

WOMEN'S HEALTH II

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6 CONTINUING EDUCATION CONTACT HOURS

“In the end, aggregate information can only carry us so far. Then we must make a conceptual leap to envision the lives of girls and women, what they are and what they can become.”

Carol Goodheart, in Worell and Goodheart, 2006, p. 10.

Course Objective

This course provides an understanding of the challenges faced by women within various life domains and developmental phases due to gender differences, cultural structure, and life span development. Major topics include women's relationships, midlife, and older women.

Accreditation

This course is approved for 6 continuing education contact hours by the National Association of Social Workers for social workers and counselors (NASW Provider ID # 886398989).

Mission Statement

Continuing Psychology Education Inc. provides the highest quality continuing education designed to fulfill the professional needs and interests of mental health professionals. Resources are offered to improve professional competency, maintain knowledge of the latest advancements, and meet continuing education requirements mandated by the profession.

Learning Objectives

Upon completion, the participant will be able to:

1. Acknowledge gender differences in friendships and relationships.
2. Describe variables promoting relationship satisfaction.
3. Recognize women's frequent midlife events, challenges, and physical, psychological/emotional experiences.
4. Discuss prevalent challenges encountered by older women.
5. Indicate research-supported ways in which older adults maintain well-being throughout the aging process.

Faculty

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INTRODUCTION

Mental health may be defined as “successful mental functioning, resulting in productive activities, fulfilling relationships, and the ability to adapt to change and cope with adversity” (U.S. Department of Health and Human Services, 2000, p. 37). Physical and psychological factors interact to promote health as evidenced by the fact that eight of the top ten causes of death in the U.S. are related to the following behavioral issues: tobacco, diet, lack of exercise, alcohol, motor vehicles, firearms, sexual behavior, and illicit drug use (Mokdad, Marks, Stroup, & Gerberding, 2004). Key proportional contributions to health status are: access to care, 10%; genetics, 20%; environment, 20%; and lifestyle behaviors, 50% (CDC, cited in Institute for the Future, 2000, p. 23). Psychological factors significantly affect immune function and health and it is theorized that gender-related circumstances may be an intervening variable in this process. Women live, on average, seven years longer than men in the United States and across many cultures worldwide (in Adler & Coriell, 1997). Though women live longer than men, women experience greater morbidity (have more disease and disability affecting quality of life), for example, more men than women die from cardiovascular disease but more women actually have the disease. The leading causes of death for women in the U.S. are heart disease, stroke, lung cancer, and breast cancer.

The causes of gender differences in morbidity and mortality are unclear, but are presumed to involve biological causes and social/psychological factors associated with gender roles. Feminist beliefs attribute women's poorer health to social dynamics such as women having less education, lower income, and less political power compared to men (Lee, 1998). Gender differences in stress linked to gender roles and poverty, and gender differences in coping and social support are related to health (O'Leary & Helgeson, 1997). Research has shown that acute and chronic stress, negative emotions, social support, marital conflict, coping style and hostility affect the body's immune activity and health (in Kiecolt-Glaser, McGuire, Robles, & Glaser, 2002b). Additionally, negative emotions caused by stress stimulate the production of pro-inflammatory cytokines, and inflammation can cause many health risks as people age, including cardiovascular disease, diabetes, arthritis, osteoporosis, some cancers, Alzheimer's disease, periodontal disease, frailty, and functional decline. This distress-related immune dysfunction is theorized to be a mechanism underlying many health risks (Kiecolt-Glaser, McGuire, Robles, & Glaser, 2002a).

Socioeconomic status (SES) affects mortality and morbidity – the poorest people have the worst health while the wealthiest have the best health (Adler & Coriell, 1997; Williams & Rucker, 1996). Race correlates to poorer health outcomes through its connection to SES. The prevalence of chronic diseases is greater among low SES groups, above all, osteoarthritis, hypertension, and cervical cancer (Adler,

Boyce, Chesney, Cohen, & Folkman, 1994; Carroll, Bennett, & Smith, 1997). Amazingly, women appear to experience fewer health benefits than men in the upper SES levels (Adler & Coriell, 1997). The relationship of SES to health outcomes is known but how SES impacts health is not clear; interactions between gender, SES, race, and illness seem to affect gender and racial differences in mental and physical health.

Kemeny (2003) disputes the notion of a single general physiological response to all stressors, instead, she believes that specific stressful circumstances and the specific way an individual appraises them can initiate different emotional and physiological responses. Examples of this process include appraisals of threat versus challenge, uncontrollability, and negative social evaluation, each of which stimulates a specific psychobiological response. It is theorized that these types of appraisals are influenced by gender-related variables.

This course examines women's health through the dimensions of gender, culture, life span development, and well-being. The challenges of pervasive gender disparities that affect women's health and corresponding therapeutic treatment approaches and ideas are highlighted with the hope that such knowledge will lead to resourceful action and empowerment.

WOMEN'S RELATIONSHIPS

The meaning of friendship varies with age and gender. Young children, aged 3-4 years, understand friend as a playmate and “someone who likes you” (Berk, 1993). Sharing and playing together becomes significant during ages 4-7 years. Gender segregation develops during this time resulting in mixed-gender friendships being atypical. Girls choose to have more closeness in relationships than boys, hence, girls are more selective, have fewer friends and establish friendships more slowly (Berndt, 1986). Adolescent girls engage in more psychologically intimate relationships having emotional closeness, trust, sensitivity, and security than boys (Blyth & Traeger, 1988; Buhrmester & Furman, 1987; Reisman, 1990). Boys generally have larger groups of friends with whom they play physical, competitive games. Youniss and Smollar (1986) found that 35% of boys compared to 5% of girls in their study acknowledged the level of communication in their best friendships was guarded, distant, and superficial. Androgynous boys display equivalent same-gender intimacy as girls (Jones, & Dembo, 1989).

Adult women's same-gender friendships parallel their childhood friendships by being intimate, and conversational (Johnson, 1996); they are described as expressive, communal, or “face-to-face,” while men's same-gender friendships are viewed as instrumental, agentic, or “side-by-side” (Reisman, 1990; Wright & Scanlon, 1991). Women communicate with each other, whereas men do things together. Women's friendships are often emotionally richer, more complex and holistic, and more likely to include

psychological intimacy involving sharing confidences and emotional supportiveness compared to men (Jones, Bloys, & Wood, 1990; Reisman, 1990; Veniegas & Peplau, 1997, Wright, 1989; Wright & Scanlon, 1991). Though women's friendships are more expressive than those of men, they still can be instrumental as women do things together and assist one another on various tasks (Duck & Wright, 1993; Monsour, 1992).

Adult men continue to interact with same-gender friends in groups engaging in structured activities (i.e., sports) and special purposes (i.e., repairing a car) which contain inherent boundaries (Jones et al., 1990; Mazur & Oliver, 1987) yielding less self-disclosure. Interacting in activities does allow for expression of socioemotional concerns (Wood, 1994), and men report feeling emotionally close to their male friends (Veniegas & Peplau, 1997). Reisman (1990) found that men would like to disclose personal feelings and reveal affection and tenderness with their male friends more frequently than they do. Androgynous men indicate more involvement in their relationships (Barth & Kinder, 1988), easier communication style and more self-disclosure than gender-typed males, and similar disclosure level as gender-typed and androgynous women (Jones et al., 1990; Siavelis & Lamke, 1992). Men's same-gender friendships offer less self-affirmation and emotional support than women's same-gender friendships (Johnson, 1996; P. H. Wright, 1985; Wright & Bergloff, 1984). Men often feel less close and related to the same-gender friend, and that they know him and are known by him less (Buhrke & Fuqua, 1987). College senior men rated their best male friend interactions less meaningful than did college senior women, particularly regarding intimacy and self-disclosure (Elkins & Peterson, 1993; Reis, 1986).

Adult mixed-gender friendships offer interaction not usually attainable in same-gender friendships. Women appreciate men's friendships without the psychological intensity of women's companionship, and like men, women gain from the different perspective offered by the opposite sex (Swain, 1993; Werking, 1994; Wood, 1994). Men welcome female friendships because men receive intimacy, closeness, emotional support, a feeling of acceptance, and therapeutic value not generally present in men friendships (Elkins, & Peterson, 1993; Hammersla & Frease-McMahan, 1990; Reis, 1986). Men are often more open and disclosing to women than to men (Reisman, 1990; Wright & Scanlon, 1991).

Brehm (1992) defines loneliness as a state of deprivation and dissatisfaction caused by an inconsistency between our desired type of social relations that we want and the type we have at present. Being alone does not necessitate a feeling of loneliness and we can feel lonely in the company of another, hence, loneliness may be unrelated to being with someone or not. Women report more loneliness when the word "lonely" appears in the measuring instrument, such as "How often do you feel lonely?" (Borys & Perlman, 1985), and men indicate more loneliness when the word "lonely" does not appear in the question, for example, "I am not close

to anyone now" (Russell, Peplau, & Cutrona, 1980). It is more socially acceptable for a woman than a man to admit loneliness (Brehm, 1992), yet women are less likely to feel lonely (Reis, 1986), and the loneliness they feel is not a function of whether they are in a romantic relationship.

Baumeister and Leary (1995) suggest that "human beings have a pervasive drive to form and maintain at least a minimum quantity of lasting, positive, and significant interpersonal relationships" (p. 497) that include enjoyable, stable, and mutually beneficial interactions. This "belongingness hypothesis" applies to women and men, but women display a very strong interest in and ability to experience connection. The presence of these social bonds are considered related to positive emotional and physical outcomes while the loss of these positive connections relates to various negative outcomes (Baumeister & Leary, 1995). Arguably, this justifies why love and intimacy are rewarding and breakup, divorce, and loss are punishing.

Women and men initially desire a highly attractive partner but ultimately have relationships with those of relatively equal to their own attractiveness (Baumeister, Wotman, & Stillwell, 1993; Gonzales & Meyers, 1993). Men are more concerned with the physical attractiveness of their partner than are women (Davis, 1990). Beginning in about ninth grade, boys highlight good looks in defining the ideal woman, and girls accentuate interpersonal traits in describing the ideal man (Stiles, Gibbons, & de la Garza-Schnellmann, 1990). Women's attractiveness correlates with their dating popularity and their partner's marital satisfaction (Berscheid, Dion, Walster, & Walster, 1971; Jackson, 1992).

David Buss (1988, 1989, 1991; Buss & Barnes, 1986) suggests a psychobiological/evolutionary assessment of mate selection premised on the idea that women and men – and all living species – desire to have their genes passed on. Men are expected to seek an attractive, young, and healthy woman who can produce a number of healthy offspring. Women are envisioned to seek a strong and dominant man who can provide for the entire family unit, which equates to the man having earning power and education. Much evidence in the United States and other countries supports this theory (Regan & Sprecher, 1995).

Women and men tend to understand the other's preferences and modify their strategy for attracting potential partners accordingly (Buss, 1988; Child, Low, McCormick, & Cocciarella, 1996). Supportively, new brides disclosed that they attempted to attract future husbands by donning stylish clothes, makeup, jewelry, and being clean and well-groomed (Buss, 1988). Grooms admitted to showing off new possessions and announcing they made good money. Ads in the personal columns illustrate these gender preferences in that women indicate their attractiveness and the economic status of desired partners while men state their wish for an attractive partner and their own financial stability (Bailey, Gaulin, Agyei, & Gladue, 1994; Child, Low, McCormick, & Cocciarella, 1996; Davis, 1990; Gonzales & Meyers, 1993; Greenlees & McGrew, 1994; Sprecher, Sullivan & Hatfield, 1994).

