# WOMEN'S HEALTH

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5 CONTINUING EDUCATION 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 gender development in children and adolescents, women's careers, merging of family and work, women's relationships, women's mental health challenges, motherhood, midlife, and older women.

**Accreditation**

The California Board of Behavioral Sciences accepts NBCC-approved courses.
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**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. Describe contributing factors to gender development in children and adolescents.
2. Discuss gender differences in the domain of work.
3. Explain obstacles that impede women's career choices and how to circumvent them.
4. Acknowledge gender differences in friendships and relationships.
5. Illustrate variables promoting relationship satisfaction.
6. Identify causal factors for women's depression.
7. Expound upon prevalent mental health challenges for women.
8. Convey common motherhood attitudes and experiences.
9. Understand how therapists may help mothers balance the polar tensions of motherhood.
10. Recognize women's frequent midlife events, challenges, and physical, psychological/emotional experiences.
11. Discuss prevalent challenges encountered by older women.
12. Indicate research-supported ways in which older adults maintain well-being throughout the aging process.

**Faculty**

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## INTRODUCTION

Many positive changes for women in society have occurred in the last generation that have improved their well-being. Women experience increased liberation from sex-role stereotypes, improved options in work, motherhood, division of labor in families and in relationships in general. There is greater public awareness of violence, coercion, and abuse against women. Conversely, such harmful stressors still exist, and more women are confronted by historically traditional men's issues, including loss of a job, new health risks such as rising lung cancer rates in women, and allocating time to spend with children. Frustrating societal mixed messages involve families encouraging their young daughters to reach their goals and ambitions, but as adults they may encounter discrimination through the "glass ceiling" that restricts career advancement, or criticism for mothers who work or do not work outside of the home. In the United States, for every dollar that a man earns, a woman earns only 79 cents, African American women earn 70 cents, and Hispanic/Latinas earn 58 cents (U.S. Department of Labor, 2004). The gender wage gap is closing somewhat as women are identifying opportunities, asking for more money matching their male counterparts, and rejecting initial employer offers and negotiating (Babcock, Gelfand, Small, & Stayn, 2004).

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 & Corriell, 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.

Historically, women were frequently viewed negatively by male intellectual leaders in Western civilization (in Bohan, 1990; Hunter College Women's Studies Collective, 1983). Women were perceived as imperfect men or as reproducers lacking in intellect beyond reproduction and serving. Aristotle (384-322 B.C.) described women as deformed (Aristotle, trans. 1953), and a Greek anatomist, Herophilus of Alexandria, suggested that women were unperfected men as evidenced by his mis-observation of dissections of human bodies that women possessed testes with seminal ducts connected to the bladder, as men had (Laqueur, 1990). Modern medicine knows he saw ovaries and Fallopian tubes that do not connect to the bladder. Martin Luther assumed that women were created to die in childbirth, as many did, and Jean Jacques Rousseau (1762/1966) believed that nature expected women to obey and please men. Friedrich

Nietzsche (1886/1966) recognized women as possessions predestined for service, and Charles Darwin (1881/1971) wrote that men's intellect was superior to that of women in every endeavor. Plato (c. 427-347 B.C.), Aristotle's teacher, believed that women were less competent than men, but he saw variation in that some women were more competent than some men and were more appropriate than men as leaders (Plato, trans. 1955).

Despite the pervasive negative perception of women in Western civilization, there were always some groups that believed in equality and rejected dominance (Mead, 1935; Sanday, 1981). Women had value, status, and power in several groups of original inhabitants of North America (Almquist, 1989; LaFromboise, Heyle, & Ozer, 1990; Lips, 1993; Norton, 1980; Woloch, 1984). The Iroquois proclaimed that women were the progenitors of the nation and that women would own the land (Sanday, 1981). Women of the Seneca controlled all tribal land, had ultimate authority over distribution of surplus food, and exerted significant influence regarding tribal decisions of warfare and peace (Jensen, 1990). The Hopi and Navajo maintained strong traditions of women's power (O'Kelly & Carney, 1986). One aspect of the colonization efforts by the Europeans who traveled to this country was to put pressure on the Native Americans to institute established European values of women's subordination (Almquist, 1989; Jensen, 1990). Through history, many women have influentially voiced positive ideology about women. Today, it is difficult to comprehend the injustices of earlier generations of women as we tend to take our rights for granted. Our great-grandmothers, however, are cognizant of not being able to vote, speak in public places, inherit goods, own property, receive an education, have credit in their name, or transact business.

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.

## GENDER DEVELOPMENT IN CHILDREN AND ADOLESCENTS

The World Health Organization defines gender as "the socially constructed roles, behaviors, activities and attributes that a given society considers appropriate for men and women;" it refers to the nonbiological characteristics of being male or female, for example, the cultural expectations of femininity and masculinity. Bussey and Bandura (1999) propose that gender is learned in the following three ways: a) modeling gender-related behavior, attitudes and values of significant others, for example, a girl may see females in a movie reacting in subordinate fashion to males, b) the nature of our experience in terms of the consequences that follow the performance of gender-linked behavior, for instance, a girl might learn that the consequence of being forceful in a small group exercise resulted in negative peer reactions, and c) direct instruction of how men and women "should" behave and think, hence, she could be directly instructed that girls should be "feminine" and not overly assertive. Children simplistically view gender, due to cognitive limitations, and believe that one aspect of gender determines all aspects. Until gender constancy develops, at roughly age 5, children think that gender can be changed as easily as changing clothes or hairstyle unless they have learned that genitalia defines male/female differences (Bem, 1989). Children become quite rigid regarding gendered behavior once gender constancy develops, thus, a 7-year-old girl may demand to wear dresses despite her mother never wearing a dress because "girls wear dresses." After gender constancy and gender identification have developed (commonly after age 7), children generally attend more to the behavior of and interact with same-sex models. The underlying thought appears to be, "Since I'm a girl for life, I will learn what girls do."

From birth, children learn the traits and behaviors that coincide with each sex, but individual differences appear resulting from environmental models, direct gender messages about ways boys and girls should behave, and reactions to their behavior. Girls in the United States reveal greater flexibility in gender conceptualizations and behavior than boys (Bauer, Liebl, & Stennes, 1998; Blakemore, 2003), possibly because a broader range of acceptable behavior exists for girls than boys (i.e., girls can wear dresses or pants but boys only wear pants). This greater flexibility may allow for the acquisition of a larger range of traits, including both communion (nurturance, expressiveness, connection, warmth, support, compassion) and agency (assertiveness, instrumentality, self-efficacy, competence), though communal traits will be emphasized for girls. Instrumentality relates to a constellation of traits that was historically termed "masculinity" but is currently deemed to represent a collection of characteristics relating to independence, self-sufficiency, internal locus of control, and the perceived ability to control the environment.

From age 7 to pre-puberty, children generally exhibit gender-typed traits (Hall & Halberstadt, 1980), play in same-sex groups, and focus attention on same-sex models (Maccoby, 1998). A child may encounter disapproval from her same-sex and other-sex peers if she crosses gender lines, and she might simply feel more comfortable interacting with same-sex individuals, hence, experiencing two dissimilar worlds strengthens gendered behavior. Consequently, girls and boys often enter puberty with different interests, attitudes communication patterns, and play styles.

Gender intensification occurs during the time of puberty as boys and girls are challenged to learn and adjust to the gendered norms of adulthood (Hill & Lynch, 1983). Enacting gender for many teens involves being attractive to the other sex and preparing for adulthood, with future work and family roles becoming significant issues. Girls often focus upon interpersonal goals, attracting a mate, and they

frequently become less career oriented than boys. Girls, ages 10-13, commonly encounter a "crossroads" (Brown & Gilligan, 1992) whereby their journey toward self-development is challenged by the cultural messages of being a subordinate woman and appearing more appealing to boys and men. This can translate into becoming less assertive and confident, more concerned with one's appearance and body image, and feeling behaviorally limited. Given such stress, it is not surprising that the incidence of depression and eating disorders significantly rises among Caucasian girls after puberty, and many indicate that they are less happy than they once were (Nolen-Hoeksema & Girgus, 1994; Wichstrom, 1999). The increase in depression may be due to displeasure with bodyweight, social pressures related to attaining a mature female body, the greater importance of feminine sex role identification, a ruminative coping style, and any previous sexual harassment or abuse; many girls are more prone to sexual harassment from males (Abrams, 2003). Research indicates rates of sexual harassment for girls, ages 11-16, within a range of 45% to 83% (American Association of University Women, 1993). African American girls display a more resilient pattern, possibly because their womanhood models are more the outspoken strong women in their community and less the thin, sex objects portrayed in the media. A strong ethnic identity seems supportive in opposing the pressurized effects of idealized femininity (Abrams, 2003). Pride in one's heritage, as African American and Latina girls may demonstrate, might facilitate resistance to female passivity or body dissatisfaction.

Conventional thinking suggests that boys and girls are advised to display clear gender identity and to accept cultural gendered norms, however, in general, individuals who demonstrate both the stereotyped masculine traits of instrumentality and assertiveness, and the stereotyped feminine traits of nurturance and expressiveness (androgynous individuals) appear to possess the most behavioral flexibility in work and interpersonal relationships. Further, people with egalitarian attitudes toward gender roles or who are not exclusively gender conforming are more likely to possess higher self-esteem and better mental health and relationships than those exhibiting more traditional attitudes and conforming behavior. Research since the 1970s reveals that individuals with strong instrumental active traits (masculine and androgynous people) have higher self-esteem, and less anxiety and depression than those low in these traits (Basow, 1992: Broderick & Korteland, 2002). Traditional socialization of girls does not promote these traits, suggesting a possible cause for higher depression and anxiety and lower self-esteem than male cohorts. Traditional gender typing in girls may need re-evaluation with respect to mental health. Similarly, those with strong nurturant expressive traits (feminine and androgynous individuals) have better communication and decoding of nonverbal cues skills, and they report more relationship satisfaction (Basow, 1992). Individuals low on these traits, more likely male than female, may not express their feelings well, possibly impacting intimacy in relationships and raising the probability of stress-related physical disorders. Traditionally gender-typed individuals seem susceptible to different issues whereas gender-balanced or androgynous persons appear more likely to avoid such psychological, relational, and physical problems (Woodhill & Samuels, 2003). Interestingly, college women are becoming more gender-balanced.

Spouses with egalitarian attitudes (belief that women and men are equal and should share child care and employment duties) show a tendency for better adjustment and mental health, higher self-esteem, and more satisfactory personal relationships than those who manifest traditional gender roles (men should be dominant and women and men should be responsible for different activities; Bussey & Bandura, 1999). Children of egalitarian parents and those raised by single parents tend to be the most egalitarian; with girls more egalitarian than boys.

Boys display more gender-role conformity and rigidity in enforcing gendered norms than girls. Children who conform to traditional gender-role norms experience fewer difficulties in peer interactions, beginning in preschool and peaking in adolescence (Bussey & Bandura, 1999). This social acceptance, however, may thwart one's needs and desires (Brown & Gilligan, 1992; Heilman, 1998), and increases the risk in girls of developing body dissatisfaction and eating disorders (Martz, Handley, & Eisler, 1995). The majority of girls are dissatisfied with their bodies and over 50% of fifth grade girls are on diets. Girls that adhere to the traditional female gender role tend not to engage in sufficient career preparation. Girls and boys perform similarly in early grade levels but by junior high, girls and their parents believe that girls have less math aptitude and they avoid such classes and related activities (Eccles, 1987). Steele (1997) found that simply reminding women of their gender may yield poorer performance on college-level math tests than if their gender (and the related stereotype of math inadequacy) were not mentioned.

