# The Effects of Multiple Roles and Social Networks On the Physical and Psychologic Health Of Middle-aged Women

By

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# DEDICATION

*I dedicate this thesis project*

*to my daughters,*

***Megan Amanda** and **Whitney Ryan.***

*Thank you for allowing me to fulfill*

*my most rewarding role in life*

*with joy.*

## ACKNOWLEDGEMENTS

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## ABSTRACT

TITLE: The Effects of Multiple Roles and Social Networks on the Physical and Psychologic Health of Middle-aged Women

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Relatively little is known about the health needs and concerns of one of the fastest growing subgroups of the population – women in midlife. What is claimed to be understood has been obtained largely through studies using adult males as both the subjects of research and as the standard of health for both genders.

Even less is known about the impact of multiple roles for midlife women within their social network structures, and the potential impact of these variables on health. The paucity of research in this area is alarming considering that middle-aged women are enacting the largest number of life roles they will ever have. This is occurring during a time of rapid change for this cohort of the population. Women are choosing entry into professional careers first and forgoing childbirth until the third, and even fourth, decade of life. In addition, the population of elder citizens – mostly women, is also growing, and midlife women will be called upon to be their caregivers. The health impact of these and other life roles for middle-aged women is largely unknown.

The purpose of this qualitative study was to identify and examine the physical and psychologic health impact of multiple roles and social networks on midlife women through analysis of their lived experiences. The phenomenological method of inquiry was used for

this purpose, and as a means of respecting women as the accurate sources of this knowledge.

A snowball sample of six Caucasian women between the ages of 35-65 were chosen to participate in group sessions and individual follow-up interviews. Informal interview guides were used to extract information on the variables of interest. Interviews were audiotaped, transcribed verbatim, and analyzed for significant meaning using the techniques of Colaizzi (1978) and Van Manen (1990).

The meaning of multiple roles, social networks, and health emerged from shared stories. While women reaped many benefits of engaging in various life roles and social networks, negative aspects of both variables were identified and examined for their potential impact on health. Themes emerging from lived experiences included the fast pace of life, isolation, the need for personal time, and self blame. Two core experiences common to all participants were a sense of disillusionment with life and lack of control in making life choices.

Women are twice as likely to use health care services than men, yet little is known about the health needs of this segment of the population from their unique perspective. This study adds to the body of nursing knowledge about the impact of multiple roles and social networks on women's health. It will also aid nurse professionals in providing health care that focuses on the needs of women within the context of their daily lives.

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# CHAPTER ONE

**"I live in the land of my middle years –**

**somewhere in the center of my life's space, time, and being.**

**I live it in the middle of a world peopled by friends, family, co-workers,**

**and many others;**

**in the middle of a world that perplexes me.**

**As I experience my life, I stand apart from it, yet squarely in it.**

**I try to capture its meaning – to understand it".**

(Brown, 1994, p. 43)

# Chapter One

## Introduction

This chapter presents the purpose statement, research question, and statement of the research problem. Support is given to the significance of this study to the art and science of nursing.

## Purpose Statement and Research Question

The purpose of this study was to identify and examine the multiple roles middle-aged women occupy in our contemporary western society within the context of their social network structures. The impact of both variables on women's perceptions of their physical and psychologic health was revealed via analysis of the lived experiences of midlife women. Through this method of inquiry, the researcher developed an understanding of the following research question: What perceptions do middle-aged women have regarding the impact of multiple roles and social network affiliations on their physical and psychologic health?

## Statement of the Research Problem

Relatively little is known about the health needs and concerns of middle-aged women with exception of reproductive issues and menopause (Bruenjes, 1994; McKinlay, Triant, McKinlay, Brambilla, and Ferdock, 1990; Thomas, 1995). The paucity of research in this area is alarmingly disproportionate considering that middle-aged women comprise one of the fastest growing subgroups of the population. It is estimated that by the year 2000, the number of midlife women between the ages of 35-64 will be approximately 42% of the

female population (Duffy, 1988). Although women live longer than men (an average of 7.5 years), they will live their middle and elder years with more chronic and disabling conditions – in many cases three or more (Clancy and Massion, 1992; Dyehouse, 1992; Massion, Clancy, and Maxwell, 1995; Thomas, 1995).