Women and men of the same culture report very similar desired preferences for a mate implying that every culture teaches women and men what is deemed valuable in that particular culture, therefore, cultural differences are more prevalent than gender differences (Buss et al., 1990). College and noncollege students in the United States specify the following preferred traits in a mate: affectionate, kind, considerate, loving, dependable, understanding, loyal, interesting to talk with, honest, and a good sense of humor (Buss & Barnes, 1986; Fehr, 1993; Goodwin, 1990; Peplau, 1983; Sedikides, Oliver, & Campbell, 1994). Nevid (1984) found the three highest-rated meaningful relationship characteristics among college women and men were honesty, fidelity, and personality; a difference in value of physical attractiveness was apparent in that women emphasized relatively greater importance of personal characteristics while men stressed physical characteristics more than women.

Both women and men value *dyadic attachment* – coupling or nest building, highlighting being together as much as possible and being confidants to one another (Cochran & Peplau, 1985). Women value being equalitarian and autonomous in relationships more than men, for example, having one's own career and group of friends. Women's attitudes about love are often pragmatic whereas men's attitudes are often idealistic, romantic and potentially cynical (Dion & Dion, 1973; Hendrick & Hendrick, 1995, 1996; Rubin, Peplau, & Hill, 1981). The pragmatic attitude assesses a relationship via a "shopping list" of essential criteria for a successful relationship (Lee, 1973). Men's idealism is reflected in the attitude that true love lasts forever while women believe that generally people can love any one of several people. Further, men's idealism links to their recognizing love earlier and falling in love more quickly (Hill, Rubin, & Peplau, 1976; Walster, Walster, & Berscheid, 1978), but greater disappointment ensues upon relationship failure leading to becoming cynical; men are more cynical about women possibly due to men's idealism.

Men demonstrate more *ludic* behavior, defined as playful enjoyment of a game; a ludic attitude perceives sex as a pleasant pastime lacking in serious commitment (Hendrick & Hendrick, 1986, 1995, 1996). Men's ludic orientation may explain why they are less likely to feel exploited sexually in relationships that end (Baumeister et al., 1993).

Similarity between partners correlates with relationship satisfaction, and some pertinent similarities are age, interests, sexual attitudes, backgrounds, ideas about marriage, educational aspirations, physical attraction, and intelligence (Hill et al., 1976); similarity in religion is essential for some groups (Markstrom-Adams, 1991). Agreement about gender role behaviors, particularly involving dual-career marriages, is important in dating relationships and marriages (Peplau, Rubin, & Hill, 1976, 1977) as couples disagreeing on this theme reported less relationship satisfaction and had higher probability of breaking up within one year compared to those with shared attitudes (41% versus 26%). Likewise, egalitarianism is linked to dating couples' commitment and marital satisfaction (Grauerholz, 1987) and such equality

intersects with factors of self-disclosure and the man's self-esteem. Higher levels of self-disclosure, and expression of love by the partner yield higher relationship satisfaction among women and men in dating relationships (Hendrick, Hendrick & Adler, 1988; Siavelis & Lamke, 1992). Prager (2000) found that the three essential characteristics of intimate interaction are self-disclosure, positive emotion, and feeling understood by the partner. College men's self-esteem was associated with their partner's relationship satisfaction but college women's self-esteem was not associated with their man's relationship satisfaction. The connection between men's self-esteem and women's satisfaction may result from assumptions of male power (Peplau & Campbell, 1989). Men possessing positive self-esteem and inner security are more likely to not require dominant relationship control, share personal feelings, and contribute to the "women's work" of developing and sustaining the relationship. The advantage of such is that happiness, commitment, and love are all rated higher given each partner perceived as contributing equally to maintain the relationship (Fletcher, Fincham, Cramer, & Heron, 1987).

Women are somewhat more likely to terminate dating relationships and marriages and to express more relationship problems than men do (Hill et al., 1976; Rubin et al., 1981). Lack of similarity is a common reason for relationship termination, also desire for independence, meeting someone else, parental pressure, and 75% of women and men quoted boredom (Hill et al., 1976). Individuals reflect on levels of need-fulfillment and accompanying cost when contemplating relationship termination (Drigotas, Rusbult, & Caryl, 1992). Couples in dissolved relationships often indicate lack of increase in rewards, satisfaction, investment, and commitment, thus, the relationship was not growing (Simpson, 1987). Gratification of needs during the relationship exceeds the importance of commitment with respect to relationship dissolution, particularly if hope abounds of finding a better partner (Simpson, 1987).

Men are more likely to be upset with the relationship breakup than women (Hill et al., 1976; Rubin, Peplau, & Hill, 1981). Women are more willing than men to accept that love and the relationship has ended – they are practical; they utilize more active, healthy coping strategies to resolve the ensuing depression (Mearns, 1991). Men tend to be idealistic, romantic, and have difficulty believing the relationship has ended. Men often feel the breakup was sudden while women, who apply more sensitivity to nuances of relationships, are more likely to have been cognizant of problems even if they are not initiator of the breakup (Drigotas & Rusbult, 1992; Jacobson, Follette, & McDonald, 1982; Rubin et al., 1981). A woman may have attempted to prevent the breakup in subtle ways which the man did not notice (due to his idealism), supportively, men have more difficulty than women in detecting meanings and messages from nonverbal cues. Women sense the breakup was gradual and may have been preparing for the inevitability in ways men have not. Moreover, relationship dissolution is often easier for women than men because women generally

maintain interpersonal support from other women while men receive support from relationships with women that is not characteristic of male relationships. Men are more likely to lose a bigger part of their interpersonal life than women during a breakup, however, in noncomparitive terms, women do experience significant loss, and the level varies across individuals.

An alternative to marriage is cohabitation, defined as living together without marriage. For young couples not previously married, this arrangement is commonly a delay rather than a substitute for marriage whereas for older or previously divorced couples it can replace marriage to avoid experiencing another possible failed marriage, or losing a spouse's pension or children's inheritance upon remarriage (Brehm, 1992). Some couples opt for cohabitation to evade the responsibility of husband and wife roles (Brehm, 1992). Decision-making, division of labor, communication, and relationship satisfaction appear equivalent between cohabiting and married couples (Blumstein & Schwartz, 1983; Murstein, 1986; Yllo, 1978). Cohabiting couples tend to be more equalitarian in completing household work, and are more likely to become traditional upon marriage; they are more abusive than married or dating couples. The most frequent research finding indicates that married partners who cohabited are less happily married and have more divorces than previous non-cohabitators (Bennett, Blanc, & Bloom, 1988; Newcomb, 1987); 53% of first marriages following cohabitation ended within ten years versus 28% of non-cohabitation marriages (Riche, 1988). Cohabiting couples are less committed to the relationship than married couples (Kurdek & Schmitt, 1986a, 1986b). A possible explanation for higher divorce and lower satisfaction rates among cohabitators is that a "relational clock" may start before marriage begins, in other words, there may be a timeframe in which problems inevitably ensue in any relationship and this clock, for cohabiting couples, starts before signing the marriage license (Brehm, 1992).

Approximately 95% of Americans are legally married at some point in life which exceeds the rate for most European countries and for the United States in the 19th century. Marriage rates are declining, with a predicted 90% marriage rate near-term (Norton & Moorman, 1987; Rogers & Thornton, 1985). The most common reasons for marrying include love, companionship, sex, children, and financial security. Women of yesteryear frequently thought of marriage as financially necessary and romantic love a bonus, in fact, in the mid 1960s, only about 25% of women believed romantic love was necessary for marriage compared to roughly 67% of men (Kephart, 1967). As the number of employed women has increased, the percent of women considering romantic love as mandatory for marriage has risen to 80%, the same as men (Simpson, Campbell, & Berscheid, 1986). Being gainfully employed provides women with freedom to choose to remain single or to marry for love, not financial necessity.

Young married couples are very happy (Campbell, 1975; Hatfield & Rapson, 1993), but most married couples report

that disappointment sets in (Hartfield & Rapson, 1993). Frequently, a steady decline in marital satisfaction during the first twenty years of marriage is extant followed by a rebound upon children leaving home (Levenson, Carstensen, & Gottman, 1994), but variance exists. Happily married people generally display some or all of these characteristics: well-educated, married after their teens, were well-acquainted before marriage, their parents are happily married, good communication and conflict resolution skills, and they have egalitarian habits (Birchler, 1992; Cate & Lloyd, 1992; Kurdek, 1991, 1993; Levenson et al., 1994).

Nonverbal communication such as eye contact, facial expressions, and body movement is a relevant source of communication, in fact, nonverbal communication is more likely to be believed given an inconsistency between verbal and nonverbal communication (Keeley & Hart, 1994). These researchers state, "nonverbal behaviors are indicative of quality communication. Research indicates that people pay close attention to nonverbal behaviors as indicators of the health of their relationships" (Keeley & Hart, p. 161). Halford, Hahlweg, and Dunne (1990) conducted cross-cultural research with couples and observed "the most outstanding feature of unhappy couples is their inability to terminate negative interaction, particularly in nonverbal communication... In contrast, happy couples manage to deescalate such a process or refrain from starting it at all" (p. 499). Unhappy partners commonly are more confident about but less correct in their communication with each other (Noller & Venardos, 1986).

Happily married people are committed to the relationship and to each other, respect and nurture one another, and they can rely on each other (Antill, 1983; Bee, 1987; Kelly & Burgoon, 1992; Kobak & Hazan, 1991). Commitment develops as relationships develop and Johnson, Caughlin, and Huston, (1999) illustrate three important types of commitment: personal commitment is a general intention toward the partner; structural commitment is experiencing barriers to dissolving the relationship; and moral commitment is believing in a moral obligation to continue the relationship. Level of commitment, mutuality of commitment, and trust are vital to a well-functioning relationship (Drigotas, Rusbult, and Verette, 1999). Marital satisfaction links to the emotional intimacy of expressing feelings (Merves-Okin & Amidon, 1991) and to spiritual intimacy (Hatch, James & Schumm, 1986). Greater happiness is reported when both partners of a couple are expressive (androgynous or feminine) compared to couples with one or both members being low on expressive traits (Antill, 1983; Bradbury & Fincham, 1988; Peterson, Baucom, Elliott, & Farr, 1989). Fundamental similarity between the partners, such as in education, background, intelligence, and values also promotes emotional sharing (Diamond, 1986; Kurdek, 1991). Gottman (1994) advocates that couples should not drop below a ratio of five positives (rewards, reinforcement or gratification) to one negative (cost, punishment or missed reward) to maintain a positive and stable relationship. Fundamental dissimilarity usually

signals some status difference that weakens equality. High levels of education and self-esteem tend to facilitate resolving conflict and managing the waning of idealistic romanticism that marks early stages of marriage (Belsky & Rovine, 1990; Kurdek, 1991). Young, middle-aged, and older adults generally agree on a love relationship's most important characteristics. A study of married couples chosen by their friends as possessing happy and loving relationships found that the vital characteristics were emotional security, respect, communication, help and play behaviors, sexual intimacy and loyalty (Reedy, Birren & Schaie, 1981).