From childhood and beyond, girls are less physically aggressive than boys (Verhulst et al., 2003), but are more likely to report feelings of 'internal distress," for example, fears and worries, or feelings of anxiety (Epkins, 2002). By early adolescence, girls reveal higher rates of depressive disorders than boys (Angold, Costello, & Worthman, 1998). The Centers for Disease Control and Prevention (2002) indicate a significant difference of 35% of girls compared to 22% of boys report feeling sad or hopeless almost every day, and 24% of girls compared to 14% of boys considered attempting suicide in the prior one-year period. "Internalized distress," therefore, is common for girls and may need to be anticipated in their reactions to undesirable life events or psychological/physical stressors.

The physical and hormonal changes of puberty may heighten girls' concerns of their body image, physical appearance, and self-concept which is related to increased rates of depression. Breast development relates to a more positive body image but increases in follicle stimulating hormone (stimulates the release of eggs from the ovary)

relates to decreases in body image (Slap, Khalid, Paikoff, Brooks-Gunn, & Warren, 1994). Moving through puberty links to increased internalization of the "thin ideal" (Hermes & Keel, 2003). One theory explaining the link between the transition of puberty and increased girls' depression rates notes that puberty increases girls' oxytocin levels, a hormone that stimulates affiliative needs and behaviors, and depression may ensue when affiliative needs are frustrated (Frank & Young, 2002). Peer affiliations are somewhat unstable during adolescence, hence, the potential for girls' depression or dysphoria is higher.

Early puberty has been connected to depression, phobic disorders, subclinical bulimia, substance abuse, disruptive behavior, low self-esteem, poor coping skills, low support from friends and family, suicide attempts, tobacco use, and perception of being overweight (Graber, Lewinsohn, Seeley, & Brooks-Gunn, 1997; Killen et al., 1997). The relationship between early puberty and psychological issues may exist because girls who appear older than their age encounter greater challenges in their daily interactions but they may lack the emotional maturity or coping skills prerequisite for the situations (Ge, Conger & Elder, 1996). Also, early-maturing girls experience dating relationships earlier and are more likely to participate in problem behaviors such as smoking, drinking, or substance use (Ge et al., 1996). Conversely, girls experiencing later puberty appear more protected from the stresses of early or on-time puberty (Ge et al., 1996). Despite girls' puberty being a potentially difficult time, most girls cope well with the transition.

Studies have repeatedly shown a lowering of self-confidence in girls between the ages of 11-15 (American Association of University Women, 1991), characterized by a decline in self-esteem and an increase in depression. The gender difference in adult depression rates can frequently be connected to early adolescent experience, moreover, self-esteem, mood, and body image issues that may affect women through the life span often begin in early adolescence. Studies have shown that many preadolescents who had displayed a strong sense of self begin to relinquish and devalue their feelings, thoughts, beliefs, and perceptions during early adolescence (Brown, 1998). Clinicians in the early to mid 1900s, including Freud, thought this disruption as normative, as do current researchers of female development who describe how adolescent girls experience a retrenchment and appear to abandon their own authority. This silencing transition is associated with dysphoria, eating disorders, and involvement in risky behavior such as drinking and driving, unprotected sex, or sex without desire (Tolman, 1999). The pressures to exemplify the notion of femininity seem to negatively affect the experience of self during and after adolescence (Brown, 1998).

Whereas some girls experience a crisis during adolescence, others preserve their active voice, positive self-concept, and motivation to succeed. Some factors that facilitate a positive transition from girlhood to womanhood include equitable treatment at home (Silverstein & Blumenthal, 1997) and at school (Piran, 2001); encouragement and nurturance of a critical voice and view in social relationships (Brown, 1998; Smith, 1991); a feeling of physical safety (Larkin et al., 1996); healthy and positive relationships and role modeling (Fine, 1988; Piran et al., 2002); and active engagement in empowering experiences (Piran, 2001).

Generally, as adolescence moves forward, girls spend less time at home, however, continuing a supportive emotional bond with the family is important and is linked to more positive self-esteem and decreased incidence of eating disorders and substance abuse. The process of self-management, created by making one's own decisions and independently functioning, establishes separation from family rather than emotional or physical detachment. Daigneault (1999) determined that both daughters (at the age of independence) and mothers desired living independently from one another but wanted to maintain the relationship.

Peers influence adolescents in good and bad ways, for example, in relation to body image, academic achievement, and substance abuse. Adolescents and their friends are generally similar – they influence one another, but also because they select friends with similar traits and identities. In later adolescence, they become less rigid in defining "normal" behavior and more accepting of individual differences among peers. As adolescence evolves, peer relationships manifest more self-disclosure and trust, and 90% report having dates before age seventeen. Research shows, despite common thought, that girls' friendships continue to be important during the beginning of heterosexual dating, and adolescent women strive to resolve jealousy and establish norms and consensus of views that facilitate dealing with life's challenges (Eder, 1993).

The following health-inducing factors may help therapists and parents alike in working with adolescent females:

- As adolescents experience limiting social circumstances and stereotypes, at puberty and beyond, encourage their observations and reactions and offer validation; this process may empower them to meet challenges of the larger social environment (Brown, 1998; Piran et al., 2002).
- Consciousness-raising and relational groups, with family, friends, teachers, mentors, and others, epitomized by gender equity and support, has protective and nurturant value. MacKinnon (1989) explains, "through socializing women's knowing, (consciousness-raising) transforms it, creating a shared reality that clears a space in the world within which women can begin to move" (p. 101). Various consciousness-raising group themes include body experience (Piran, 2001), sexual harassment (Larkin et al., 1996), and depression (Ross, Ali, & Toner, 2004). Such groups foster a critical voice, offer social support and empowerment, and promote social change.
- Casey and Shore (2000) illustrate the power of mentoring such as women mentors in schools who encourage academic excellence, including in math and science – subjects which girls may lag boys' performance. Reis and Diaz (1999) observed that economically disadvantaged urban, high-achieving girls appreciated such supportive adults and believed they were important to their success.

- Encouraging an adolescent to design and recommend anti-harassment policy in the school can yield empowerment and self-esteem if the school enforces such (Piran, 2001), but may produce opposite effects if the school does not follow through with the plan (Orenstein, 1994).
- Promoting competence and agency, which are associated with well-being, can be encouraged within personal, social, academic, and professional areas. Accentuating personal abilities ands skills over appearance provides adolescent girls with an agentic attitude and protection against objectifying body-related messages (Parker et al., 1995). Discussing women's desire and agency regarding sexuality can increase women's ownership of their bodies. Parental and peer support and acceptance often improve adolescent self-esteem.

Girls' involvement in exercise or sports is linked to more positive health such as improved self-esteem (Butcher, 1989). Contrarily, girls participating in highly competitive sports or activities demanding a slim physique – ballet, cheerleading, aerobics instruction – have higher incidence of body dissatisfaction or problematic eating concerns. Thus, it can be health-inducing to promote girls' involvement in sports that enhance body image and self-esteem, and activities that utilize physical and psychosocial abilities such as playing a musical instrument, singing in a choir, Girl Scouts, etc.

Fostering children to develop to their full potential with a broad range of traits and behaviors will likely culminate in the healthiest children and adults. As girls mature into adulthood, they may wish to expand their self-concept of being feminine to include agentic roles of assertiveness, instrumentality, and skill-development, while maintaining positive body image and self-esteem. Gender identity, therefore, may be separate from the possession of traits and behaviors facilitating a healthy expansion of self. In fact, gender is not static, rather, it is an on-going negotiated process (Deaux & Stewart, 2001). The adult roles that we adopt shape our gendered norms such that anyone raising children often becomes more nurturant and empathic while anyone in a leadership role tends to become more assertive and dominant. The social role theory (Eagly, 1987) proposes that many gendered behavior patterns of adulthood result from assuming different social roles, thus, we constantly re-define our gender identity in various situations.

## WOMEN'S CAREERS

Approximately 60% of women were employed in the year 2000, and 75% of those aged 25-44 were employed; compared to 19% in the year 1900 and 34% in 1950 ("Study: Women increase," 1995; Ries & Stone, 1992). Over 90% of women will work outside the home at some point during their life. The "dual-earner" family is the most common family lifestyle (Gilbert, 2002). Barnett and Hyde (2001) note that "work/family role convergence" exists meaning that both women and men believe that work and family are important, and many prefer the two roles equally.

Women and men require a diversity of significant satisfaction sources, in support, we attribute Freud as saying that the psychologically well-adjusted person is able "to love and to work" effectively. Evidence shows that women, as men, wish to bring their talents and capabilities to bear in productive work, and multiple roles are "good" for people. Findings reveal that homemakers lacking in other ways to achieve and produce are highly vulnerable to psychological distress, especially when children leave home. Many mothers and grandmothers of today's young adults enjoyed fulfilling their family ambitions but may have regrets if marriage and family was the only productive outlet. Contemporary mothers often promote their college-age daughters to pursue both career and family thus producing more options. The women in the Terman studies of gifted children, when examined in their 60s (Sears & Barbie, 1977), demonstrated that the employed women reported the highest life satisfaction levels, those who were housewives all of their lives were least satisfied with their lives, and the most psychologically disturbed were those women with very high IQs (above 170) who did not work outside the home; women of high intelligence not pursuing a meaningful career endured psychological ramifications for that failure.

Barnett and Hyde (2001) indicate that experiencing the multiple roles of both worker and family member are important to women's mental and physical health. Most findings show that despite multiple roles being time-consuming, they protect against depression (Crosby, 1991) and promote mental health. Adolescent girls possessing high marriage and family commitment and who begin dating early often have lower occupational goals (and lower self-esteem) than other girls (Danziger, 1983; Holms & Esses, 1988). Women pursuing women-dominated rather than men-dominated careers are more likely to lower their career goals because of family plans (Murrell et al., 1991). Several hypotheses justify the benefits of multiple roles for women (Barnett & Hyde, 2001): a) stress or dissatisfaction in one domain can be "buffered" by satisfaction in a different role; b) the additional income of a second job may relieve pressure of being the only wage-earner and can be vital when a spouse becomes unemployed; c) jobs often provide additional social support which enhances well-being.

Despite increasing numbers of working women, their work is focused within traditionally female occupations with lesser wages than men. Sex segregation exists in the occupational world, for instance, over 90% of preschool through middle school teachers, dental hygienists, secretaries, child-care workers, cleaners and servants, nurses, and occupational and speech therapists are women (U.S. Department of Labor, Bureau of Labor Statistics, 2003). Conversely, women are significantly under-represented in scientific and technical careers and high-level positions in business, government, education, and the military. High technology offers a number of fast-growing and well-paid occupations, but women represent only 10% of engineers, 30% of computer systems analysts, 25% of computer programmers (U.S. Department of Labor, Bureau of Labor Statistics, 2003), 8%

of physicists and astronomers, and 4% of pilots. Those women pursuing nontraditional careers display more nontraditional attitudes about the role of women and they often score higher on instrumentality then other women (Lobel, Agami-Rozenblat, & Bempechat, 1993; Strange & Rea, 1983); are less likely to report a definite marriage desire (Sandberg, Ehrhardt, Mellins, Ince, & Meyer-Bahlburg, 1987); or plan to postpone marriage and children (Parsons, Frieze, & Ruble, 1978); and they plan to attain more education than those pursuing women-dominated occupations (Murrell et al., 1991).

