stereotypical roles and
expectations that come with their childbearing years, and that by midlife,
they are looking beyond these expectations to new opportunities and
challenges.
APPENDIX A. ITEM CONTENT FOR MEASURES

Interactional indicators

Marital satisfaction
1. At the present time, how satisfied are you with your marriage?
2. All things considered, how happy are you with your marriage relationship?
3. All things considered, how happy do you think your spouse is with your marriage relationship?

Role agreement: How often, if ever, do you and your husband disagree about each of the following activities?
1. cooking?
2. housekeeping, except cooking and child care?
3. earning the family income?
4. being a companion and friend to each other?
5. sex?
6. caring for and training children?

Income satisfaction: Which one of the following statements usually describes your ability to get along on your income?
1. You can never make ends meet.
2. You have just enough, no more.
3. You have enough, with a little extra sometimes.
4. You have money left over.

Indicators relating to the self

Reflected appraisals: Tell how you think your husband would describe you.
1. likable <--------------------> not likable
2. incapable <------------------> capable
3. self confident <-----------------> lack self confidence
4. satisfied <-------------------> frustrated
5. useless <---------------------> useful
6. unintelligent <------------------> intelligent
7. friendly <---------------------> unfriendly

Role performance: How well do you think you do each of the following things?
1. cooking?
2. housekeeping, except cooking and child care?
3. being a companion and friend to your spouse (such as spending time together)?
4. being a sexual partner?
5. caring for and training children?
Self-efficacy: How strongly do you agree or disagree with these statements about yourself?

1. There is really no way I can solve some of the problems I have.
2. Sometimes I feel that I’m being pushed around in life.
3. I have little control over the things that happen to me.
4. I can do just about anything I really set my mind to.
5. I often feel helpless in dealing with the problems of life.
6. What happens to me in the future most depends on me.
7. There is little I can do to change many of the important things in my life.

Self-esteem: Please indicate which response best describes how much you agree or disagree with how it describes you.

1. I feel that I’m a person of worth, at least on an equal level with others.
2. I feel that I have a number of good qualities.
3. All in all, I am inclined to feel that I’m a failure.
4. I am able to do things as well as most other people.
5. I feel I do not have much to be proud of.
6. I take a positive attitude toward myself.
7. On the whole, I am satisfied with myself.
8. I certainly feel useless at times.
9. I wish I could have more respect for myself.
10. At times, I think I am no good at all.

Indicators of physical and psychological well-being

Perceived health threats: What do you think your chances are of developing health problems from eating the following foods?

1. food high in fat
2. food high in cholesterol
3. food high in sugar
4. food high in salt
5. food with bacteria or viruses
6. food with agricultural chemical residues
7. food with additives which improve the product appearance or shelf life
8. drug residues in meat and milk
Diet efficacy: Tell how you feel about each statement.

1. Even though I know that my way of eating is not good for me, I just can't seem to change my habits.
2. I often feel helpless in choosing foods that will be healthy for me and my family.
3. Even though I know that my way of eating is not good for me, I just can't seem to change my habits.
4. It seems that almost everything I like to eat is bad for me.
5. No matter how hard I try to change, I end up falling back into some of my old eating habits which I know are bad.
6. If I changed the way I eat, I would be a much healthier person.
7. When it comes to food, I have no will power.
8. I find myself eating "junk food" I know is not good for me.
9. I eat more when I feel down.
10. Many days, because I'm in a hurry, I eat whatever is handy.

Depression: Look at the following list of ways you may have felt or behaved at some time. Please tell me how frequently you have felt this way.

1. . . . lacked enthusiasm for doing anything?
2. . . . had a poor appetite?
3. . . . felt bored or had little interest in things?
4. . . . lost sexual interest or pleasure?
5. . . . had trouble getting to sleep or sleeping?
6. . . . cried easily or felt like crying?
7. . . . felt downhearted or blue?
8. . . . felt low in energy or slowed down?
9. . . . felt hopeless about the future?
10. . . . had any thoughts of possibly ending your life?
11. . . . felt lonely?
### Married women at midlife

- Correlation Coefficients -

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- Signif. LE .05 ** - Signif. LE .01 (2-tailed)

### Younger adult married women

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- Signif. LE .05 ** - Signif. LE .01 (2-tailed)
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