Generally, men report more marital satisfaction than women (Fowers, 1991; Suito, 1991; Wood, Rhodes, & Whelan, 1989); married men are less depressed than either married women or single men, and report more life-satisfaction than single men (Fowers, 1991; Steil & Turetsky, 1987; Gottman, 1994); and unrewarding marriages negatively impact women more than men (Helson, Mitchell, & Moane, 1984). Most women are not fulfilled within two marital domains: issues of equality and expression of love and care (Shek, 1995). Most marriages are characterized by lack of equality (Cooper, Chasson, & Zeiss, 1985; Finlay, Starnes, & Alvarez, 1985; Fowers, 1991) and this is more stressful for wives than husbands. Husbands, more than wives, typically believe in innate roles, are more traditional, and less equalitarian (Mirowsky & Ross, 1987; Peplau & Gordon, 1985). Distressed couples disagree about equality more than nondistressed couples (Fowers, 1991). Women are acquiring more power in marriages due to being gainfully employed, still, they often earn less than men resulting in less power, along with less physical strength and less power from traditional gender roles (Blumstein & Schwartz, 1983; Hatfield & Rapson, 1993; Steil & Weltman, 1991).

Four basic marriage structures exist, each with varying equality and satisfaction. The most common type of marriage is the *modern marriage*: the wife is employed by choice, in addition, she does the housework and possibly child-care as well (Breuss & Pearson, 1996; Hochschild, 1989; Ross, Mirowsky, & Huber, 1983; Schwartz, 1994; Steil & Weltman, 1991). Rare but increasing are *equalitarian marriages*: the wife is employed by choice and duties are shared (Schwartz, 1994). These couples report lower distress and higher satisfaction than partners of the other marriage types (Gray-Little & Burks, 1983; Ross et al., 1983; Schwartz, 1994); they experience more intimacy, companionship, mutual respect and understanding, better communication, and their relationship is top priority (Schwartz, 1994). *Traditional marriages*, meaning that the wife does not work outside of the home but the husband does, offer psychological benefits if she chooses not to work (Fitzpatrick, 1988; Peplau, 1983). The *traditional desired marriage*: the wife takes care of housework and children and is employed but not by choice (Rosen, 1987; Ross et al., 1983), is the only marriage type producing distress for the husband, and it induces the highest distress for the wife. Neither partner benefits from this marriage type (Ulbrich, 1988).

Women's dissatisfaction with men's expression of love and care seems related to gender communication differences. Friendship interaction styles generalize into marriage interactions, thus, men emphasize doing things and women highlight saying things and disclosing feelings (Wills, Weiss, & Patterson, 1974). Lillian Rubin (1983) labeled marital partners as "intimate strangers" because their history of different communication styles (Breuss & Pearson, 1996; Wood, 1996) translates into men and women preferring to converse about different things. Women take pleasure in sharing feelings, personal issues, and details of the day while men are often less experienced at sharing feelings and they don't value revealing daily details (Wood, 1996). Amongst all social classes, women value self-disclosure more than men, hence, women may view men's relative disinterest in personal talk as rejection of intimacy. Many men who enjoyed disclosure during dating commonly stop such openness in marriage which adds to women's responsibility for the relationship's emotional work (Miller, 1973; Weiss, 1975). Men still love their wives but their style of showing love – by instrumental actions rather than words – differs from that of women (Cancian, 1985; Rubin, 1976, 1981). Francesca Cancian (1985) expressed her concern that love and intimacy are defined in feminine manner resulting in the typical husband feeling threatened and controlled by his wife's interest in greater intimacy. Talking about the relationship may threaten the husband leading to a cycle of his withdrawal, compelling the wife to insist on more sharing, followed by his added withdrawal. Broadening the concepts of love and intimacy to embrace instrumental activities might increase women's recognition of men's expression of love and care.

Conflict and disagreement occur in good and bad relationships, generally, the difference is not in quantity of conflict but in how disagreement is handled (Langhinrichsen-Rohling, Smutzler, & Vivian, 1994; Peterson, 1983). Satisfied couples reinforce their partner, express humor and motivation to negotiate and compromise, and attribute positive events to their partner (Aida & Falbo, 1991; Fincham & Bradbury, 1993). In opposition, dissatisfied couples belittle their partner and frequently convey negative views and emotions (Gottman & Levenson, 1992; Levenson & Gottman, 1985). Equalitarian couples often are reasonably direct about their concerns; they raise the issue, discuss it, and avoid coercive techniques (Falbo & Peplau, 1980; Gottman, 1979). Women and men employ game playing strategies in marriages with power differences (Cataldi & Reardon, 1996). Traditionally expressive women apply more manipulative methods such as regression, debasement, and the silent treatment whereas men limit their manipulation because they believe they will have their way (possibly due to higher status), but they might act charming. Women of lower status assume they will not get their way and tend to utilize techniques of those lower in power, for example, pouting, crying, withdrawing affection, dropping hints, flattering, and pleading (Howard, Blumstein, & Schwartz, 1986).

Status differences fuel the *demand/withdraw pattern* whereby one individual pressures another, who responds by withdrawing, causing increased pressure followed by increased withdrawal (Christensen & Heavey, 1990). A woman desiring communication, for instance, may demand and complain and the man then withdraws (Cancian, 1985; Christensen & Heavey, 1990). This ineffectual pattern links to status, specifically, women with lesser status and power are more likely to request change while men with more power often wish to maintain the status quo. Interestingly, the pattern reverses when men want a change – they demand and women withdraw. Christensen and Heavey (1990) studied the demand/withdraw pattern in parents regarding child rearing issues in which either the mother or father wanted a change. Both husbands and wives frequently used demand when talking about a change they wanted and both generally withdrew when discussing a change the partner requested. Satisfying relationships tend to avoid demand/withdraw patterns and the game playing of relationships with inequality.

The factors related to distressed marriages also predict divorce: having children before marriage, early age of marriage (particularly before 20), frequent disagreements, relative lack of education and money, and lack of equality, similarity, effective communication, and commitment (Glen & Supanic, 1984; Kitson, 1992; Kurdek, 1993; McGonagle, Kessler, & Gotlib, 1991; Norton & Moorman, 1987). In a longitudinal study, Huston, Caughlin, Houts, Smith, & George (2001) determined that negative emotion exhibited fairly early in marriage predicted early divorce (mean of 7.4 years following marriage), while lack of positive emotion shown fairly early predicted later divorce (mean of 13.9 years following marriage). Generally, one person wants divorce more than the other because marriage costs outweigh satisfactions (Kelly, 1982; Levinger, 1976); the initiator of divorce is more likely the woman than the man – 67% to 75% of all divorces in the United States are initiated by women (Ahrons, 1994; Gray & Silver, 1990; Kelly, 1982; Kitson, 1992; Spanier & Thompson, 1983), except men initiate divorce more after age 55. Comparable to dating relationships, women are more attuned to relationship concerns and experience dissatisfaction before men (Blumstein & Schwartz, 1983; Gray & Silver, 1990; Huston & Ashmore, 1986; Kitson, 1992). Regardless of the initiator, divorce represents a difficult decision made after months or years of contemplation; divorced people often report having underestimated the pain associated with divorce (Wallerstein & Kelly, 1980). Communication difficulties was the main reason for divorce by women and men in a study of over 600 people, with other common factors including basic unhappiness, and incompatibility – women cited these more (Cleek & Pearson, 1985). Women, more than men, report that they felt unloved (66% versus 37%). Men's major complaint (53%) was that their wives neglected their needs and wishes, in response, a major complaint by women was

being criticized by husbands. Women also complain of their husband's emotional/verbal abuse, self-centeredness and distance.

Divorce effects appear more severe for men than women, at least in the short-term (Price & McKenry, 1988). Divorced people are overrepresented among psychiatric patients, alcoholics, and suicide victims (men are 50% more likely than women to commit suicide after divorce). Women encounter more long-term concerns following divorce, possibly due to experiencing lower financial status (Gorlick, 1995; Morgan, 1991; Price & McKenry, 1988). Most women receive little money from their former husbands, even if they receive child support (Arendell, 1987; Price & McKenry, 1988; Waldman, 1992). Women's income decline ranges from 30% to 73% (Duncan & Hoffman, 1991; Morgan, 1991; Weitzman, 1985). Divorced women frequently must accept low-paying unstable jobs which pressures them and their children, who are probably living with her (Chase-Lansdale & Hetherington, 1990; Hetherington, 1989). Amato (2000, p. 1282) notes that divorce "benefits some individuals, leads others to experience temporary decrements in well-being that improve over time, and forces others on a downward cycle from which they might never fully recover." In general, divorced women recover after several years to better functioning levels than in the few months following the divorce, but they frequently do not attain well-being levels reported by women who are still married (Lorenz et al., 1997). Divorce renders women and their children vulnerable to psychological stress until such time that they create an acceptable life and reinstate stability and comfort. Higher distress levels before, during, and immediately after a divorce generates slower recovery (Whistman & Jacobson, 1989). Hendrick (2004, p. 178) states, "Remarriage is one of the most positive actions a divorced person can take, since emotions, economics, and parenting are all likely to improve when one has a supportive partner." Unfortunately, remarriage divorce rates are higher than first marriages, possibly due to the complexities of remarriage.

Traditional women in traditional marriages may face more adjustment issues than more equalitarian women (Weitzman, 1985). Divorce causes little pain for about 33% of women who maintain hope for a new chance and enjoy psychological growth (Rice, 1994; Schwartz, 1994). Five years following divorce, most people approved of the divorce, even if they initially opposed (Wallerstein & Kelly, 1980). Divorced women, similar to widows, frequently indicate having discovered personal strengths (53% versus 15% of men) they were unaware of (Brown & Fox, 1979). Older and younger women studied at less than eight months after separation and then one year later demonstrated psychological growth during the year (Bursik, 1991a, 1991b).

Relationships are integral in the process of personal growth. Friendships through the lifespan foster understanding of ourselves and the world. Women have more opportunity to express their agency and their communion. Equalitarian relationships promote greater

satisfaction and growth but such equality is not probable if either or both partners are gender-typed. Some men are conducive for equalitarianism due to greater self-esteem, intimacy, or an upbringing favoring expressiveness while others develop the capacity given openness to personal growth and learning from their wives and female friends. Carl Jung professed that women and men can learn from one another ways to develop both the animus and anima – traits that are commonly buried – given appreciation of those neglected traits and a willingness to grow.

MIDLIFE

Widespread agreement is lacking on when middle age begins, but many believe it starts around age 40 and ends in the mid-60's (Etaugh & Bridges, 2004). Rather than a biological or psychological event initiating middle age, individuals experience various life events and role changes pertaining to physical changes, sexuality, marital status, parenting, caregiving for family members, grandparenting, and retirement.

People generally have good health during midlife, but the first signs of physical aging begin and early indications of chronic health conditions may develop. Rate of aging and appearance of chronic illness varies substantially across individuals. Genetic makeup and lifestyle choices such as healthy nutrition, exercise, and not smoking promote health during the middle years (Goldman & Hatch, 2000). Getting older is not generally appreciated in our youth-oriented culture, but the stigma of aging is worse for women than men and this disparity is termed the “double standard of aging.” Graying hair and wrinkles increase the perceived status and attractiveness of older men but decrease the attractiveness and desirability of older women. One explanation for this difference is that a woman's sexuality and ability to bear children – socially valued qualities – are linked to physical attractiveness and youth. With age, she is viewed as less appealing because her socially useful capability as childbearer is over. Men, conversely, are perceived to acquire competence, autonomy, and power as they transition from youth to becoming older. Supportively, midlife women compared to midlife men report more dissatisfaction with their appearance (McConatha, Hayta, Riley, & Leach, 2002) and engage in more age concealment techniques (Noonan & Adler, 2002).