Overall, women make only 72.7% as much as men when both are working full-time. The year 1989 was the first time college graduate women made more money than high school graduate men, and by only $100.00 per year. Women earn only 60% of men's salaries in sales occupations. Men earn more than women in all positions within academia, from lecturer to full professor, and number of publications is not the cause (Caplan, 1993; Cohen & Gutek, 1991). In 1991, women physicians earned less than their male counterparts even when comparing physicians of the same age and specialty (Council on Ethical and Judicial Affairs, AMA, 1994). In pediatrics, a medical specialty associated with women's ability to care for children, women earn 78% of men's hourly wage. The income differentials are not explained by differences in ability, education, absences, limitations on job hours, work interruptions, or years on the job (Betz & Fitzgerald, 1987; Blau & Ferber, 1986; Corcoran, Duncan, & Hill, 1984; England & McCreary, 1987; Thacker, 1995). In assessing the causal variables for gender income disparity, researchers have suggested that men are paid more simply because they are men (Betz & Fitzgerald, 1987). In conjunction with women's lower income, women are not assured of being financially represented by a husband. Currently, the average marriage lasts seven years (Harvey & Pauwels, 1999), and there are 12 million single-parent households raising 20% of the children – mostly headed by women. Women are more likely to be widowed than men and women constitute 75% of the elderly poor, hence, there is high probability of a woman needing to be financially responsible during adult life and failure to prepare for this period with adequate education or training can lead to dire consequences. Therapists may wish to assist women to make career choices that offer satisfaction and economic sufficiency.

Most women acknowledge that discrimination against women exists but they often deny that such is happening to themselves as individuals. People generally implement cognitive strategies that shield them from feeling deprived which is termed "denial of personal discrimination" (Crosby, 1982, 1984; Crosby, Pullman, Snyder, O'Connell, & Whalen, 1989; Nagata & Crosby, 1991). To accept that one is underpaid implies that someone is responsible for the inequality and women may choose not to blame others for the pay differential. Additionally, such an acknowledgement carries a risk of being pitied or scorned by others. This denial process generally culminates in women possessing a lower sense of personal entitlement than men (Bylsma & Major, 1992; Major, 1989). Research experiments reveal that women work longer, do more work, complete more correct work, and work more efficiently than men for an equal amount of pay, and they believe the pay is fair (Jackson, 1989; Summers, 1988).

College women and men were more influenced regarding entitlement and satisfaction by receiving information pertaining to the pay of members of their own gender rather than the opposite gender; women judged their performance more by measurement and standards of other women (Bylsma & Major, 1994). This tendency to compare oneself with members of one's own gender is often reflected in the workplace where women are likely to only have pay information of other underpaid women (Major & Testa, 1989; Treiman & Hartmann, 1981). Knowledge is one variable that can bolster personal entitlement as demonstrated by a study in which college women and men were informed that others (with gender neutral names) were paid more than they, and both genders felt entitled to more money than subjects who were informed that others were paid lesser amounts (Bylsma & Major, 1992). Individuals informed that they performed well felt deserving of more pay than those advised that they performed poorly. The workplace seems not to have presented women with feedback on their performance nor access to information about their peers' pay.

Most women either want or have to work for financial reasons (Lerner, 1994). They can be single, married with husbands not earning enough for necessities or extras, or mothers raising children without much financial support; the courts award child care payments to about 58% of potentially eligible women, and only roughly 51% awarded child support actually receive the full amount (U.S. Department of Commerce, 1992). Employment generates financial and psychological benefits. Over 50% of employed women, including working-class mothers, report they would continue working even if it was unnecessary for financial reasons. A mere 21% of employed mothers report they would quit their current job in order to stay at home with children. Roughly 56% of full-time homemakers state they would opt to have a career if they could live life over again. Full-time homemakers often disclose negative aspects of housework such as its repetitive, fragmented, and demanding nature, high isolation and low social rewards linked to the homemaker role (Ferree, 1976; Lopata, 1971; Oakley, 1974, Pleck, 1983). Conversely, employed women believe employment offers advantages such as mental stimulation, use of skills, self-expression, and interpersonal relationships (Andrisani, 1978; Beckman, 1978; Moore, 1985). Employment beyond homemaking generally presents interesting tasks, contact with the world, and feelings of efficacy and accomplishment (Repetti, Matthews, & Waldron, 1989). Employed compared to nonemployed women have better mental and physical health and more satisfaction with their lives (Walker & Best, 1991; Amatea & Fong, 1991). Such employment benefits transcend prestigious careers and span the range of women's

occupations, including clerks, factory workers, domestics, waitresses, typists, and beauticians (Ferree, 1976; Hiller & Dyehouse, 1987). Employment may be functional for women during life transitions, for example, divorced women perceived their work as comforting and beneficial to damaged self-esteem (Crosby, 1990). Supportive of self-esteem differences between employed and nonemployed women, Birnbaum (1975) compared homemakers who were University of Michigan graduates with honors (15 to 25 years before the study) with married women on the University of Michigan faculty who had children and with a second group of single women on the faculty. The homemakers reported not feeling competent in social skills, traditional housework, or child care; they had the lowest self-esteem, felt unattractive and lonely, worried about their identity, missed challenge and creative involvement more frequently, and some of their traits reflected a fear of failure.

Various circumstances affect women's life-satisfaction in relation to employment status, for instance, women who report dissatisfaction with their primary work role, whether paid employment or homemaker, display poorer physical health and shorter life spans than those who report satisfaction (Palmore, 1974). Mothers of 1-year-olds who wanted employment but were not working showed mild depression compared to mothers who did not want nor have employment who scored as not depressed (Hock & DeMeis, 1990). Homemakers supporting liberal gender role attitudes feel more restricted and depressed than homemakers with traditional attitudes (Kingery, 1985). Employed mothers with sole responsibility for children and without child care exhibit high depression whereas employed mothers with child care and partners who share child care duties are low in depression (Reifman, Biernat, & Lang, 1991).

Several obstacles impede women's career choices. First, women tend to avoid taking mathematics in school and they are a significantly overrepresented group lacking in this background, but a complete math background is essential for some of the best career opportunities, including engineering, scientific and medical careers, computer science, business, and the skilled trades (Chipman & Wilson, 1985). Sells (1982) elaborates that four years of high school math are essential to pass the standard college freshman calculus course that is required for most undergraduate majors in business administration, economics, agriculture, engineering, forestry, health sciences, nutrition, food and consumer sciences, and natural, physical, and computer sciences. Only the arts and humanities do not require a math background. Sells (1982) revealed a strong relationship between college calculus background and higher starting salaries, and stated, "Mastery of mathematics and science has become essential for full participation in the world of employment in an increasingly technological society" (p. 7). It appears that lack of math background rather than lack of math innate ability explains females' poorer performance relative to males on quantitative aptitude and mathematics achievement tests (Chipman & Wilson, 1985). Therapists can inform female clients that a sound math background will increase their career choices and income. Second, in education or job content domains, college women often score lower than college men on self-efficacy expectations domains pertaining to math, science, computer science and technology, mechanical activities, and outdoor and physical activities, whereas women have higher self-efficacy expectations scores than men in social domains of activity. These differences reflect stereotyped patterns of gender socialization. Bandura's (1997) concept of self-efficacy expectations relates to our belief that we can or cannot successfully complete certain tasks or behaviors. Low self-efficacy expectations generally leads to avoidance behavior and quitting upon discouragement or failure, and impedes performance. This concept interacts with the career options that we will attempt, performance on school coursework, and job training requirements. Self-efficacy significantly affects career choice and occupational membership (Betz et al., 2003), consequently, women's lower self-efficacy attitudes limit their perceived career options. Therapists can intervene in this process by reminding female clients that persistence is frequently vital in pursuit of long-term goals, especially when confronting obstacles, intermittent failures, and gender or ethnic discrimination or harassment. Third, an inverse relationship for women exists between being married and/or number of children and every measurable criterion of career achievement (Betz & Fitzgerald, 1987). Fitzgerald, Fassinger, and Betz (1995) articulate that "the history of women's traditional roles as homemaker and mother continue to influence every aspect of their career choice and adjustment" (p. 72), generally by setting limits on achievement by planning careers in relation to the effect on home and family. Arnold and Denny's (Arnold, 1995) research on high school valedictorians demonstrated that girls, but not boys, experienced lower aspirations and self-esteem after college, and those with stronger home/family priorities showed greater decline in both aspirations and self-esteem. Farmer (1997) conducted a longitudinal study of Midwestern high school female students and found that career motivation was inversely related to homemaking commitment. This inverse relationship is not applicable to men, in fact, high achieving men are as likely as less highly achieving male counterparts to be married with children. Fourth, the education system itself may not offer equitable treatment to girls as compared to boys which can discourage girls' higher education attainment. Research concludes that girls obtain less teacher-attention than boys, gender harassment in schools is rising, and curriculum and text discount contributions of girls and women (American Association of University Women, 1999; Sadker and Sadker, 1994). Lack of support may also continue in college through messages of "she doesn't belong" in fields such as engineering and the physical sciences. This bias is important because the nature and level of education is highly associated with career achievement, socioeconomic status, and lifestyle. Men and women earn more with increasing educational levels.

Supportive environments can counteract some of women's barriers to career achievement. Parental support and availability are important in the development of career aspirations (Fisher and Padmawidjaja, 1999; Pearson and Bieschke, 2001). Maternal employment, especially in nontraditional careers, is linked to daughters' higher career motivation (Betz & Fitzgerald, 1987). Women entering male-dominated fields generally come from intact families with educated parents and maternal employment. They report that their parents promoted their career goals more than marriage. Mothers without high-level education and careers are also influential as many daughters reported having gained from maternal strength and encouragement. Gomez et al. (2001) found that Latino high-achievers often had nontraditional female role models, such as a mother or someone else who was nontraditionally employed. A second facilitative factor in girls' pursuit of nontraditional careers is receiving support from male family members (Hackett et al., 1989). Successful professional women have been motivated for nontraditional roles by their father's "masculine approval" to accomplish in a "man's way" (Donelson, 1999; Hennig & Jardin, 1977), or it might have been a brother, boyfriend or teacher (Astin, 1978). Betz (2002) observed that many women in pursuit of nontraditional career fields relied on male mentors due to a lack of accessible female mentors. A third helpful variable in nontraditional career development is displaying personality traits such as instrumentality, internal locus of control, high self-esteem and a feminist orientation on women's career achievements (Fassinger, 1990). This internal drive to achieve has proven effective despite disapproving parents (Weitzman, 1979). High achievers have also originated from lower socioeconomic classes and from parents without a college education and realized marked success in business, academia, or government service (Boardman, Harrington, & Horowitz, 1987), medicine (Mandelbaum, 1978), and politics (Kelly, 1983). These women accomplished simply because they decided on such.