The main physiological change for most middle-aged women is menopause, the cessation of menses, and is viewed as loss of reproductive capability and sexual functioning decline. The media perpetuates the idea that menopause is a disease with deterioration requiring treatment by drugs (Derry, 2002). Actually, most middle-aged North American women diminish the significance of menopause, believe it is a transitory inconvenience, and are relieved at the cessation of their menstrual periods (Ayubi-Moak & Parry, 2002). Postmenopausal women view menopause more positively than younger midlife women while young women maintain the most negative views (Sommer et al., 1999). Menopausal

experiences and attitudes vary across cultures signifying they are, in part, culturally constructed. Women of high social castes in India indicate few negative symptoms, Mayan women rarely experience hot flashes, and Japanese women report significantly less hot flashes than U.S. and Canadian women (Etaugh & Bridges, 2004).

The rate of chronic illness begins to increase in midlife as men reveal a higher incidence of fatal diseases (i.e., heart disease, cancer, stroke) whereas women show higher prevalence of nonfatal diseases (e.g., arthritis, gallstones, urinary incontinence). The gender health paradox is characterized by “Women are sicker; men die quicker” (Goldman & Hatch, 2000). Interestingly, women experience 64 years in good health and without disability compared to only 59 years for men. Women live roughly seven years longer than men, therefore, women more than men, generally live many years with chronic, frequently disabling, illnesses (Etaugh & Bridges, 2004). The following two biological theories explain women's greater longevity: a) Women's second X chromosome is protective against various potentially lethal diseases, for instance, hemophilia and some types of muscular dystrophy are more likely to occur in individuals with only one X chromosome (men), and b) Women have a higher estrogen level, which before menopause, may be protective against heart disease (Gaylord, 2001). Women's health risks and mortality rates vary by ethnic group and socioeconomic status, for example, African American and Native American women, who reveal lower family income compared to Asian American and Caucasian women, have higher mortality rates (Torrez, 2001).

Several lifestyle factors account for the gender difference in mortality. First, men have a greater tendency than women to perform risky behaviors such as smoking, drinking, violence, and reckless driving. Second, women utilize preventive health services and seek medical treatment when feeling ill more so than men (Addis & Mahalik, 2003). This supports women outliving men after diagnosis of a potentially fatal disease. Third, probability is greater for women than men to have extensive social support networks of family and friends – a variable associated with living longer (Etaugh & Bridges, 2001). In contrast, middle-aged women more than men are overweight and physically inactive which contributes to many diseases and medical conditions such as heart disease, many types of cancer, and stroke – the three main causes of death in women and men. Further, women's frequency of smoking has increased while men's rate has declined, thus, smoking-related deaths from cancer, including lung cancer, have increased for women and decreased for men (Centers for Disease Control and Prevention, 2002).

Similar variance exists between midlife and young women regarding sexual activity and satisfaction. Middle-aged women sustain only slight and gradual decreases in sexual activity, but some women have greater declines due to physical or psychological changes. Some women report lower sexual interest and capacity for orgasm during midlife,

others indicate the opposite tendency, and some individuals state an increased desire for non-genital sexual expression such as cuddling, hugging, and kissing (Etaugh & Bridges, 2001). Menopausal changes in sexual physiology and hormone levels influence women's sexuality in midlife. Estrogen production declines causing the vaginal walls to become less elastic, thinner, and more easily irritated, promoting painful intercourse. Sexual arousal is slower and the number and intensity of orgasmic contractions are lower, however, few women are cognizant or complain of the changes. Positively, slower arousal time for both women and men may increase the duration of pleasurable sexual activity (Etaugh & Bridges, 2004). Middle-aged women's sexual history affects present sexual functioning in that past enjoyment stimulates preference for continuation in midlife and beyond (Etaugh & Bridges, 2004). Psychological factors also influence middle-aged women's sexuality, in fact, sexual interest and pleasure may be enhanced as concerns about becoming pregnant have abated, and there is commonly an increase in marital satisfaction when grown children have left home. Conversely, lack of marital satisfaction or anxiety over family matters, finances, or work can diminish sexual experience (Rathus, Nevid, & Fichner-Rathus, 2002).

The notion that middle age is fraught with crisis and self-doubt is not supported by research. Studies indicate that midlife women view this phase of life as replete with energy and growth opportunities. Mitchell and Helson (1990) describe the early postparental phase as women's prime of life. Other researchers have portrayed midlife as a time of "postmenopausal zest," whereby women experience greater determination, energy, control over their life, and ability to pursue and fulfill their dreams. Women can concentrate on personal growth, their spouse, work, and community due to freedom from reproductive issues, feeling accomplished for having launched children into the world, and possessing more free time. Few women undergo a midlife crisis but many experience a process called a *life review* – a reflective self-evaluation of many life domains. One common life review theme for women is the search for an independent identity which Helson (1992) attributes to their decreased dependence and constraint linked to marriage and motherhood as children grow up. Some women attempt to reinforce or create their individuality through pursuit of education or work.

Paid work is a significant predictor of psychological well-being for many middle-aged women. Midlife women who are either starting or building their career are psychologically and physically healthier than women who are maintaining or lessening work involvement (Etaugh & Bridges, 2001). Women who have fulfilled their occupational goals as crystallized in young adulthood enjoy a better sense of life purpose and less depression in midlife compared to those who have not met their expectations (Carr, 1997). Additionally, work satisfaction predicts a feeling of well-being as greater reported work satisfaction by women equates with the better they feel in general (McQuaide, 1998). Some

women who are full-time homemakers or students attain the same heights of psychological well-being experienced by employed women. Some midlife women who had chosen the domestic role as their life goal possess an equivalent sense of purpose in life as women who accomplished an occupational role. Naturally, women who are unintentionally not working, perhaps due to early retirement or layoff, are less satisfied with midlife than women with a chosen role (Etaugh & Bridges, 2001). Midlife well-being is therefore achieved in numerous ways with an underlying prerequisite of being engaged in roles of choice.

As expected by individual differences, some midlife women are fulfilled by traditional roles, contrarily, others are left discontented by missed educational or occupational opportunities. Some middle-class women who dedicated themselves solely to marriage and motherhood report regrets in midlife over their earlier traditional role decisions. Stewart and Vandewater (1999) studied regrets of college-graduate women in the mid 1960s and found their issues focused on not pursuing a more prestigious career, marrying before settling in a career, and not returning to work after having children. Those women who implemented changes based on these regrets enjoyed more psychological well-being at midlife than those not adjusting their life direction.

In the United States, men are more likely to be married than women during midlife, particularly from ages 55 to 64 when 78% of men and only 67% of women are married (U.S. Census Bureau, 2003). After divorce or widowhood, women remarry less often and do so less quickly than men. Several reasons support women's much lower remarriage rates compared to men: a) In the U.S., there are only two men for every three women by age 65, and this disparity increases with age (U.S. Census Bureau, 2003); b) Western culture approves of men marrying younger women but not the reverse pattern which increases men's choice while decreasing women's options; and c) previously married women are less interested in remarriage than previously married men (Etaugh & Bridges, 2004).

Despite the high divorce rate, most marriages end by death of a spouse. Women have a greater chance of widowhood than men because women live longer and often marry men older than themselves. In 2000, the count was 11 million widows compared to only 2.6 million widowers in the United States (Spraggins, 2003). Loss of a spouse or partner often produces restlessness, sleep disturbances, depression, emptiness, anger, and guilt. Adjustment to the loss generally occurs within two to four years, but loneliness, yearning, and missing the partner can persist for an extended time (Cutter, 1999). Approximately 10-20% of widows sustain long-term issues such as clinical depression, alcohol and prescription drug abuse, and greater vulnerability to physical illness; these concerns are more prevalent among younger women, those with a depression history, those with less satisfactory marriages, those whose husbands' deaths followed deaths of other significant people, those whose partners died unexpectedly, those who relied on their husbands for most social contacts, and those with limited financial and social

resources. Family and children support, especially daughters, and women friends who are widowed offer significant improvement in psychological well-being. Intriguingly, more loneliness is found among women who were married for many years compared to women who live alone (Fields & Casper, 2001; Fingerma, 2001).

A significant event for many midlife women is the departure of their children from home. This postparental phase is commonly but incorrectly perceived as an unhappy "empty nest" stage of life for women, however, contemporary women often depict postparental years in positive terms. Early findings on the empty nest reported this phase of life related to a "syndrome" whereby parents, especially mothers, suffered with grief, sadness, and depressive symptoms. Further, many women revealed greater anxiety, guilt, and stress over concern with their children's well-being during this transitional stage. The women who were most vulnerable to this syndrome felt they were losing their pivotal role as mother and they lacked other important life roles to identify with (Raup & Myers, 1989). Current researchers are discovering positive factors to the departure of children from home, and that most women do not experience the more negative consequences described in earlier research. Women rarely included the empty nest when listing the significant transitions or turning points in their lives; when mentioned, role loss and sadness were not the main descriptions. Alternatively, women expressed pride in the child's achieving independence, and freedom to pursue their own interests (Leonard & Burns, 1999). Many women have indicated more happiness and less "hassles" when children leave home, but women who worried about their children leaving home beforehand may not gain such benefits. The positive aspects of the empty nest may generalize across cultures as suggested by a Hong Kong longitudinal study that observed whether depressive symptoms could be predicted by stressful life events prevalent during midlife and later adulthood. For women, departure of children from home did not produce an increase in depressive symptoms, rather, there was a slight decrease in such symptoms during the transition (Chou & Chi, 2000). Children can present tension in a marriage, in turn, women indicate greater marital satisfaction upon their children leaving home (Bee, 2000). Given less complexity and time demands of family relationships during this stage, women may enjoy more intimacy with their partners, and initiate their life review leading to new options for a personal identity. There is a growing trend of young adult children returning to live at home – approximately 25% return. Some parents report adjustment difficulties of their own upon the return, for instance, those parents who enjoyed the children leaving experienced awkwardness at maintaining their sexual relationship due to sharing the home with their adult children (Dennerstein, Dudley, & Guthrie, 2002). In contrast, changes to their parental and child-care roles can be difficult for women whose essential identity was that of mother. Mothers who held a job and established an additional identity to motherhood while child-rearing have less difficulty in

surrendering child-care responsibilities when their children depart from home than women who mainly identify themselves with the mother role (Lippert, 1997). For women having difficulty with the empty nest transition, therapists may assist client in attaining alternative roles and self-definitions culminating in this life chapter becoming ego-expanding and growth-inducing.

Mothers are still parents upon their children's departure, but parenting is redefined and becomes a different type of interpersonal relationship that is less involved. The number of contacts are often reduced but mothers continue to offer advice, support, and periodic goal-directed assistance (Etaugh & Bridges, 2001). A large number of adult children return home for varied periods of time after leaving, for instance, due to divorce or financial reasons. Almost 50% of middle-aged parents with children over age 18 have an adult child still living at home. Parents' sentiment to this return home relates to the level of continued dependence on the parents. Parents report more parent-child strain the greater the children's financial dependency and the lower their educational attainment. Parents' satisfaction with the return home correlates to their child's self-esteem, perhaps because self-esteem predicts the difficulty level in acquiring self-sufficient adult roles. These findings imply that parents feel most satisfaction and well-being upon perceiving their children's attainment of the normative roles of adulthood (Etaugh & Bridges, 2001).

Midlife adults have been called the "sandwich" or "squeeze" generation because while raising their own children they may have responsibilities assisting their aging parents as well. The amount of aging parent assistance varies from very little to around-the-clock care, usually provided by the middle-aged (or elderly) daughter or daughter-in-law (Katz, Kabeto, & Langa, 2000). These caregivers comprise the essence of the long-term care system in the United States, providing 75% of the assistance required by the frail elderly. Parent-care responsibilities of middle-aged women are increasing because parents are living longer, and the birthrate is declining resulting in fewer siblings to contribute care. Midlife women are likely to be employed, hence, providing parent-care adds to the complexity of their roles and responsibilities. For some, caring for and reciprocating nurturance to elder parents is gratifying, but for many, such caregiving can strain psychological and physical functioning. Older women caregivers with limited finances and support system are most vulnerable to psychological distress (Etaugh & Bridges, 2001).

Approximately 75% of Americans over age 65 are grandparents, surprisingly, over 50% of women become grandparents by age 47 (Sheehy, 2002). While the grandchild is an infant, grandmothers provide the children's parents with substantial emotional support, information, assistance with infant care and home chores, and possibly financial support. Almost 50% of American grandmothers offer such extensive help on a regular basis (Black et al., 2002), but more often in ethnic minority groups than Caucasians. African American, Latina, and Native American

grandmothers contribute significantly to the family (Etaugh & Bridges, 2004). In 1970, 2.2 million American children lived in homes with a grandparent which increased to 4.5 million in 2000 (Pruchno & McKenney, 2002), including 12.3% of African American, 6.5% of Latin American, and 3.7% of Caucasian children. Contributing factors include an uncertain economy, and an increase in single mothers which has led young adults and their children back to their parents' home. Also, elder adults are living with their adult children's families upon inability to live independently. The arrangement can be beneficial to all as grandparents can satisfy some parental responsibilities and grandchildren can interact with their grandparents (Etaugh & Bridges, 2004).

Over 50% of the 4.5 million children in the U.S. living with a grandparent in the home are being raised by the grandparents without a parent (Pruchno & McKenney, 2002), and these "skip-generation parents" are most often grandmothers. Factors leading to grandparents raising their grandchildren include parental child abuse or neglect, substance abuse, psychological or financial issues, and AIDS cases (Kinsella & Velkoff, 2001). Parenting grandmothers exist across racial and socioeconomic groups (Harm, 2001), specifically, 67% are Caucasian, 25% are African American, and 10% are Latin American. African American grandparents raising their grandchildren compared to Caucasian women, indicate being less burdened and more satisfied with the caregiver role, despite being in poorer health, experiencing more difficult life situations, and being alone (Etaugh & Bridges, 2004).

Gainfully employed middle-aged and older women have risen sharply the past three decades. About 67% of married women and 70% of unmarried women ages 45 to 64 are in the U.S. work force. Men have been retiring earlier during the same three decade period. In 1970, 91% of 45- to 64-year-old married men were working which declined to 84% in 2002. These demographic changes, which exist across all ethnic groups, result in the highest-ever proportion of women paid workers age 45 and over (U.S. Census Bureau, 2003). Financial need has been the motivator behind employment for many working-class women, African American women and single women, additionally, for many women, the common pattern has been moving in and out of the work force due to changing family roles and responsibilities. Some women seek employment after their children have grown or following divorce or death of their spouse (Etaugh & Bridges, 2004). Coupled with economic fulfillment, work offers a sense of challenge, productivity, meeting new people, and creating new friendships which fosters women's sense of personal satisfaction and recognition beyond the family (Choi, 2000). For middle-aged and older women, working and maintaining outside interests enhances physical and psychological well-being. Work-centered women tend to expand their interests as they age and enjoy greater life-satisfaction. Employed older women experience higher morale than women retirees, and the lowest morale was reported by women who never worked outside of their home (Etaugh & Bridges, 2001).

Aging women encounter age discrimination in the workplace, and at a younger age than men (Rife, 2001). Women are viewed as becoming older earlier in life than men which equates to a double standard of aging. Western society stresses sexual attractiveness and being young as relevant women traits and stereotypes older women as unproductive – these attitudes impose barriers for women seeking or maintaining employment.

Women and men differ on their readiness to retire from the workplace. Women enter retirement age with a different work and family history, and less retirement planning and financial resources than men (Kim & Moen, 2001). Typically, men have worked several decades and are motivated to retire upon meeting Social Security or pension requirements, but women may have begun working after children began school or were launched suggesting ongoing interest in remaining employed and perhaps building Social Security and pension benefits. Increasing numbers of women continue working after their husbands retire, and for varying reasons. Women who did not work while raising young children, compared to those who did work, more often continue working after their husbands retire. Widowed and divorced women plan for delayed retirement or no retirement at all more than married women (Choi, 2000). Women with strong work identities reveal more dissatisfaction toward retirement than those with weaker work identities. As well, professional women are less inclined to retire early compared to other women (Etaugh & Bridges, 2001).

Some women choose early retirement, and for differing reasons. Poor health is one of the major causes of early retirement, for example, given that aging African American women and men tend to have poorer health than aging Caucasians, they are more likely to retire earlier (Etaugh & Bridges, 2001). Women who are primary caregivers to elder parents, spouses, or other relatives may retire early, in fact, almost 25% of these women decrease their hours or take time off without pay; some are forced to retire earlier than desired by their employer. Women whose husbands have poor health are five times more likely to retire early relative to women whose husbands maintain good health (Dentinger & Clarkberg, 2002). Some women desire retirement to have more time with family, friends, or to enjoy or develop interests (Etaugh & Bridges, 2001).

Retirement has often been associated with a man's transition, but women's greater workforce involvement means couples often experience two retirements (Moen, Kim, & Hofmeister, 2001). These researchers noted couples reporting that retirement was a happy time, though, the transition to retirement (the first two years after leaving a job) involved marital conflict for women and men. Both spouses retiring at the same time yielded more happiness than each spouse retiring at different times. The greatest marital conflict occurred when husbands retired first, possibly due to discomfort with the role reversal of working wife and husband staying at home.

OLDER WOMEN

Older women are affected by the “double standard” of aging (Sontag, 1979) which refers to the two stereotypes confronting aging women: ageism (negative stereotypes and attitudes directed at older people), and sexism (negative attitudes and stereotypes toward the female gender). In Western culture, women gain value based on their level of physical attractiveness, but with age that characteristic diminishes. Women are challenged to maintain positive self-esteem despite these societal stereotypes.

WIDOWHOOD

Women are increasingly likely to become widows as they age, astoundingly, roughly 800,000 older adults in the U.S. experience widowhood annually (U.S. Department of Health and Human Services, 1999). There is greater likelihood of women becoming widows than men, at all ages and across all ethnic minority groups, specifically, 45% of all women over age 65 are widows compared to 15% of men (U.S. Bureau of the Census, 2001). The odds increase dramatically for women over age 65 to face widowhood, especially African American women of whom 83% are widows. These statistics reveal men's higher mortality risk and their propensity to marry younger women than themselves.

Widows are confronted with required adjustments in all life domains and such changes are often difficult and painful, even when there is preparation time. The survivor must adapt to losing a long-term cherished relationship, create and become comfortable with a new identity as being unmarried, and perform daily living activities and routines alone rather than in unison with her partner (Utz, Reidy, Carr, Nesse, & Wortman, 2004). Bereavement in later life is often less distressing than in earlier life; older women compared to younger women have more loss experience, and they gain support from peers also experiencing their partner's death or illness (Moss, Moss, & Hansson, 2001). Further, older women regulate their emotions better than young women resulting in the experience of less intense emotions, in this case, grief (Carstensen, Fung, & Charles, 2003). Nonetheless, the grieving process may last years for some women and may develop into clinical depression (Lichtenstein, Gatz, Pedersen, Berg, & McClearn, 1996). Inordinately long-enduring depressive symptoms are atypical in a normal grieving process and may require therapeutic treatment. In the absence of remarriage, well-being levels may not return to pre-existing levels for up to eight years after the loss (Lucas, Clark, Georgellis, & Diener, 2003). Negative health effects can persevere for years after death of spouse (Goldman, Koreman, & Weinstein, 1995), with worse effects for men than women. Findings based on data from the National Survey of Families and Households indicate that widowhood predicts depressive symptoms in men but not women, and men's depression seems directly related to the loss of the spouse (Lee, DeMaris, Bavin, & Sullivan, 2001). There is adaptive significance to women bearing fewer

depressive symptoms than men given widowhood because women remarry less often after becoming widows and have higher likelihood of remaining widowed at every life-stage. Men remarry after the death of spouse at five times the rate of women which demonstrates men's larger pool of eligible partners (Mastekaasa, 1992). About 2% of women and 20% of men who are over age 65 in the U.S. remarry (Smith, Zick, & Duncan, 1991). Women who do remarry convey fewer concerns both in daily living and in recalling their concerns after their spouse's death. Widows choosing not to remarry frequently disclose that they have greater freedom and no desire for a new relationship (Davidson, 2001).

Widowhood often changes a woman's self-definition due to cessation of the wife role, further, family, friends, and acquaintances may become more reserved. The challenge becomes establishing balance between the past identity of wife and the new identity of widow through active adjustment and acquiring alternative roles and ways to define oneself. Friendships help to counterbalance the loss and foster a sense of well-being. Women show greater tendency than men to be dedicated to and benefit from their roles as friends. Surprisingly, being committed to the role of friend and the accompanying identification as a friend predicts well-being, even more than income or marital status (Siebert, Mutran, & Reitzes, 1999).

RETIREMENT

The early findings on women's retirement in the 1970s revealed women having more positive attitudes about retirement than men. That body of research probably does not generalize to contemporary women because older cohorts of women worked less consistently and for financial necessity instead of a stronger work commitment as compared to current women. More current researchers indicate lower retirement satisfaction for women than men, and more initial stress when retirement begins (Seccombe & Lee, 1986). Problems are reported by women with lower status jobs (Richardson & Kilty, 1991), and women in professional level careers (Price, 2000).

The Cornell Retirement and Well-Being Study examined retirement experience of over 750 retired individuals, aged 50 to 72, in the mid 1990s. The women displayed less continuous work histories than men, specifically, they worked fewer years, took more breaks from work, and had more part-time employment. Unlike the men, women who worked more (fewer work breaks and part-time employment) expressed greater retirement satisfaction than women with less continuous work histories. These findings were consistent even when factors such as income, health, nature of the job, and the reason for and timing of retirement were controlled. Retirement satisfaction was predicted for men by the degree of advanced planning for the transition whereas for women, by the timing of their work patterns (Quick & Moen, 1998).

Other retirement gender differences include women spending more time with relatives and becoming involved in

organization work (Dorfman, 1995). The decision to retire due to poor health of a spouse or other family members is more often made by women than men.