Gender discrimination is against the law, however, workplace informal discrimination exists (Fitzgerald & Harmon, 2001). A woman's career path has been termed an obstacle course (Ragins & Sundstrom, 1989). Awareness of these obstacles can facilitate their avoidance and limit women's self-blame for lack of advancement given periodic incorrigible discriminatory practices (Caplan, 1993). *Treatment discrimination* is defined as differential and unfair treatment after having been hired and involves slow rates of promotion, receiving less attractive jobs, low raises, and limited training opportunities (Terborg & Ilgen, 1975). Failure to give women required resources to complete the job is one form of treatment discrimination, for example, women managers are designated less authority and power than their male counterparts, and they are granted less control over finances and resources, less access to information, and less autonomy and support for their decision-making (Denmark, 1993; Kanter, 1977; Ragins & Sundstrom, 1989). Women may be denied important information by not being part of the influential organizational social network that is sometimes called the "Old Boys' Network" which may be segregated by gender and race (Ibarra, 1993; Konrad, Winter, & Gutek, 1992). Men with network connections are privy to job possibilities sooner and can take advantage of being a "friend of a friend," which is important in managerial, high-income and academic positions (Braddock, 1990; Caplan, 1993; Cohen & Gutek, 1991; Ragins & Sundstrom, 1989).

The *glass ceiling* refers to barriers that inhibit women (or other groups) from progressing in an organization based on attitudinal or organizational bias. The Department of Labor selected a Federal Glass Ceiling Commission which concluded that a corporate ceiling exists as evidenced by only 3-5% of senior corporate leadership positions are occupied by women (Federal Glass Ceiling Commission, 1995, pp. 68-69). A well-known glass ceiling case promoting the concept that women should be feminine involved Ann Hopkins, who was rejected for partnership in a prominent accounting firm (Fiske, Bersoff, Borgida, Deaux, & Heilman, 1991; Sachs, 1989). She added $40 million in new business which was more than the 87 other candidates (all male) who were nominated for partnership. The opposition was mainly from some partners (8 of 32) who had limited contact with her and disapproved of her "unfeminine" interpersonal skills. They counseled her to wear makeup, jewelry and to walk more femininely. Her lawsuit went to the U.S. Supreme Court which determined that the firm was guilty of gender discrimination because it managed a woman with an assertive personality differently than a man with a similar-type personality. This case represented the first time that the Supreme Court referred to psychological evidence on stereotyping in its decision. Evidence was presented by Susan Fiske (Fiske et al., 1991) and the American Psychological Association presented a friend-of-the-court brief confirming Fiske's testimony.

Another obstacle for women working in nontraditional careers is being a *token* – a person whose gender or ethnicity comprises less than 15% of the work group. Tokens may suffer stress, social isolation, greater visibility, and verbal or nonverbal expressions of "you should not be here." Sexual harassment also is a workplace concern that yields lower job satisfaction and organization commitment, job withdrawal, anxiety and depression, and stress-related illness (Norton, 2002). Few women make formal charges because that requires time, money, and she can be classified as a troublemaker (Riger, 1991). Further, organizations may blame the victim leading to her receiving negative job evaluations, being demoted or fired. An additional factor affecting women's careers is that their workload at home has not decreased despite having full-time jobs. Farmer (1997) indicated that only a small percent of men perceive parenting and homemaking as their responsibility, instead, they simply "help out." The majority of husbands and wives believe that husbands should increase household duties if the wife is employed, however, this attitude does not convert into action. Regardless of women's employment status, they perform more household labor, including child-care, than men

(Biernat & Wortman, 1991; Lamb, 1987; Wethington & Kessler, 1989). American women spend more time and American men spend less time in child care (4-year-olds) than parents in other countries (i.e., Belgium, China, Nigeria, Spain; Owen, 1995). Androgynous and expressive men perform more household duties than instrumental men, however, their wives complete twice as much (Gunter & Gunter, 1990). A leading cause of conflict is unequal division of household labor (Stohs, 1995). Yoder (1999) concludes that women in married couples perform 33 hours of home chores weekly compared to their husbands' 14 hours. This 70% to 30% ratio does not include child-care, thus, women are working two full-time jobs which can affect career performance and satisfaction. Employed and unemployed wives' time spent in domestic work increases 5% to 10% with each child, while husbands' involvement decreases with each child. Unfortunately, most organizations do not offer subsidized child or elder care, paid family leave, flextime, job sharing, or telecommuting which would assist women with careers and family (Fitzgerald & Harmon, 2001).

The concepts of status and traditionalism attempt to explain why household labor is deemed women's work rather than work to be shared by both partners. Status becomes a factor because, within couples, the higher wage earner has more financial and overall power (Biernat &Wortman, 1991), in turn, men may use their status to avoid non-fun aspects of housework and child-care. Traditionalism is reflected through the idea that a man who is earning money and financially providing for the family is automatically a good parent and provider, and women support this notion (Blumstein & Schwartz, 1983). Likewise, women more than men are "trained" since childhood to do housework; women feel that "it is my job" while men believe "it is not my job." Women may also feel guilt for supplanting home-time with employment and may lower such guilt and raise self-esteem somewhat through extra traditional household activities (Baruch & Barnett, 1986; Lerner, 1994). For men, more housework and child-care correlates with less marital satisfaction and increased complaining (Baruch & Barnett, 1986; Blumstein & Schwartz, 1983; Broman, 1988; Crouter et al., 1987); their lower satisfaction is partly due to feeling resentful about being coerced to perform the activities, correspondingly, women resent the coercion they feel is necessary to enlist their husband's help.

The majority of professional women believe that their family life has positive or neutral effects on their career and that their work life has positive effects on family relationships (Emmons, Biernat, Tiedje, Lang, & Wortman, 1990; Rudd & McKenry, 1986). Employers' concerns that women's family life might negatively affect their work are not well founded (Kirchmeyer, 1993); instead, this concern of a work decrement given family life was applicable more for men than women – possibly due to men's lesser homemaker training producing less stress-management capability with home roles.

Effective coping strategies assist and are vital to high-achieving women, such as "flexibility, creativity, reframing and redefining challenges, barriers, or mistakes, maintaining a balanced perspective in understanding how racism and sexism may affect careers, developing support networks, and developing bicultural skills where applicable" (Ritchie et al., 1997, p. 298). These researchers also recommend establishing interconnectedness with others during the process. A feminist orientation may offer a sense of connection and has been shown to be helpful in women's career achievements (Fassinger, 1990).

Therapists can be facilitative in helping women identify work for which they are intrinsically motivated and impassioned by the following (Betz, 2002, in Worell and Goodheart, 2006):

1. Promote education and training (including mathematics).
2. Examine client's self-efficacy expectations regarding educational and career goals. Probe feelings of apprehension in areas where she is inexperienced; develop and strengthen her skills and competencies rather than reinforcing her attitude of futility.
3. Expand client's coping mechanisms and self-efficacy in relation to perceived barriers to goal attainment.
4. Work within client's capabilities and cultural values.

Therapists can be helpful to currently working women experiencing discriminatory practices in these ways (Betz, 2002, in Worell and Goodheart, 2006):

1. Assist client in developing a support system.
2. Encourage clients to receive full participation in homemaking and child rearing from their husband or partner. Communicate to client's partner that home duties are his responsibility and to his benefit to perform.
3. Construct behavioral and cognitive coping strategies.
4. Ensure client has grievance procedure information relative to discrimination and harassment.

## MERGING OF FAMILY AND WORK

In 2001, the U.S. Census reported that about 57% of women (across ethnic groups) maintained full-time employment outside of the home and roughly 23% worked part-time; 78.7% of single and 69.6% of married mothers with children under age 18 were employed (U.S. Bureau of Labor Statistics, 2002, 2003). Relative to mothers with infants, in 2000, 66% of African American women, 57% of Caucasian and Asian American women, and 42% of Hispanic women were in the labor force (U.S. Census Bureau, 2000). Nearly 53% of all American mothers return to work within six months after the birth of their first child (Haley, Perry-Jenkins, & Armenia, 2001)

Employed women's earnings have increased slowly. Women's full-time median earnings increased 3.5% from $28,227 in 2001 to $29,215 in 2002 (men earned on average $38,275; Boston Globe, 2003). The increase has mainly been realized by college-educated women. Resulting from the large numbers of women in the labor force, the

percentage of dual-earner families in the United States has risen. In 1992, 42% of Caucasian and 33% of African American families were comprised of men as the breadwinners (earned 70% or more of the family income; Steil, 2001). By comparison, in 2001, and across ethnic groups, 53.7% of married couples were comprised of both partners employed full-time, and families with only the husband being employed constituted only 19.4% of married couples (U.S. Bureau of Labor Statistics, 2002). Between 1947 and 1997, married women's earnings supplied a 150% increase in median income of dual-earner couples (U.S. Census Bureau, 1998).

Despite their greater employment, women still perform most of home and child-care labor (Hochschild & Machung, 1989; Mikula, 1998; Steil, 1997, 2000). About 70% of U.S. wives perform most of the child-care, shopping, cooking, and laundry duties whereas husbands contribute between 20% and 35%. Women complete 80% of the routine and time-consuming work and 90% of the planning, supervising, and scheduling of child-care (Coltrane, 1996; Steil, 2000). Women generally contribute more emotional work and care-giving within the family unit, including child, elder, and relative care, totaling an extra week to their monthly workload (Gerstel & McGonagle, 1999). The net result is that married women have less leisure time than married employed men, particularly when they have young children (Thrane, 2000). Women have thusly experienced role expansion instead of role redefinition (Crosby, 1991).

The majority of women appear content to perform more family responsibilities, specifically, only approximately 30% of married women consider the division of family labor as unfair, regardless of whether they are in the labor force (Major, 1994; Mikula, 1998). Steil (2000) terms this finding "the paradox of the contented wife." People often perceive the world through subjective ideology, for example, often the disadvantaged promote the status quo as passionately as the privileged (Jost, Pelham, Sheldon, & Sullivan, 2003). The cultural ideology accepts gender imbalances, therefore, women agree to work "a second shift" unlike their husbands (Hochschild & Machung, 1989). Conventional ideology believes that home is the natural domain of women and work is the domain of men (Cabrera, Tamis-LeMonda, Bradley, Hofferth, & Lamb, 2000; Pasquera, 1993; Steil, 2000). A 1996 survey revealed that 85% of Americans believe that both spouses should contribute to family income (Steil, 2000), but societal ideology praises the husbands' economic contributions and views women's earnings as solely supplemental to men's (Barnett, 1997). Women and men naturally assume that women are responsible for caregiving duties (Gerstel & McGonagle, 1999). One explanation for this traditional ideology is that women may be more financially dependent on their husbands because women have limited access to higher paying jobs, in turn, women feel less deservingness in family-related work decisions. This feeling of non-entitlement restricts their lobbying for changes that could enhance economic and emotional independence. The asymmetrical earnings of women and men reinforces the unequal division of household labor at the beginning of marriage when young couples struggle to pay the bills (Becker & Moen, 1999; Hochschild & Machung, 1989). Deutsch (2001) observes, "the key decisions parents made about employment when they first had children may have had long-term effect on their earning potential and their place in the labor force" (p. 27). Another explanation for the employment-household division of labor ideology imbalance utilizes social justice theories that explain how individuals' sense of entitlement is based on social comparisons with others, especially with people who we perceive as comparable to ourselves relative to the issue under consideration (Crosby, 1982; Major, 1994). Women often compare their situations with situations of other women (Zanna, Crosby, & Lowenstein, 1986), including their mothers (Silberstein, 1992); many women feel they are doing better than their mothers. Men view themselves being more engaged in domestic life compared to their fathers (Silberstein, 1992).

Studies have examined behavioral responses when gender imbalances oppose egalitarian preferences. One response is to redefine behaviors as more egalitarian than they truly are. Women and men reinterpret their situations skewed toward being fair and legitimate (Major, 1994; Zvonkovic, Greaves, Schmiege, & Hall, 1996). Zvonkovic et al. (1996), in a study of 61 couples from various socioeconomic levels, determined that couples reinterpret their work decisions when they contradict their gender-role ideology; a woman with traditional gender roles explained her teaching job as opportunity to learn about children and school, and improve her parenting skills. Hochschild and Machung (1989) noted that dual-earner couples ignored significant imbalances in household duties and utilized personal preferences (i.e., I like to cook) to justify imbalances. Likewise, Dryden (1999) detected that most women understand the link between gender inequality and marriage in general, but demonstrated reluctance to admit this link in their own relationships.

Greenstein (1996) determined that husbands perform relatively limited domestic labor unless both spouses have nontraditional values regarding gender and marital roles. Deutsch (1999) concludes that balanced sharing of household labor increases intimacy because challenging the culture's role expectations creates new and varied identities for themselves and their relationship. Egalitarian behavior and beliefs enhances the emotional quality of a relationship by valuing the partner's aspirations, skills, and needs resulting in an equal relationship investment (Steil, 2000).

Researchers have pondered the combined effects of paid labor and considerable domestic duties upon women, especially mothers. Evidence indicates that people participating in multiple roles declare better physical and mental health than people with fewer roles (Ayers, Cusack, & Crosby, 1993; Barnett & Hyde, 2001). Crosby (1991) believes that multiple roles facilitate practical and psychological benefits; in practical terms, enacting several roles provides women and men relevant tools to meet family responsibilities, for instance, providing income can help

prevent economic stress. Psychological benefits ensue due to three mechanisms: First, each role augments the others by offering variety in living, and change engenders balance among different experiences. Adult development theories profess that engaging in social roles is pivotal in health and well-being (Vanderwater, Ostrove, & Stewart, 1997). Second, multiple roles increase positive experiencing through repeated interacting with different people and audiences. Third, various roles can buffer negativity from any one role and lower the chance of depression and anxiety. Alternative perspectives are produced along with a breather from other difficult roles. Multiple roles may foster a healthier perspective on a work situation by engaging in pleasurable home time, or work time may alleviate pressure from a family situation. Enacting different identities at work and home increases social support which protects self-esteem. Employed women report obtaining valuable social support from coworkers (Repetti, Matthews, & Waldron, 1989).

The life enhancement possibility of multiple roles varies with our circumstances, as Holcomb (1998) illustrates "work and family life are not static, but moving targets, and the cost and benefits of working change over time as circumstances change" (p. 109). The quantity of roles combined with the quality of each role determines the value of multiple roles (Barnett & Hyde, 2001; Barnett & Rivers, 1996). Some jobs and careers are easier to combine with family roles than others. Professional jobs often yield more rewards and flexibility of arrangements than working-class jobs (Roschelle, 1999). Low-wage and low-quality jobs expose low-income women to role-overload (Pasquera, 1993; Sidel, 1992), as does lack of social support. Working mothers who cannot afford child-care may feel stress despite job contentment. Unemployment and underemployment among the poor places greater importance on creating flexible home arrangements because the roles of providing child-care and housework can become burdensome during life and employment transitions (Romero, 2001; Seccombe, 2000). Parenthetically, wives who believe their paid employment is as important as their husbands' indicate less depression and overload compared to wives who interpret their provider role as secondary to their husband.

Many workplaces are being economically rewarded for offering family-friendly policies. Galinsky (2001) states that companies employing flextime, extended parental leaves, and manager training programs are significantly lowering employee turnover resulting in savings. Employees who use family-friendly strategies frequently receive the highest performance evaluations. Worthy of note, companies with a large percentage of women and/or African Americans in executive positions are most likely to implement family-friendly policies (Galinsky, 2001). Caring for young children is reported to be stressful by American working parents (Haley et al., 2001), but the burden of work-family conflict is reportedly more among women and the most by low-income women. Regrettably, workplace family-friendly policies are generally only available to middle-class, professional women and men (Gerson & Jacobs, 2001).

## 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-cohabitors (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 cohabitors 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; 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; Suitor, 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 (1981) 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.

## WOMEN'S MENTAL HEALTH CHALLENGES

### DEPRESSION

Women are two to four times more likely than men to experience two types of depression – major depressive disorder and dysthymic disorder (Kessler, McGonagle, & Zhao, 1994; McGrath, Keita, Strickland, & Russo, 1990; Nolen-Hoeksema, 1990; Sprock & Yoder, 1997). Symptoms for each type of depression include sad mood, sleep and eating changes, loss of interest in customary activities, loss of concentration, fatigue, and feelings of worthlessness. The two disorders mainly differ in symptom severity and duration and not in the symptoms themselves. Dysthymia symptoms are less severe, but chronic. The probability of a woman

experiencing major depression during her lifetime is 10-25%, and 6% for dysthymia (APA, 1994).

Depression can be as debilitating as having physical conditions and it produces almost as many hospitalizations and sick days (Blumenthal, 1996). Though more women are diagnosed with depression and more women attempt suicide, more men actually commit suicide; men use guns or hang themselves whereas women employ slower-acting methods which allow for recovery such as medication overdose.

The following seven reasons contribute to women's higher depression rate: Biological factors may increase vulnerability as women have different hormone levels that also fluctuate. Some findings indicate that significant estrogen level changes are linked to certain types of depression, for instance, postpartum depression (Hamilton, 1989). Also, the rate of depression gender difference is not exhibited until puberty and then diminishes among older adults (Sprock & Yoder, 1997), hence, the gender difference is most noticeable during women's reproductive years when their hormone profile is most different to men's. Another biological explanation suggests that the activity of brain chemicals such as the neurotransmitters serotonin and norepinephrine is influenced by reproductive hormones (Halbreich & Lumley, 1993), and the resulting interaction of these neurotransmitter chemicals with hormones may be a factor in women's greater depression rate. Conversely, most biological correlations to depression (genes, brain chemistry) are comparable in men and women so this theory does not easily explain the gender differences in depression rate (McGrath, Keita, Strickland, & Russo, 1990).

Society's expectations and stereotypes accept women's expression of emotions more than men, therefore, women may be less inhibited to release emotion than men. Stereotypes may also influence doctors to perceive depression in women more than men.

Women are exposed to cultural stressors that increase depression likelihood (Wu & DeMaris, 1996) such as women live in poverty more than men, and they experience abuse and discrimination more frequently than men. Women having experienced sexual abuse or other types of victimization display more vulnerability to depression (Cutler & Nolen-Hoeksema, 1991). Women experience greater stress due to enacting multiple roles as mother, wife, daughter possibly caring for elder parents, housekeeper, and employee. Pressure to satisfy the demands of multiple roles may explain why depression gender differences are greater among married versus unmarried individuals (Gove, 1972; Radloff, 1975; Wu & DeMaris, 1996). Married women who are not in the workforce may obtain some of their identity from their husbands and their accomplishments, such self-concept being influenced by and dependent upon another (i.e., husband, child, parent) is termed *derived identity* and creates vulnerability to depression (Warren & McEachren, 1985). Married women working outside the home experience less depression than their counterparts not in the labor force (Kessler & McCrae, 1982; Ross, Mirowsky and Huber, 1983); it is theorized that working outside the home establishes an identity separate from the family that protects women from depression.

The societal balance of power is skewed toward men and this comparative lack of power may increase women's vulnerability to depression and anxiety disorders. Wenegrat (1995) suggests that women possessing the least power and control are most susceptible to depression, while women with power and control are least likely to experience depression. Seligman's (1991) learned helplessness findings reinforce the correlation between power or control and depression. Seligman discovered that animals receiving uncontrollable shocks (shocks were unrelated to the animal's behavior) learned to be helpless and stopped trying to escape the shocks. Seligman believed that depressed people, similarly, learn depression from their perceived inability to control their life events leading to apathy and failure to actively attempt change. Conversely, those believing that their behavior affects outcomes attempt to control outcomes by modifying their behavior. Professional women who ascribed positive outcomes to their actions had lower depression probability than women who perceived no control over outcomes (Marshall & Lang, 1990).

Gender roles may also play a part in women's greater depression compared to men. An *instrumental role* consists of masculine personality traits such as assertiveness, dominance, independence, and competitiveness, while an *expressive role* comprises feminine traits of being nurturant, emotional, cooperative, and nice to others. Girls are socialized to demonstrate an expressive role whereas boys, an instrumental role. Research on these gender roles and depression determined a relationship for instrumentality, but not for expressivity (Whitley, 1984), hence, people low in instrumentality experience more depressive symptoms than individuals high in instrumentality. Assertive and independent women are thereby less likely to be depressed. Bromberger and Matthews (1996) examined gender roles and depression in middle-aged women and also found that women low in instrumental traits show the most depressive symptoms, and that high scores on expressive traits is not related to higher depressive symptoms. This study observed that women who suppress feelings of anger and are highly self-focused when stressed suffer more depressive symptoms.

Nazroo, Edwards, and Brown (1998) researched the influence of roles on depression by exploring the reactions of couples whereby each partner endured a stressful event, such as their child having a life-threatening illness, threat of eviction from their home, a late miscarriage, serious economic concerns, or infidelity. Each partner was therefore exposed to a stimulus that might produce a high depression risk, yet, women showed greater likelihood of experiencing depression than their male partners. The study ruled out the possibility that the men had reverted to substance abuse or anger/violence instead of depression as response to the stress. Nazroo, Edwards, and Brown (1997) studied the same couples and determined that women's greater vulnerability to depression after exposure to stress was dependant on the nature of the stressful event. Women were five times more

likely compared to men to have depressive symptoms following concerns with children, home, and reproduction. These researchers theorize that women's higher depression risk is associated with the importance of the life event to their role identity. Predictably, women with high identification to a role (i.e., being a mother) are more probable to experience depression after a crisis within that role (e.g., miscarriage) than women reporting low identification to a role. They reason that women do not have more life crises than men, instead, they show more sensitivity to some events than men due to the perceived importance of certain roles. The research team infers that socialization differences between the two genders influences higher versus lower role importance and sensitivity.

Another gender difference factor in depression links to the type of coping strategies individuals utilize when depressed. Nolen-Hoeksema (1987) illustrates the following two coping mechanism response styles: the *ruminative style* involves focusing one's thoughts and behaviors on the depressive symptoms, which extends the depression, and the *distraction style* in which individuals focus their thoughts and behaviors away from the depressive symptoms and instead, attend to neutral or positive thoughts, which decreases depression. An example of distraction style is focusing attention on a work project rather than thinking about that which is depressing. Research shows that men more frequently use a distracting style in response to depression while women generally use a ruminative cognitive style (Nolen-Hoeksema, Morrow, & Fedrickson, 1993; Nolen-Hoeksema, Parker, & Larson, 1994). Upon controlling for differences in response style, gender differences in depression disappeared (Butler & Nolen-Hoeksema, 1994), therefore, gender differences in depression rate may result from gender differences in using rumination.

People using a ruminative style are evaluated more negatively by others than people utilizing a distracting style (Schwartz &Thomas, 1995), thus, the social milieu responds more favorably when perceiving the depressed person as taking action to decrease the depression rather than prolonging the depression by focusing upon it.

Finally, social support is a contributing factor to gender differences in depression in that supportive social networks are commonly more important to women than men (Belle, 1982; 1987), and women often feel disconnected and more vulnerable to depression when the social network collapses. The prevalence of depression is lower among people who interact with a supportive social network (Sherbourne, Hays, & Wells, 1995). Treatment programs that utilize social support may significantly foster recovery from depression. Women with multiple depression risk factors were examined and placed into an experimental group which offered group discussions and weekly interactions with a peer, or into a control group that did not include the peer support group. The experimental group scored significantly lower on depression than the control group (Genero, Goldstein, Unger, and Miller, 1993).