The effect of retirement upon a woman's identity varies with the level of importance the work role has on her self-concept. Professional women, therefore, may face more identity threats than nonprofessional women given loss of high social status, social contacts, and professional challenges, along with the sudden appearance of stereotyping and discrimination they avoided while working (Price, 2000). The work role for women of all occupational levels contributes to their identity and sense of competence, hence, this role loss may threaten some of their assumptions about self and capabilities. Women who experience their retirement as favorable and positive at the beginning of the transition are more likely to reveal positive morale and high levels of well-being during the retirement phase (Kim & Moen, 2002). Therapists can facilitate adjustment to retirement by encouraging women to find alternative resources for identity through involvement in community, volunteer organizations, or family relationships to maintain positive self-concept. Such participation may allow retirement to be regarded as time for developing new skills and interests instead of lost work time. Enhancing appreciation of the woman's economic and societal contributions while employed may also be therapeutic. Financial needs may also accompany the psychological challenges of maintaining identity and self-esteem during retirement. Solutions to the basic physical needs of housing, nutrition, and health care may require exploration. Women who have finances to sustain their household, socialize, exercise, and even travel have more options to redirect their activities away from formerly work time and establish a new valuing of self.

Therapists often find that cognitive-behavioral and interpersonal individual psychotherapy work effectively for depression and anxiety in older adults (Scogin, Floyd, & Forde, 2000). Older women can thereby resolve unfinished issues concerning retirement or changes in family roles, and acquire new attitudes and behaviors toward improved well-being. Older adult group therapies are effective for moving through depression and secondarily, creating socialization opportunity (Thompson, Coon, & Gallagher-Thompson, 2001). Bereavement women's support groups are available (Gottlieb, 2000), and effective as they allow women to express their concerns with other newly widowed women and receive support for their significant loss.

Older women encounter numerous challenges to their self-concept due to family and career transitions, but the majority effectively re-define themselves such that self-esteem, competence, and balance are maintained – despite potential discrimination from ageism, sexism, and racism for ethnic minority women.

PHYSICAL HEALTH ISSUES IN OLDER WOMEN

Life expectancy has increased significantly over the past century. Medical advances such as vaccines, antibiotics, and improved obstetric care have essentially eliminated widespread causes of death for children and young adults allowing the preponderance of people to reach old age. Improved treatment for chronic illness has also extended the expected life span.

Women have lower mortality rates than men at every age and in all countries that report health statistics (Idler, 2003) which equates to the majority of older adults being female and this gender difference increases with age. As indicated earlier, some theories explaining the gender difference in longevity suggest a female biological advantage due to sex hormones or genetic differences, better health-related behaviors and utilization of health care, less stressful and dangerous workplace environments, and lower risk-taking behavior (Gold, Malmberg, McClearn, Pedersen, & Berg, 2002). Older women report more illness symptoms and have more chronic health conditions than men, but life-threatening chronic health conditions are more common among older men, even in brother-sister twin pairs (Gold et al., 2002).

The beginning of old age is generally thought to be age 65, and may last twenty years or more. Since the health issues of 65-year-olds differ from 85-year-olds, gerontologists have classified at least two age groups: the young-old (65-75) and the old-old (late 70s and older); some add the third group of oldest-old who are over 85 (Smith, Borchelt, Maier, & Jopp, 2002). Most young-old people live healthy and active lives while the majority of the old-old suffer with at least one chronic health problem, and many have two or more. Functional limitations result from these health issues and become more common with aging culminating in the requirement of assistance with daily living. Further, older adults undergo natural physical and cognitive functioning declines characteristic of normal aging. Medical interventions and lifestyle changes can slow or reverse functional deficiencies related to illness, but older adults must learn to manage age-related functional declines.

Assessing the physical health of older adults requires more than simply counting chronic illnesses and their symptoms because physical health across all age groups is interrelated with psychological well-being (Smith et al., 2002). Research shows that illness and disability can be related to depression and other psychological distress factors (Williamson & Schulz, 1992), and psychological stress can impair physical health (Marsland, Bachen, Cohen, & Manuck, 2001). Findings propose that functional limitation and disability, not simply the presence of chronic illness, lowers psychological well-being among older women (Smith et al., 2002).

Many normal age-related declines in sensorimotor systems are related to functional impairment in old age, especially in the oldest-old. Older adults may sustain neurological and muscular function declines, proprioception changes causing difficulty in maintaining balance, decreased bone density and muscle mass, age-related declines in vision and hearing, and

slower reaction time (Ketcham & Stelmach, 2001). These declines and changes can negatively affect balance and motor control in older adults, producing a fear of falling and greater functional limitation. Some research reveals a link between mobility impairment and increased mortality risk, especially for those who do little exercise (Hirvensalo, Rantanen, & Heikkinen, 2000).

Health-inducing behaviors and personal resources such as social support and self-efficacy can assist older women with chronic illness to be functionally independent. Seeman and Chen (2002) conducted a large longitudinal study of older adults with and without chronic illness and found that regular exercise was linked to less functional decline during the study for all participants, with or without chronic illness. Social support buffered the negative effects of chronic illness upon functional ability whereas negative social interactions were associated with greater disability.

A common adaptation method used by older adults to maintain independence given reduced functional abilities is termed selective optimization with compensation by Baltes and Baltes (1990). Older adults retain their well-being and functional independence by selectively focusing on activities that are perceived as more highly valued and within their ability level, while utilizing cognitive restructuring or behavioral substitutions to compensate for the loss of other abilities. This adaptive method is one reason for the broad individual differences in response to chronic illness and functional disabilities. Gignac et al. (2000) studied older adults with osteoarthritis or osteoporosis and observed that participants used numerous strategies of activity selection, optimized current abilities, and compensated for lost capabilities through using assistive devices or changed routines to preserve the highest level of functional independence. Conventional gender roles affect women's choices of valued activities and life domains within which they feel capable. Women's selection of these valued and competent life domains helps explain gender differences in attitudes and behavior.

Older adults' chronic illnesses and disabilities vary pertaining to level of functional impairment, for instance, hypertension has low impact, stroke or visual impairment limit many activities, and progressive deteriorative conditions as arthritis produce increasing disability over time.

Arthritis:

Arthritis, the most common chronic illness within the older adult population (U.S. Bureau of the Census, 1996), is not life threatening but represents a widespread cause of pain and functional limitations. Arthritis symptoms increase psychological distress in younger adults while older adults exhibit better psychological adjustment but greater functional disability (Burke, Zautra, Schultz, Reich, & Davis, 2002). Older women with osteoarthritis or rheumatoid arthritis, however, are at greater risk for depression given elevated pain (Zautra & Smith, 2001). The quality of life for older adults with arthritis is associated with subjective evaluations of the illness context, in other words, difficulty performing a

high value activity links to reduced satisfaction with level of physical functioning (Rejeski, Martin, Miller, Ettinger, & Rapp, 1998). Research on Latina women of varying ages with rheumatoid arthritis, for example, found that inability to fulfill culturally valued family roles linked to greater emotional distress (Albraido-Lanza, 1997). Old-old women with arthritis-related functional impairment or pain are more likely to experience psychological distress when valued roles of grandparent or homemaker are negatively affected, likewise, the young-old may experience this pattern when their work, sports involvement, or travel are impacted.

Lifestyle changes can significantly improve quality of life for older women, reduce rate of physical decline, and lessen pain and functional disability. Longitudinal studies with large representative samples show that even low amounts of physical activity can increase physical functioning and slow the development of functional declines (Miller, Rejeski, Reboussin, Ten Have, & Ettinger, 2000). Regrettably, many older women unrealistically believe that exercising at their age is risky (O'Brien-Cousins, 2000). Older women more than older men experience nonmedical barriers to exercise (Satariano, Haight, & Tager, 2000) as many older women were raised when exercise was culturally viewed as a man's activity and health benefits of physical activity were not universally known. Group walking programs for older women have encouraged greater physical activity for this population across different ethnic groups (Clark, 1999; Shin, 1999).

Vision and Hearing Impairment:

Sensory acuity and sensorimotor integration declines are predictable with age, fortunately, significant sensory impairment generally does not arise until the oldest-old age group (Fozard & Gordon-Salant, 2001). Sensory impairment, particularly visual impairment, predicts functional disability among older adults (Reuben, Mui, Damesyn, Moore, & Greendale, 1999). Visual changes in older adults include visual acuity, sensitivity to light and glare, color discrimination, decreased vision in low light, and presbyopia (Fozard & Gordon-Salant, 2001). Some older adults will encounter chronic illnesses as glaucoma and cataracts. Women report more vision loss disability than men (Raina, Wong, Dukeshire, Chambers, & Lindsay, 2000).

Hearing loss for older adults results from age-related changes combined with auditory system damage due to long-term exposure to noise and other environmental factors (Fozard & Gordon-Salant, 2001). Hearing loss generally begins earlier and is more significant in men than women (Fozard & Gordon-Salant, 2001; Raina et al., 2000). Women accept hearing loss more than men but they report more distress regarding the loss of social functioning and interpersonal communication than older men (Fozard & Gordon-Salant, 2001). Women experience more benefit from hearing aids, perhaps due to gender differences in the type and severity of hearing loss.

Personal resources, for instance, social support, significantly help older adults adjust to sensory impairment. McIlvane and Reinhardt (2001) examined older adults with

visual impairment and found that social support from family and friends was associated with positive psychological well-being. This was especially valid for women, who appeared to need support across a variety of social network members to gain benefits.

Heart Disease:

Heart disease is the leading cause of death in the industrialized world and can occur at any age, though, the incidence of heart disease and its risk factors such as hypertension and elevated cholesterol increases with age. Younger adult men have more risk of serious heart disease than women, but this disparity lessens with age (Smith & Ruiz, 2002). Women who endure myocardial infarction or bypass surgery fare worse than men, have higher risk of depression and other psychological adjustment issues (Brezinka & Kittel, 1996), and reveal more symptoms and physical limitations, especially in household duties (Sharpe, Clark, & Janz, 1991). Comorbidity of heart disease with other disorders such as diabetes or depression is linked to poorer prognosis (Clouse et al., 2003). Lifestyle changes including improved diet, healthy exercise and stress management are vital in managing heart disease. Unfortunately, as indicated earlier, older women are often averse to including exercise in daily living (O'Brien-Cousins, 2000; Satariano et al., 2000). Improved management of heart disease occurs given social support from family and friends, and maintaining social activities as such interaction buffers stress and elicits positive health behaviors (Janz et al., 2001; Smith & Ruiz, 2002).

Diabetes:

Diabetes is an endocrine system disease involving abnormal glucose metabolism. Type I diabetes often begins in youth and involves pancreas dysfunction resulting in a lack of insulin production which renders the body unable to metabolize glucose and leads to elevated blood glucose levels. Type II diabetes entails the body becoming resistant to insulin thus harming pancreatic cells; it is more frequent in older adults, but the prevalence is increasing in younger individuals and children. Obesity and over-consuming simple carbohydrates are type II diabetes risk factors (Gonder-Frederick, Cox, & Clarke, 2002). Type II diabetes is more prevalent among Native Americans, Hispanic Americans, and African Americans and type I is more frequent among Caucasians. Significant health risks exist for each type of diabetes including blindness, kidney failure, vascular disease, and neuropathy. Type II diabetes has been associated with cognitive impairment, particularly within older adults (Coker & Shumaker, 2003); sadly, cognitive impairment creates difficulty in following dietary and treatment protocol for diabetes control.