The American Psychological Association (1996) listed the following additional risk factors for depression among women:

1. The personality characteristics of passivity, dependency, pessimism, and negativity are related to depression.
2. Sexual and physical abuse is associated with depression; approximately 50% of women with depression were sexual or physical abuse victims, frequently, before age 21.
3. Women with young children and with a larger number of children are more susceptible to depression than women without young children or women with few children. Marriage tends to insulate men, but not women from depression.
4. Poverty leads to depression and the majority of poor people are women. Minority group women are especially likely to be poor and sustain stress from discrimination.
5. Women who want children but cannot, and those having multiple miscarriages are more susceptible to depression.
6. Alcohol or drug abuse is related to depression.
7. Lesbians are more likely to experience depression than heterosexual women.

Russo (1995) suggests that clinicians may be more likely to overdiagnose depression in women and to perceive women as being depressed when they are not. Loring and Powell (1988) exposed the tendency for clinicians to misdiagnose depression in Caucasian women. They gave 290 psychiatrists two case histories, each described client symptoms indicative of an axis I diagnosis of schizophrenia and an axis II diagnosis of dependent personality disorder. The case histories were varied by gender (female or male) and ethnicity (African-American or Caucasian), and a fifth case history did not include gender or ethnicity information (neutral). Results revealed that male clinicians (African-American and Caucasian) diagnosed women, regardless of ethnicity, as depressed more often than any other disorder – female clinicians did not demonstrate this bias. This misperception and misdiagnosis was more prevalent for Caucasian than African-American women.

An accompanying concern to overdiagnosis of depression in women is the fact that antidepressant medication is a common treatment for such, therefore, antidepressants might potentially be overprescribed for women (McGrath et al., 1990). Hohmann (1989) researched data from the 1985 National Ambulatory Medical Care Survey to ascertain any gender differences in prescribing psychotropic drugs by primary care physicians to patients visiting their private offices. Women … "were 82% more likely than men to receive an antidepressant" (p. 486), which the researcher concluded was higher than reasonable expectation. Antidepressant medications are not to be downplayed, as they have proven to be effective for many clients receiving professional treatment, generally, in tandem with psychotherapy (McGrath et al., 1990). Marsh (1995) emphasizes the importance of effectively matching

psychopharmacologic interventions with women in treatment who will benefit from them.

The World Health Organization (WHO; 2000) recommends the following protective factors against mental health issues, especially depression: 1) Exerting some degree of autonomy and control in response to severe life events, 2) Access to resources that produce choices in the face of severe life events, and 3) Receiving support from family, friends, and if necessary, health providers when confronting difficult life situations.

## ANXIETY DISORDERS

The anxiety disorders of agoraphobia and panic disorder occur more frequently among women than men (Eichler & Parron, 1987). Women are approximately twice as likely as men to display agoraphobia (Magee, Eaton, Wittchen, McGonagle, & Kessler, 1996), generalized anxiety disorders (Wittchen, Zhao, Kessler, & Eaton, 1994), and simple phobias (Magee et al., 1996), and their social phobia rate is about 40% higher (Magee et al., 1996). Wittchen et al. (1994) observed that individuals describing their employment status as "homemaker," mostly females, experienced higher rates of agoraphobia, simple phobia, and generalized anxiety disorder, implying the effect of gender roles upon anxiety conditions.

*Agoraphobia* involves anxiety about places or situations that would be difficult to escape from, for example, elevators or crowded rooms. Avoidance behavior develops regarding these places that may progress to not leaving home due to fear of possibly encountering such anxiety-inducing situations. Another symptom can involve inability to be home alone due to fear of being overcome by anxiety.

The gender role socialization of advising young girls to stay close to home and not to confidently explore the world is considered pertinent to agoraphobia (Gelfond, 1991). McHugh (2000) believes that the additional factors of marital status, marital conflict, and violence against women contribute to women's increased inclination to remain nearby the home. Given these social structures, social changes may be required to lower the agoraphobia rate among women rather than treating each woman individually (Gelfond, 1991).

Agoraphobia may occur with or be initiated by panic attacks. *Panic attacks* are sudden episodes of intense fear occurring with a minimum of four additional symptoms, including palpitations, sweating, trembling, shortness of breath, chest pain, dizziness, fear of losing control or dying, and stomach upset (APA, 1994). Each attack generally persists for ten minutes or less, but the symptoms become quite severe, in fact, many people think they are having a heart attack, stroke, or dying during initial attacks. In situations where the attack is connected with a specific stimulus, for instance, a restaurant or clothing store, individuals rapidly desire to avoid encountering the stimulus.

## EATING DISORDERS

Over 90% of those with eating disorders are female, and most are late adolescents or young adults (Grant & Fodor, 1986). The two subtypes of eating disorders are anorexia nervosa and bulimia nervosa. The National Institute of Mental Health approximates that 1% of adolescent girls develop anorexia and 2-3% develop bulimia (Eichler & Parron, 1987). *Anorexia nervosa* involves refusal to maintain a minimally normal body weight (at least 85% of normal weight for one's age and height), strong fear of gaining weight, distorted body image, and amenorrhea (absence of menstruation). The disorder generally commences at approximately age 17, often due to a stressful event, for instance, starting college, a new job, or death of a loved one (APA, 1994). Common beliefs of women with anorexia include: selectively attending to a minor detail and ignoring other pertinent information, over-generalizing one specific event to many situations, amplifying the effect of an event, thinking in extremes, associating impersonal events to self, and superstitiously linking two unrelated events that are not related. Anorexics are behaving in ways that support their belief system, therefore, effective treatment responds to their distorted thoughts that cause the behavior (Garner & Garner, 1992).

Anorexics frequently manifest depressive symptoms, obsessive-compulsive behaviors, and numerous health concerns related to their semistarvation state (APA, 1994), such as anemia, cardiovascular problems, osteoporosis, and impaired kidney function. Sadly, 10% of female anorexics ultimately die from starvation, suicide, or related medical problems (Eckert, 1985; Smith, 1996).

Several theories exist regarding the cause of anorexia nervosa. One explanation is that girls who develop this disorder have difficulty separating themselves from overly involved, controlling, and demanding parents (Harvard Mental Health Letter, 1992; 1997). Young women with anorexia often strive to gain the approval of others and have been characterized as perfectionists, possibly attempting to fulfill the high expectations they believe their parents have for them (Pike, 1995; Smith, 1996). This theory suggests that girls display anorexic behaviors in the attempt to gain control and develop a separate identity (Gilbert & Thompson, 1996). Another theory considers the fact that often eating disorders run in families, therefore, there may be a genetic link, with a tendency to develop the disorder passed along to each next generation (Harvard Newsletter, 1997; Pirke, Vandereycken, & Ploog, 1988; Strober, 1991). A third theory attributes the American culture's promotion of "thin is beautiful" as a cause of this disorder. Supportively, the prevalence of eating disorders among women has increased the past several decades coinciding with the ideal female body image having become thinner during this timeframe (Myers & Biocca, 1992). African American girls often describe the "ideal" girl based on personality characteristics rather than physical attributes as is common among Caucasian girls (Nichter & Vuckovic, 1994); reflective of

this perceptual difference, African American women display lower eating disorder rates than Caucasian women (Root, 1990).

*Bulimia nervosa* involves binging on large quantities of food and then purging to avoid weight gain. Purging can become a reinforcer because it relieves the immediate discomfort from overeating and the mental distress from the binging behavior and weight gain. As with anorexics, bulimics possess an impaired perception of their body size and shape, are described as perfectionists and overly concerned with how others perceive them (Johnson & Pure, 1986; Pike, 1995). Health concerns include stomachaches, bloating, nausea, dehydration, loss of potassium, and erosion of dental enamel from the vomit acids, but this disorder is not as deadly as anorexia (Harvard Newsletter, 1992). Bulimics have greater likelihood than non-eating disordered women to experience depression, alcoholism, panic disorder, and phobias (Kendler et al., 1991; Walters et al., 1992). Some research proposes that these individuals have impaired peer relationships (Herzog, Keller, Lavori, & Ott, 1987).

Often, there is an overemphasis on weight within the girl's family, for example, the mother or sister has a weight issue or is routinely dieting (Hsu, 1990; Pike, 1995). Having a relative with an eating disorder or mood disorder associates with the development of bulimia (Pike, 1995). Bulimic girls tend to grow up in families with conflict, higher amounts of aggression and anger, and lower levels of support (Johnson & Flach, 1985), along with more exposure to violence, as witnesses or victims, and experiencing parental indifference in combination with extreme parental control. Women with eating disorders, particularly bulimia, have higher probability of childhood sexual abuse than non-eating disordered women (Vanderlinden & Vandereycken, 1996).

Similar to anorexia, some evidence points to a genetic or familial component to bulimia. In identical twin studies, when one twin has bulimia then the other twin is eight times more probable to become bulimic compared to the general population (Kendler et al., 1991). A biological cause may exist as bulimic women reveal altered amounts of the brain chemical serotonin, and continue to do so after returning to normal weight and not demonstrating bulimic behaviors in more than one year (Kaye, 1997). This researcher proposes that the chemical difference may justify why only some women become bulimic in a culture that promotes thinness to almost all women. Other research indicates that bulimia is influenced by friendship networks and social norms whereby young women conform to peer pressure to binge, thus, peer pressure is considered a possible risk factor for eating disorders (Crandall, 1988; Pike, 1995).

Women with bulimia show better prognosis and long-term recovery rate than women with anorexia (Garner & Garner, 1992). In one study, female bulimics had a recovery rate of 56% one year after entering a treatment program compared to 10% for female anorexics (Herzog et al., 1993). Recovery probability increases over time, in other words, eating-disordered women with more distant onsets are more likely to be recovered than those with more recent onsets (Theander, 1985). Prognosis is better for women who lose less rather than more weight (Herzog et al., 1993); for younger rather than older individuals (Garner & Garner, 1992); and for women without other concerns such as depression or personality disorders (Herzog et al., 1993; Zerbe, 1993).

## ALCOHOL AND DRUG ABUSE

Over the past several decades, gender differences in alcohol consumption and abuse have remained stable – males use and abuse more than women (Neve, Drop, Lemmens, & Swinkels, 1996). Women's lifetime prevalence rates of alcohol abuse or dependence are 41-51% those of men, and rates of drug abuse or dependence are approximately 65% those of men (Kessler et al., 1994). A range of 4 to 18 percent of women will sustain significant issues with alcohol or drug abuse/dependence at a given time over their lifetime (Kessler et al., 1994; Vogeltanz & Wilsnack, 1997). Additionally, many women experience "problem drinking," but are not diagnosed with an alcohol disorder (Vogeltanz & Wilsnack, 1997). This pattern reflects gender role norms that promote men to externalize their concerns through aggression and drinking and women to internalize their issues which links to depression and anxiety (Huselid & Cooper, 1994). Warner, Weber, & Albunes (1999) illustrate a double standard regarding drinking and drugs, with more acceptance for drunkenness in men and condemnation of drunken women.

Transcending the differences between women and men, many women have alcohol and/or drug issues, in fact, surveys indicate that 4.5 million women are alcoholics or abuse alcohol, 3.5 million misuse prescription drugs, and 3.1 million use illegal drugs (CASA, 1996). Higher socioeconomic backgrounds and higher education in women associates with their greater likelihood of drinking and drinking more heavily compared to women from low socioeconomic groups and those with less education. Caucasian women have greater likelihood of using alcohol and abusing drugs than African American or Hispanic women. Alcohol use often decreases as women age yielding relatively low alcohol abuse and dependence rates among elder women (Wilsnack et al., 1995). Nonetheless, many older women do have alcohol problems, presenting concern that their needed medications may negatively interact with the alcohol (Wilsnack et al., 1995).

Approximately 70% of alcohol or drug abusing women are childhood sexual abuse victims (CASA, 1996). The substance abuse is theorized to be a coping mechanism for the emotional trauma stemming from the earlier physical abuse (Rohsenow, Corbett, & Devine, 1988). Other predisposing factors to substance abuse issues include depression, eating disorders, and sexual dysfunction; these disorders may also be the result of alcohol or drug abuse. Another risk factor is that women are frequently influenced by their partner's drinking behavior more than men being influenced by their partner (Wilsnack et al., 1994; Vogeltanz

& Wilsnack, 1997). Women with alcohol dependency often display co-occurring anxiety (Kessler et al., 1997) or mood disorders (Grant & Harford, 1995; Kessler et al., 1997). Women are more likely than men to indicate that alcohol dependence followed these psychological difficulties (Kessler et al., 1997). Women who drink excessively suffer with higher rates of numerous illnesses (i.e., liver disease, hepatitis), and display higher mortality rates than men (Vogeltanz & Wilsnack, 1997).

## MOTHERHOOD

The 2000 U.S. Census revealed that almost 33% of American women are raising children, roughly 67% of these women are in the labor force; about 17% of women raising children are the head of their household and more than 33% of these women are below poverty level.

Various developmental perspectives on motherhood abound, for example, traditional developmental theory portrays women as mainly catalysts for child development. Attachment theory explains that infants must establish emotional attachment with their mother so that later emotional development may begin (Bowlby, 1969/1982). Early attachment theory professed that mothers were exclusively responsible for their children's emotional development and assumed mothers know how to accomplish this feat. Harlow's (1974) primate research showed that physical contact between mother and infant rhesus monkeys was pivotal to emotional development. Monkeys deprived of maternal contact lacked capacity to develop relationships with other monkeys. These findings contributed to changes in child-care facilities and practices, and promoted the belief that mothers were mandatory and responsible for appropriate emotional development. Harlow stressed, "Nature has not only constructed women to produce babies, but has also prepared them from the outset to be mothers" (1974, p. 6). Such perspectives have strengthened traditional gender roles for women and men. Similarly, bonding theory explained the derivation of mothers' sensitivity to their children's needs. Klaus et al. (1972) advised that hormonal processes active during childbirth prime the mother to bond with her baby in early postpartum. A mother was deemed at risk of abusing or neglecting her child given the absence of contact with the infant during this sensitive time. Bonding theory implied that sufficient maternal behavior is instinctive rather than learned behavior, and biological mothers are assumed to be innately ideal caregivers, especially given contact with their babies early in postpartum.

The psychoanalytic perspective on motherhood reinforced traditional sex roles and blamed mothers. Freud (1949) considered maternal behavior and the essence of the mother-child bond as being biologically based, and he placed responsibility for the child's later personality development on the mother. Helene Deutsch (1945), a psychoanalyst, hypothesized that a woman's need for self-love is shifted to her child, she accepts accompanying pain and self-sacrifice for the benefit of her child, and motherhood is vital to women's psychological development. Ensuing psychological theories alleged that motherhood is prerequisite for women's adulthood.

Woman-centered perspectives on motherhood include Chodorow's *The Reproduction of Mothering* (1978), a psychoanalytic view suggesting that women mother (care for and socialize children) because they are themselves mothered by women, and this life cycle is reinforced by a social structure that diminishes the value of women's labor. Daughters enjoy a deep relationship and identify with their mothers which strengthens their desire to be a mother. Sons identify less with their mothers and learn that mothering is women's labor, which has diminished value in their masculine world. They ultimately reject femininity and their nurturance capacity remains undeveloped. Chodorow's theory launched more woman-centered perspectives on motherhood. A second woman-centered view on motherhood is offered by Hrdy (1999) who combines feminist theory and sociobiology to propose that perception of the ideal mother as self-sacrificing, unconditionally loving, and dedicating all energy to child nurturance is erroneous. She argues that mothers make choices that contradict traditional gender roles for their own self-preservation, potentially at their children's expense; also, mothers combine family and work such as historically foraging for food, pursuing employment, or recruiting child-care assistance. Mothers are not blamed or idolized in this theory. Another woman-centered model of motherhood, social cognitive theory, illustrates the relevance of environmental, cognitive, and behavioral factors in formulating women's experience of motherhood (Bussey & Bandura, 1999). One example is *modeling*, whereby women learn maternal behavior examples through resources such as personal experience, interaction with others, and mass media. This model contends that women learn to be mothers rather than being destined by their biology, hence, individual differences exist in response to motherhood. Biology allows women to give birth and lactate, but it does not dictate their emotions or behavior.

Traditional motherhood psychological theories spotlighted the child's needs but current models have become woman-centered, in turn, mothers are acknowledged for their challenging work without blame or idolization, with recognition that the "ideal mother" is a myth. Unfortunately, these myths of motherhood persevere, therefore, therapists are encouraged to utilize woman-centered viewpoints in assisting mothers to examine and convert these myths into healthy realities. The motherhood myth expresses that women are innately good at parenting, but research findings indicate that most women are not well prepared for infant care. Women initially reveal low motherhood competence and confidence ratings and they receive limited social support and appreciation for their efforts. Motherhood is culturally idealized, hence, many women feel frustrated and self-critical of their attempt. Fortunately, many women also thrive in the motherhood role as do their children. Another myth involves how cultural expectations presume that fathers

are highly involved with parenting, but mothers interact more with children and perform double the custodial care as fathers, working mothers included (Hofferth, 2003). Mothers observe less father involvement in parenting than fathers observe which produces relationship stress (Milkie, Bianchi, Mattingly, & Robinson, 2002). Father involvement increases when the child is first born, male, a good student, emotionally stable, when a good relationship with the mother exists, and when the mother is more involved. Father administered love and discipline correlates with children's improved academic achievement, and discipline and control imparted by nonpaternal men is associated with less school behavior problems and improved peer behavior (Coley, 1998).

Many women experience *postpartum depression* – having negative feelings for days or months following childbirth; the severity and frequency of depression varies across individuals. The colloquial terms of *baby blues* or *maternity blues*, generally within one week of delivery, occurs in 50% to 80% of mothers (McGrath, Keita, Strickland, & Russo, 1990). Symptoms include being emotional, sad, readiness to cry, anxiety over lack of maternal feelings or the responsibility, and possibly guilt for not being the perfect mother as well as feeling empty inside as she is no longer pregnant. The blues generally subside in several days as the new mother receives support and confidence from others (Berk, 1993). A few women may undergo deeper depression requiring rest, time away, or communicating with a friend or therapist for resolution (Steiner, 1990). The reason for experiencing depression after giving birth is not apparent, but several theories abound: a) It may be related to estrogen level changes, with possible interaction with thyroid and pituitary functions (Hamilton, 1989; Sprock & Yoder, 1997); b) Unusual sensitivity to hormonal changes may be the cause given that women with a history of severe menstrual problems have a higher probability of postpartum depression (Cutrona, 1982); c) New mothers experience stress due to the delivery, being awakened at night, and feeling rundown (Gjerdingen & Chaloner, 1994; Hopkins, Campbell, & Marcus, 1987) and within a culture that idealizes motherhood, these stressors may be perceived as a reflection of incompetent motherhood (Cutrona & Troutman, 1986); d) Fear of the abrupt changes and responsibilities that accompany a child; and e) Depression may ensue after the completion of a major event as all the channeled psychic and physical energy diminishes and psychobiological shock and fatigue arises which can be labeled as depression – a period of rest is needed.

Adults are frequently shocked by the transition into parenthood that a newborn demands (Entwisle, 1985) and resolutions to new predicaments may be temporarily unknown. Greater parental satisfaction is reported when the infant sleeps through the night from an early age and is not fussy compared to an infant who often is awake and crying, but there is greater affect on mothers than fathers (Tomlinson, 1987; Wright, Henggeler, & Craig, 1986). Parenthood is a significant change in adult development and requires time, in fact, more preparation time for the transition before birth produces better adjustment afterward (Mebert, 1991). Such preparation includes not only arranging the nursery but also envisioning oneself as a parent and being ready for the work of parenthood (Ruble, Hackel, Fleming, & Stangor, 1988). Marital satisfaction decline occurs more often in couples who do not plan for parenthood realistically or have not implemented their plans (Belsky & Rovine, 1990: Moss, Bolland, Foxman, & Owen, 1986). New parents usually are not prepared for infant care despite feeling overly optimistic about their ability (Entwisle & Doering, 1981, 1988). Most men are lacking in experience with infants but believe that their wives are cognizant, actually, over 50% of wives report having no experience at all in infant care (Entwisle, 1985). Upon the baby's arrival, mothers and fathers rate themselves as less competent parents than their earlier expectations (Fleming, Ruble, Flett, & Shaul, 1988; Reilly, 1981; Ruble et al., 1988). Many women feel incompetent as mothers and experience anger, frustration, envy, or panic given the perception that they are not meeting cultural expectations and social comparisons (Fleming, Ruble, Flett, & Wagner, 1990; Gieve, 1989; Reilly et al., 1987; Ruble et al., 1990). Many experience continuing mild depression involving tearfulness, irritability, and inadequacy feelings which can increase until 16 months after delivery (Fleming et al., 1990).

Continuing concerns for new mothers include lack of help and the accompanying fatigue, and personal freedom limitations (Entwisle, 1985). Mother and father gender roles frequently become more traditional after birth of the first child, despite pre-existing sharing tendencies (Cowan, & Cowan, 1988; McHale & Huston, 1985; Palkovitz & Copes, 1988; Rossi, 1988). Women and men indicate that wives do more housework and child-care than men after arrival of a baby compared to earlier expectations (Hackel & Ruble, 1992). Fathers engage in more parenting time when the mother is employed, but not much more (Darling-Fisher & Tiedje, 1990). Mothers and fathers perform different parenting roles, with fathers as the main providers of the infants' material needs (i.e., they work more) and mothers as the primary caregivers for infants. Mothers and fathers believe that the mother is a better caretaker than the father, and mothers rated fathers higher than fathers rated themselves (Wille, 1995). The estimated time that men spend with infants ranges from less than one minute to over three hours per day (Lips, 1993), but that time is generally playing behavior rather than soothing, feeding, changing, dressing, or cleaning the baby. Men commonly take care of older children when the mother is caring for an infant (Shapiro, 1979). Men are commonly not highly involved in child-care, even if they maintain equalitarian attitudes (Duindam & Spruijt, 1997). Much individual variance exists, however, with a continuum of the traditional (very little care work at home) to the highly caring father (at least the equivalent of his wife). Wille (1995) proposes that fathers spend vastly different timeframes in infant-care due to different perceptions of competency in infant-care emanating

from diverse levels of gender role training. Fathers who have received infant-care training report more confidence and participate in more infant-care (McBride, 1990; Parke & Tinsley, 1987).