Daily insulin injections to lower blood glucose levels are required for type I diabetes, while type II diabetes is often controlled by dietary changes and exercise or together with medications. Treatment routines can become complex and necessitate daily monitoring of blood glucose levels to prevent complications (Gonder-Frederick et al., 2002; Schoenberg & Drungle, 2001). Older women may be

challenged to comply with the treatment regimen as financial concerns can limit purchases of testing materials, medications and healthy food choices, and nonmedical barriers to exercise may impede diabetes management. Findings show that self-efficacy and realistic health beliefs predict stricter conformance with diabetes treatment protocol. Perceptions of treatment benefits reinforces compliance in older adults, while young people show more concern over the costs of their diabetes regimen (Gonder-Frederick et al., 2002).

Comorbidity of diabetes and other illnesses produces greater health risks, especially heart disease. Women with diabetes are more likely to experience depression and anxiety disorders, and these psychological factors are linked to poorer health outcomes and greater disability (Clouse et al., 2003; Gonder-Frederick et al., 2002).

Cancer:

Cancer is the second leading cause of death in the U.S.; its treatment is painstakingly long, and attended by harsh side effects, and fear of recurrence. The incidence of cancer increases with age, thus, prevalence is greatest within the older population. Breast and colorectal cancers are most frequent among older women, trailed by lung and gynecological cancers whereas among women in general, lung cancer leads cancer deaths followed by breast and colorectal cancers (Andersen, Golden-Kreutz, & DeLillo, 2001).

The main intervention for older women has been cancer screening to encourage early detection because during early stages, cancer is less probable to have spread which improves survival rates and permits less aggressive treatment. Cancer screening programs, for example, mammography are related to decreased mortality among older women (McCarthy et al., 2000). Increased use of screening tests is associated with knowledge about cancer screening, and believing in personal control over one's health (Bundek, Marks, & Richardson, 1993; Suarez, Roche, Nichols, & Simpson, 1997). Older women are unfortunately less cognizant of cancer screening than younger women, especially those with less education or poor English skills (Suarez et al., 1997). Cancer prevention includes many of the recommended lifestyle changes that prevent heart disease and diabetes. A low-fat, high-fiber diet, exercise, weight reduction, and stress management all have been documented to increase immunity and lower cancer risk (Andersen et al., 2001). These lifestyle changes can improve treatment response and prognosis in women who have cancer. Many older women self-perpetuate barriers to lifestyle changes that may exacerbate living with cancer.

Cancer treatment involves unpleasant and potentially disabling side effects. Chemotherapy and radiation treatments produce severe fatigue, nausea, and loss of appetite in many people to the point where some people discontinue treatment. Stress management and cognitive and behavioral methodologies have proven effective in preparing patients for the adverse side effects and lessening the symptoms (Andersen et al., 2001). Cancer treatment can culminate in greater disability and loss of independence in

older women already undergoing daily functioning declines. Additionally, treatment effects that impinge on positive body image, such as hair loss and mastectomy may worsen pre-existing distress over age-related physical changes.

Cognitive Impairment:

Some cognitive decline is predicted within the normal aging process, particularly in "fluid intelligence" (Horn, 1982), which involves processing speed, and the ability to learn new information and solve novel problems. Fortunately, the majority of healthy older adults compensate for these losses and preserve cognitive functioning. Findings on cognitive functioning as a function of age-related declines, and disease have produced inconsistent results. Some research proposes that disease has little effect on cognitive functioning in old age (Anstey, Stankov, & Lord, 1993). Other research finds that positive health behaviors such as exercise associates with improved cognitive function (Laurin, Verrault, Lindsay, MacPherson, & Rockwood, 2001). Depression is related to cognitive changes in older adults, but does not seem involved in dementia onset (Gallassi, Morreale, & Pagni, 2001).

Dementia is a chronic and progressively deteriorative illness entailing cognitive impairment, memory loss, behavior changes, and neurological deficits; it creates disability and loss of independence among older people, especially the oldest-old (Suthers, Kim & Crimmins, 2003). Alzheimer's disease and vascular dementia are common causes of dementia. Symptoms include potentially self-injurious behavior such as wandering or leaving the oven on, and needing daily living assistance, therefore, caregivers are required. The prevalence of Alzheimer's disease is greater among women than men whereas vascular dementia occurs evenly (Andersen et al., 1999). A high rate of depression accompanies dementia, which worsens the disability (Gallassi et al., 2001). The experience of dementia reflects an enveloping sense of loss and stressful interpersonal relationships (Ostwald, Druggelby, & Hepburn, 2002).

The majority of older women enjoy a positive attitude and high life-satisfaction levels regardless of predicted physical and cognitive declines associated with aging and the incidence of chronic illness and loss of function (Heidrich & Ryff, 1993). Older women actualize social and personal resources, for example, social support, self-efficacy, and mastery to preserve psychological well-being when confronted with aging adversities and disabilities (Jang, Haley, Small, & Mortimer, 2002). Remaining active in old age and substituting new activities with previous activities that must be curtailed due to disability allows older women to maintain psychological well-being when chronic illness arises (Duke, Leventhal, Brownlee, & Leventhal, 2002); psychosocial resources as enlisting social support and maintaining a sense of optimism produce greater adaptive functioning.

Heidrich and Ryff (1993) examined the interplay of older women's psychological processes in maintaining well-being upon encountering age-related declines. Physical disability was related to psychological distress, but social integration

and social comparisons served as well-being inducing intervening variables. Women who perceived themselves as integrated into a social network while sustaining effective social roles, and who compared themselves positively to others their same age maintained positive mental health when challenged by declining health. Such research emphasizes the resilience and adaptive capacity of older women, the interconnectedness of physical and mental health, and the importance of social and personal resources in adapting to chronic illness and disability.

WOMEN'S END-OF-LIFE ISSUES

There were 35 million men and women over age 65, and 4.2 million men and women over age 85, in the U.S. in the year 2000, which combined for 13% of the population; this proportion is predicted to be 30% by 2030 (U.S. Department of Health and Human Services, 2002). The fastest growing age group in the U.S. is women approximately age 85, as they outlive men and constitute the majority of older adults. As aging women across all ethnic groups frequently survive their family members, they are left isolated and vulnerable when they need the most care. There are 20.6 million women age 65 and above in the U.S. of which 46% are widowed, 40% live alone, and 12% live below the poverty line. Older Hispanic women who live alone have a 50% poverty level (U.S. Department of Health and Human Services, 2002). Generally, older women receive lower Social Security and retirement benefits due to a lifetime of inequities such as lower pay during employment and discontinuous work histories resulting from placing family needs first (Gatz, Harris, & Turk-Charles, 1995). Against this backdrop of an increased number of older adults facing the significant challenges of aging is the contemplation of death that confronts elders.

For many, comprehending the meaning of death associates with wanting to have lived a full life. A full life has been defined as a life that has run its "natural life span" (not the biological maximum – currently, 120 years) and offers a sense of completion to the individual's psychological narrative (Brody, 1992). Steinhauser et al. (2000) suggest that a "good death" includes the following factors: a) pain and symptom management, b) end-of-life medical, emotional and social preparation, c) construction of a sense of completion including faith, relationships, resolutions, and saying good-bye, d) contributing to the well-being of others, for example, generativity, and e) empathetic treatment as a whole person. These and other findings agree with the significance of psychological, physical, social, spiritual, emotional, and medical support at the end-of-life.

Finding meaning in life when confronting life-threatening illness and death is a powerful psychological issue, as Doka (1999) states, "The central question becomes the human question: 'How can we live fully in the face of death'" (p. 247). Finding meaning in death increases the chance of having a "good death" as opposed to falling prey to depression, anxiety, or other disorders. Three interrelated

characteristics are believed to facilitate finding meaning during the end-of-life. First, being resilient helps one accept the existential concept of being alone in the world, along with creating meaning for one's life. Kastenbaum (1999) believes that resilience allows negatively perceived events such as life-threatening illness to be experienced as opportunity for growth and satisfaction. Second, asking existential "why" questions regarding purpose, and spiritual reasons for death is widespread at the end-of-life (Lander, Wilson, & Chochinov, 2000), and religious beliefs and spirituality often impart meaning and reassurance when contemplating these questions. This second characteristic, spirituality, also stimulates hope in the dying person. Hope is considered a vital mediator in religiosity being associated with enhanced psychological well-being among terminally ill people (Van Ness & Larson, 2002). The third characteristic, hope, is integral to most people, especially when confronting the end-of-life. When death is imminent, the lack of a medical cure does not negate the possibility of hope (Rousseau, 2000). Keeping hope alive when facing impossible outcomes leads to hopelessness and depression, therefore, close relationships, dignity, peace of mind, and religious faith are recommended as alternate sources of hope (Sullivan, 2002).

Death anxiety, defined as fearing the unknown after death, fear of obliteration, and fearing the dying process itself, is extant in Western societies. Among older adults, it seems related to having fewer remaining years to live, and less control over one's physical and mental health (Cicirelli, 1999). The American Psychological Association's fact sheet on end-of-life care (APA, 2003) indicates that older adults fear that their pain, emotional suffering, and family unfinished business will be overlooked. Many critically ill people dying in hospitals are given unwanted treatments, sustain prolonged pain, and have their advance directives ignored. Singer et al. (1999) report that older adults desire more information about end-of-life issues and the chance to impact their care decisions.

Older dying women may fear being a burden to as well as abandoned by loved ones. Older women who have been caregivers themselves may experience this role reversal as highly stressful (Brody, 2002). Women experience higher levels of death anxiety than men because they perceive having less instrumental control over external events. An increase in perceived self-efficacy links to lower fear of dying, implying that self-beliefs (self-esteem, self-confidence, and self-efficacy) are important mediators in managing death anxiety (Fry, 2003).

Experiencing sadness is common for women encountering terminal illness and death, in fact, sadness is a natural component of preparatory grief, and varies in intensity and importance over time (Hallenbeck, 2003). Such sadness does not warrant a diagnosis, and is a normal part of detaching oneself from loved ones and from one's life roles. Preparatory grief is a process of mourning past and future abilities, experiences, people, objects, and hopes (Haley, Kasl-Godley, Larson, Neimeyer, & Kweilosz, 2003);

physical symptoms of grief may include weight or appetite changes, fatigue, low energy, sleep disturbances, and sexual dysfunction. These symptoms may be indicative of the need for improved control of existing physical symptoms, or of clinical depression, which is considered not a normal part of the dying process. Depression needs to be identified and treated so individuals may die comfortably as possible, especially in women because women experience clinical depression at any given time in life more than men (Alegria & Canino, 2000).

Differentiating depression from grief can challenge therapists because of their common symptoms but the following psychological and physical differences exist: grief is highly variable while depression is somewhat continuous and frequently worsens without treatment. Depression symptoms include inability to experience pleasure, lack of interest in nearly all activities, hopelessness, and a negative self-image whereas grief does not manifest any of these characteristics. Depression may be present in an elderly dying woman who becomes continuously socially withdrawn or has requested an early death despite her symptoms and social issues having been sufficiently addressed (Lander et al., 2000).

Hospice care provides a choice to placement in a hospital or institution by offering multidisciplinary care to dying individuals in their homes with their families – the hospice movement is growing quickly. A 1996 Gallup poll determined that 90% of Americans would choose to die at home upon being terminally ill, and roughly 70% would desire hospice care (National Hospice Organization, 1996). At present, only 11% of women age 85 and above die at home, while 42% in this age group die in nursing homes (National Hospice and Palliative Care Organization, 2003).

POSITIVE AGING

Cultural constraints impressed on older women, for instance, feelings of being undesirable and self-disparaging, maintaining unhealthy power-imbalanced relationships, and restricting their options and potential, may become self-limiting factors that prevent a generative and healthy elder phase of life (Gergen, 1999; Gergen, 2001, in Worell & Goodheart, 2006). Research shows that older people preserve many of their capabilities and special talents, and may improve upon them. With age, individuals evolve to be more comfortable with themselves, more contented, and less interested in trying to fulfill the expectations of others. Aging women report greater ability to cope with their environments and personal relationships. Many older women perceive being on an upward psychological trajectory, and sense that progress exists in their life narratives (Greene, 2003). These findings imply that the process of aging supports enactment of life enhancing strategies (Baltes & Baltes, 1990; Rowe & Kahn, 1998).

The following four interrelated patterns of behavior, collectively called "the life span diamond," illustrate various research-supported ways in which older adults maintain well-

being throughout the aging process (Gergen & Gergen, in Worell & Goodheart, 2006):

1. Relational Resources: Having supportive social relationships with family, friends, acquaintances, and mediated connections such as chat room members and imaginal others (celebrities, fictional characters, etc.) (M. Gergen, 2001; Watkins, 1986).
2. Physical Well-Being: Healthy functioning of brain and body, indicated by medical tests and self-reports of health.
3. Positive Mental States: Experiencing well-being, happiness, optimism, and life-satisfaction.
4. Engaging Activity: Maintaining active involvement in physical and mental activities.

Gerontology research supports how these four behavioral patterns are bi-directionally interconnected and promote life-satisfaction, for example, positive mental states may influence physical well-being, and physical well-being may enhance positive mental states.

The Relational Resources – Physical Well-Being connection: Significant others, acquaintances, and mediated others affect our physical well-being in numerous ways such as engaging in physical activity together, recommending healthy foods, dieting, appearance/health suggestions, or seeking professional advice. Social relationships thusly promote better health, simultaneously, feeling healthy and fit increases our desire to be involved in relationships with others. Supportively, social support for widowed individuals is related to better health (Stroebe & Stroebe, 1996), and with recovery rate from injury (Kempen, Scaf-Klomp, Ranchor, Sanderman, & Ormel, 2001). Strong emotional attachments to others leads to faster recovery from loss, as in death of spouse (Abbey & Andrews, 1985). Married people live longer than those never married, separated or divorced (Coombs, 1991).

The Relational Resources – Positive Mental States connection: Relating to others is associated with experiencing positive mental states. Having positive relationships increases self-confidence, self-worth, improves mood, helps goal-setting behavior, and provides comfort during troubled times. As well, being in a positive mental state frequently leads to reacting positively with others culminating in an atmosphere of greater understanding and compassion – positive states of mind improve relationships. Research reveals that individuals high in social contact show more likelihood of feeling supported and cared for, and less prone to depression (Pierce, Frone, Russell, Cooper, & Mudar, 2000). Marriage is a very significant predictor of happiness (Myers, 1993), while those who live alone, never marry, or are widowed, divorced, or separated have lower probability of feeling happy (Argyle, 1999).

The Positive Mental States – Engaging Activity connection: Positive mental states offer feelings of confidence, optimism, and purpose, characteristics that stimulate the desire to engage in mental and physical activities. Likewise, engaging activity generally produces positive mental states of accomplishment, joy, good memories, and internal locus of control. Supportive research indicates that life satisfaction

correlates with engaging in planning future activities (Prenoda & Lachman, 2001). Couples engaging in arousing activities enjoy more positive feelings for each other and report greater happiness (Aron, Aron, Norman, McKenna, & Heyman, 2000). Engaging in leisure activities with friends, volunteer work, dancing, playing sports, sexual activity, and outside events correlate to feelings of happiness (Argyle, 1999). Greater involvement in religion is associated with life satisfaction. Religious involvement is related to physical health and psychological well-being among African Americans (Larson, Sherrill, & Lyons, 1999). **The Positive Mental States – Physical Well-Being connection:** Intuition alone suggests that having physical health yields positive feelings about life, similarly, feeling good about oneself facilitates nurturing the body and physical health. Conversely, depression may increase desire to hurt the body, for instance, older people, particularly men, display higher suicide risk among all age groups, possibly due to feeling depressed and alone (Canetto, 1992). Findings are suggesting that positive mental states may promote better states of physical health, for example, researchers are finding a connection between mental health and the immune system. Positive affect leads to a reduced risk of stroke (Oster, Markides, Peek, & Goodwin, 2001). People inclined to positive feelings during youth live longer than those exhibiting negativity and pessimism (Harker & Keltner, 2001). A longitudinal study of older Catholic nuns found a significant relationship between emotions that were revealed in teenage diaries and mortality. For the nuns having expressed few positive emotions in their diaries, 54% died by age 80, while only 24% died by age 80 of those who shared a high number of positive emotions (Danner, Snowdon, & Friesen, 2001). Having a positive sense of purpose positively correlates with physical health, as demonstrated by increased women's longevity who maintained control over a valued social role (Krause & Shaw, 2000). The Drexel University's Center for Employment Futures in Philadelphia 1998 survey observed that 90% of people over age 65 feel life-satisfaction, that they contributed positively to society, and reported being in good health.

The Physical Well-Being – Engaging Activity connection: Physical health allows one to engage in a broader range of activities while engaging in activities fosters physical health. Studies indicate that participating in low-impact aerobic dance classes three times a week for twelve weeks improved flexibility, muscle strength, body agility, and balance of women aged 57-77 (Hopkins, Murrah, Hoeger, & Rhodes, 1990). Engaging in volunteer work is associated with physical health (Van Willigen, 2000), as is engaging in religious activities such as attending church and involvement in church activities (Larson et al., 1999). Engaging in numerous activities as playing cards and board games, reading, and engaging in community services, is linked to faster recovery from many types of losses (Bar-Tur, Levy-Shiff, & Burns, 2000).

The Relational Resources – Engaging Activity connection: Social relationships often lead to engaging in new and varied

activities which broaden one's interests and identity. Engaging activity frequently augments interpersonal relationships, communication skills, and offers social rewards. Research indicates that widows who participate in activities with friends after the loss feel more relief than engagement with family members alone; further, most widows who remain engaged in outside interests cope very well over time (O'Bryant & Morgan, 1990). Widows seem to transition from married life to the next active phase of life through engagement in their chosen activities (Feldman, Byles, & Beaumont, 2000).

Positive aging, therefore, is facilitated by developing and maintaining social networks, enacting smart physical health practices, engaging in stimulating mental and physical activities, and exuding positive attitudes about self and life. The interconnectedness of these four behavioral patterns means that positive effects of any one will often enrich the others, and beyond, for example, engaging in physical activity is pleasurable by itself but may also improve health, personal relationships, and personal well-being. Generally, the process is self-perpetuating after inception, and can be initiated at any time, thus, an individual can choose when to pursue a friendship, interesting activity, or healthy diet. The process changes over time with fluctuations in one's preferences, energy level, opportunity for activity, and social contacts.

Many gerontologists are discovering that older women experience autonomy and pleasure in their elder years. Research from four decades ago observed older women rating their quality of life as high, partly due to increased freedom as they transcended traditional female sex role constraints (Neugarten, 1968). Other research determined that older women displayed more independence as they valued achievement or success in the view of others less with age, and valued having a sense of freedom and being happy more – regardless of the perception of others (Ryff, 1985). Adding to the value of aging is the finding that women become more emotionally stable as they age (Srivastava, John, Gosling, & Potter, 2003). The challenge for therapists is to help older adults become aware of and seize opportunities for growth, creativity, revitalization, and inspiration. Therapists are encouraged to appreciate the older population, maintain a positive perception of aging issues, and promote positive aging practices.

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TEST – WOMEN'S HEALTH II

6 Continuing Education Contact Hours

Record your answers on the Answer Sheet (click the "NASW Answer Sheet" link on Home Page and either click, pencil or pen your answers).

Passing is 80% or better.

For True/False questions: A = True and B = False.

TRUE/FALSE

1. **Men are often more open and disclosing to women than to men.**
A) True B) False
2. **People pay close attention to nonverbal behaviors as indicators of the health of their relationships.**
A) True B) False
3. **One extremely rare life review theme for women is the search for an independent identity.**
A) True B) False
4. **Comparable to dating relationships, women are more attuned to relationship concerns and experience dissatisfaction before men.**
A) True B) False
5. **In midlife, men reveal a higher incidence of fatal diseases whereas women show higher prevalence of nonfatal diseases.**
A) True B) False
6. **Few women undergo a midlife crisis, but many experience a process called a life review – a reflective self-evaluation of many life domains.**
A) True B) False
7. **Self-beliefs (self-esteem, self-confidence, and self-efficacy) are important mediators in managing death anxiety.**
A) True B) False
8. **Physical activity cannot increase physical functioning or slow the development of functional declines.**
A) True B) False
9. **After divorce or widowhood, women remarry less often and do so less quickly than men.**
A) True B) False
10. **Many older women unrealistically believe that exercise at their age is risky.**
A) True B) False
11. **Remarriage divorce rates are _____ than first marriages.**
A) higher
B) lower
C) the same
D) extremely lower
12. **Research advocates that couples should not drop below a ratio of _____ positives to one negative to maintain a positive relationship.**
A) five
B) two
C) three
D) ten
13. **Most women are not fulfilled within these two marital domains: _____.**
A) work satisfaction and leisure time
B) finances and family size
C) issues of equality and expression of love and care
D) children's discipline and finances
14. **Roughly _____ older adults in the United States experience widowhood annually.**
A) 100,000
B) 200,000
C) 800,000
D) 300,000
15. **Happily married people generally display these characteristics _____.**
A) good communication and conflict resolution skills
B) egalitarian habits
C) were well-acquainted before marriage
D) all of the above
16. **_____ of all women over age 65 are widows compared to 15% of men.**
A) 45%
B) 5%
C) 10%
D) 15%

This course, Women's Health II, is approved for 6 continuing education contact hours by the National Association of Social Workers for social workers and counselors (NASW Provider ID # 886398989).

17. **The notion that middle-age is fraught with crisis and self-doubt is _____.**
- A) not supported by research
 - B) an axiom
 - C) true 80% of the time
 - D) true 70% of the time
18. **Midlife adults have been called the “sandwich” or “squeeze” generation because while raising their own children they may have _____.**
- A) additional educational requirements
 - B) additional work requirements
 - C) responsibilities assisting their aging parents as well
 - D) financial constraints
19. **The beginning of old age is generally thought to be age _____.**
- A) 70
 - B) 73
 - C) 65
 - D) 82
20. **Married people _____ than those never married, separated or divorced.**
- A) live shorter
 - B) live the same number of years
 - C) are less happy
 - D) live longer

Please transfer your answers to the Answer Sheet (click the “NASW Answer Sheet” link on Home Page and either click, pencil or pen your answers, then fax, mail or e-mail the Answer Sheet to us). Do not send the test pages to Continuing Psychology Education Inc.; you may keep the test pages for your records.

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