Mothers' attachment to their infants and their sense of motherhood competence develops before pregnancy into postpartum months (Ruble et al., 1990). Despite the possible depression and self-disapproval of maternity blues, mothers develop a greater closeness to, and appreciation of the development of their infants; they become more involved, protective, and traditional in their mothering roles (Fleming et al., 1990). Though mothers report not being as much of a "fun" mom as expected, and feeling anxious or irritated when the infant is not sleeping or nursing well, most mothers indicate a growing sense of well-being when discussing their infant. Conversely, mothers are also interested in life domains other than motherhood, as people generally are, and there are costs for the increased investment and joy of motherhood. One study observed that mothers on maternity leave from employment felt mildly depressed or guilty when thinking of returning to employment (when the infant was three months), and grew to resent the amount of time required to care for the child (by 16 months) (Fleming et al., 1988). Along with its joys, child-care can be aversive, demanding, and boring. Children's common tendencies of whining, crying, and hitting can become unpleasant (Patterson, 1980). At-home mothers tend to feel more boredom compared to when pregnant (Ruble et al., 1990). Individual differences exist within this pattern, for example, traditional women reported more positive feelings when performing more child-care than expected; it is theorized that such work validates their values about the traditional nature of marriage and being a woman (Reilly, Entwisle, & Doering, 1987). Less traditional women reported more motherhood satisfaction given less child-care than they expected along with their spouses engaging in more child-care than other spouses (McHale & Huston, 1985).

Motherhood requires a redefinition and reshaping of one's identity. Mothers often neglect their own interests and limit their personal worlds due to responsibilities and time demands of childrearing (Lopata, 1971, pp. 192, 195). Many women continue to question their motherhood competence and are confused about the nature of proper childrearing; they are uncertain of what children need. Spending time with children can be stressful and spending time only with children is related to lower self-esteem (Wells, 1988). Though the activity of raising children can be laborious, women believe that many of the life changes are positive and lead toward greater maturity. When asked, "What are the satisfactions of the homemaker's role?" many women answered with having children, observing their growth and feeling proud of them (Lopata, 1971); children were the most important satisfaction, above general family relations, husband and a happy marriage, and home itself. Supportively, most people want babies and are having them progressively more.

Women encounter difficult issues regarding motherhood choices despite contraceptive and fertility advancements, contributions by the women's movement toward compulsory motherhood and reproductive rights, and improved economic conditions due to employment. These positive forces offer freedom but also limitations for women determining whether to become mothers. The media adds anxiety to making "right" choices pertaining to motherhood motivation and timing, child-care, parenting, and fertility by promulgating these messages:

> Want to have a child? Well don't do it too early. Don't do it too late. Don't do it before you are settled. Don't have an abortion. Don't have an unwanted child. Don't be a single parent. Don't sponge off the State. Don't miss out on the joy of childbirth. Don't think you can do it alone. Don't let your children be reared by strangers. Don't be childless for selfish reasons. Don't have a child for selfish reasons. Don't end up in solitude (Bennett, cited in Letherby, 2002, p. 2791).

Leaving work to have a child may affect one's career which presents an opportunity cost that limits women's choice. An increase in delayed parenting has been one response evidenced by births in the mother's thirties, and over-forties age groups more than doubling since 1970 in the United States. Additionally, 75% of new mothers return to work within one year of giving birth (Barrow, 1999), which for many is too early and exemplifies limited choice. The lack of an organized child-care system and flexible work schedules limits women's choices who work and have family. Motherhood is culturally undervalued – it offers limited social status and financial reward – but nonmotherhood is valued less. Having a child is the cultural norm while those who choose to remain childless are stereotyped as selfish and less mature (Hird & Abshoff, 2000); this norm limits women's choice of motherhood. Motherhood choice is impacted by ideology, economics, and social class, and may be more affected by these cultural factors than individual reasons (Hertz & Ferguson, 1996).

Societal mixed messages about motherhood can result in mothers feeling guilt, ambivalence and/or depression concerning their choices, expectations, and actions. Findings show that continuously employed mothers are viewed as being less dedicated to motherhood and more selfish than stay-at-home mothers (Gorman & Fritzsche, 2002), while women with professional careers or graduate degrees who only work part-time or are stay-at-home mothers are condemned for squandering educational opportunity and not meeting their potential. Further, developmental psychologists state that early maternal attachment and close, continuous bonding is vital for healthy development, but that such care does not guarantee the absence of later psychological issues. Another contradictory message interjects that children are resilient, and other people and experiences can foster the child's long-term psychological health.

Therapists can be instrumental in assisting women and mothers to manage cultural mixed messages, and the

common negatives of motherhood such as guilt, ambivalence, and depression. Counseling may also help mothers to enlarge the family context thus allowing need-fulfillment for both mother and children rather than only the children. Such is possible by enlightening women that their guilt is not solely due to their personal behavior but also to cultural messages defining the "good" mother. Creative thinking about parenting can help mothers understand the love-anger ambivalence frequently evoked with themes such as preadolescents and adolescents (Kurz, 2002; Seagram & Daniluk, 2002); having complete responsibility; being deeply connected to their children; trying to positively develop their children; need to protect children from harm and to control their behavior; dealing with feelings of energy depletion; and feeling guilt and inadequacy. Moreover, the vagaries of children's long-term psychological/emotional outcomes can fuel maternal ambivalence (Arendell, 2000), and such ambivalence continues with adult children (Pillemer & Suitor, 2002). Therapy can assist mothers to resolve the various themes, including: turmoil over children's independence and emotional distance; feeling inadequate given children's failure to meet maturational standards; uncertainty about level of assistance offered to adult children; and feeling positively and negatively about adult children (Rice & Else-Quest, cited in Worell & Goodheart, 2006).

Oberman & Josselson (1996) illustrate a helpful-to-therapists model of mothering that includes a "matrix of tensions" whereby mothers balance between polar tensions that include important developmental themes:

1. *Loss of self versus expansion of self* - This first and primary developmental task of motherhood stems from having a living entity growing within one's own body. Over time, the mother recognizes that the infant is a separate entity from herself.
2. *Experience of omnipotence versus liability* - This developmental challenge involves mothers' reconciling their power over the vulnerable child, the desire to enforce power, and awareness of lessening power and liability over time. Cultural expectations of being a "supermom" may create unrealistic expectations of perfection within family and work domains, including possibly taking care of elder parents.
3. *Life creation and destruction* - Therapists can foster mothers' greater understanding and acceptance of the polarities of intense love and rage that children's behavior can promote. Cognitive behavioral techniques can be explored such as creating healthy separation, timeouts, setting limits, and consequences. Additionally, approximately 50% of women experience varying levels of postpartum blues; therapists can offer help in differential diagnosis between postpartum nonpsychotic and psychotic depression, treatment, support, and medication referral.
4. *Cognitive versus intuitive parenting* - Mothering requires balancing cognitive and emotional reactions to children, and considering advice from others versus one's own interpretation of a child's behavior. Therapists can facilitate mothers' utilization of intuition and rational thought.
5. *Isolation versus community* - Loneliness can abound in a mother-child dyad, therefore, therapists can help mothers to increase inclusion of other adults, children, and enriching experiences.

Mothering has different and changing meanings, in fact, motherhood practices vary throughout historical eras and within ethnic, cultural, and socioeconomic groups. Most agree that the level of emotional care presented to very young children significantly influences later development. Mothers having experienced neglect or abuse, who lack general knowledge, or have unmanageable stress or psychological dysfunction are more likely to endure problematic parenting than mothers in better circumstances (Mowbray, Oyserman, Bybee, & MacFarlane, 2002; Oyserman et al., 2002). Mothering involves ongoing emotional work as children change and a mother's emotions change throughout the day, over time, and in reaction to her support and resources. Crawford and Unger (2004) observe that mother-child dyads constantly change as mothers and children age: "Throughout the process, the mother moves from meeting physical needs to meeting intellectual ones; emotional demands remain a constant" (p. 353). Mothers are challenged to resolve ambivalence, changing feelings, and mixed emotions. A continuous tension exists within the mother-child dyad given a mother's paradoxical wanting autonomy, yet dependence for her child; this conflict persists into parenting adult children. Therapists allow mothers to disclose the conflicting emotions of anger, sadness, and relief in order to understand and accept periodic ambivalence and negativity.

Motherhood possesses certain behavioral demands, including managing/monitoring, caretaking, and nurturing. A woman's maternal personality and capacity for empathy largely affects fulfillment of these demands. Maternal empathic capacity is negatively related to child neglect, unlike depressive symptoms which suggests that parenting ability is more related to stable personality traits than momentary moods. Shahar (2001) noted that capacity for empathy or emotional insight is critical in "emotional intelligence." Empathic capacity proposes connecting with someone and observing changing cues and feedback within a dyadic exchange. The healthy mother-child dyad interaction has been called contingency, attunement, emotional availability, reciprocity, or mutuality (Barnard & Martell, 1995). The crucial personality trait appears to be empathic capacity that rises above individual conditions and situations. Therapists can help women understand the foreseeable conflicts and myths of motherhood which may lead to women providing empathy to themselves as mothers. This heightened empathy may culminate in supportive acceptance of the tension and ambivalence of motherhood.

## 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; Fingerman, 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 my 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, Druggleby, & 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 pole 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 (Prenda & 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

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

**TRUE/FALSE**

1. **Girls in the United States reveal greater flexibility in gender conceptualizations and behavior than boys.**
   A) True B) False

2. **Regardless of women's employment status, they perform more household labor, including child-care, than men.**
   A) True B) False

3. **Comparable to dating relationships, women are more attuned to relationship concerns and experience dissatisfaction before men.**
   A) True B) False

4. **People who are low in instrumentality experience less depressive symptoms than individuals high in instrumentality.**
   A) True B) False

5. **Marriage tends to insulate men, but not women from depression.**
   A) True B) False

6. **Most agree that the level of emotional care presented to very young children significantly influences their later development.**
   A) True B) False

7. **Though the activity of raising children can be laborious, women believe that many of the life changes are positive and lead toward greater maturity.**
   A) True B) False

8. **After divorce or widowhood, women remarry less often and do so less quickly than men.**
   A) True B) False

9. **Physical activity cannot increase physical functioning or slow the development of functional declines.**
   A) True B) False

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10. **Many older women unrealistically believe that exercise at their age is risky.**
    A) True B) False

11. **Women tend to avoid taking _____ in school which can impede career choice.**
    A) mathematics
    B) English
    C) music
    D) history

12. **Research advocates that couples should not drop below a ratio of _____ positives to one negative to maintain a positive relationship.**
    A) two
    B) five
    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. **Some factors that facilitate a positive transition from girlhood to womanhood include _____.**
    A) equitable treatment at home and school
    B) healthy and positive relationships and role modeling
    C) active engagement in empowering experiences
    D) all of the above

15. **Research shows that men more frequently use a distracting style in response to depression while women use a _____.**
    A) dissociative style
    B) rationalization style
    C) ruminative cognitive style
    D) reaction formation style

16. **Mother and father gender roles frequently become _____ after birth of the first child, despite pre-existing sharing tendencies.**
    A) more traditional
    B) less traditional
    C) confused
    D) erratic

17. **The notion that middle-age is fraught with crisis and self-doubt is _____.**
    A) an axiom
    B) not supported by research
    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. **Employed women believe employment offers advantages such as _____.**
    A) mental stimulation
    B) use of skills
    C) interpersonal relationships
    D) all of the above

20. **Married people _____ than those never married, separated or divorced.**
    A) live shorter
    B) live the same number of years
    C) live longer
    D) are less happy

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