Furthermore, much of what is claimed to be "understood" about women has been obtained indirectly through studies using adult men as both the primary subjects of research, and as the 'gold standard' of health for both genders (Adesso, Reddy, and Fleming, 1992; Geary, 1995; Kasper, 1983; McBride and McBride, 1994; McKinlay et al., 1990; Murphy, 1995; Pinn, 1992; Rose, 1990). Historically, male functioning and behavior has been considered the norm from which women deviate. Women's health, therefore, has been understood in the context of male health – often distorting phenomenon that is uniquely female (McBride and McBride, 1981). The multiple roles middle-aged women occupy within their social network structures are different from those of middle-aged men and must be studied from women's perspectives in order to comprehend the effects of these variables on health.

The literature is notably sparse on studies of the interrelationships of the many roles middle-aged women assume in our society and the potential consequences on health. Research regarding multiple role responsibilities focuses primarily on the effects of these roles on marital and family relationships, especially that of paid worker, and fails to consider the larger impact of multiple roles on women themselves (McKinlay et al., 1990; Woods, Lentz, and Mitchell, 1993). Debate continues as to whether the assumption of multiple roles has a beneficial or detrimental effect on women's health (Baruch and

Barnett, 1986; Froberg, Gjerdingen, and Preston, 1986; Waldron and Jacobs, 1989). Even greater uncertainty exists as to whether social networks exert an overall positive or negative impact on health for women (Thoits, 1982: Wallston, Alagna, DeVellis, and DeVellis, 1983). While definitions of social support and social networks have historically emphasized the positive attributes, research suggests that not all social ties are supportive, especially for women (Tilden and Galyen, 1987).

Middle-age is a time when women are enacting the largest number of life roles including labor force participant, spouse/partner, parent, friend, and often caregiver to aging family members. Within each role are tasks and responsibilities that, in combination, can overwhelm women in their daily lives. Obendorf (1992) reports that by the beginning of the twenty-first century, 80% of all women in the United States between 25-64 years of age will be in the labor force while simultaneously acting as the principle caretakers of all family members. This remains true at a time when many women are choosing entry into professional careers first and postponing parenthood until their late 30's and early 40's. In 1989, the number of first births to women aged 35 and older was 46.3 per 1,000 compared to 12.4 per 1,000 in 1975, and by 1990, the rate of first births to women between 40-44 years reached 1.2 per 1,000 (Quimby, 1994).

Coinciding with the change in maternal age is the increase in the population of elders – primarily women, who are living longer with multiple chronic illnesses. Midlife women will be called upon to care for these family members (Dimond, 1993; Finucane and Burton, 1995; Green, 1991; King, 1993). Russo (1990) estimates that 72% of the 2.2 million people caring for the 1.2 million elderly persons living at home are women.

According to Brody (1995) and Quimby (1992), this additional role alone will require 20-28 additional hours per week, and is often performed without financial compensation or validation.

Women have historically been, and continue to be, the primary caregivers and supportive nurturers to family members while holding their own in the labor force. This trend will obviously continue for middle-aged women as they continue to work outside the home, wait longer to bear children, and provide care to elder parents and extended family members. Instead of redistributing role responsibilities with other members of their social networks to create a more egalitarian system of task distribution, women report assuming a disproportionate amount of the responsibility for the household, children and family while continuing to 'bring home the bacon'. As Green (1991) states, "labor that has been traditionally performed by women and has gone unrecognized in terms of money or status is hard to distribute" (p. 7).

The time and energy commitment to these roles, combined with other life roles such as spouse/partner, homemaker, and friend, may have an enormous impact on women's health. The physical and psychological consequences of the tremendous contributions middle-aged women make to these roles, in concert with their social networks, is largely ignored (Dimond, 1993; Green, 1991; Nolan, 1986). Nursing research has yet to acknowledge women as the accurate sources of wisdom about their lived experiences of multiple roles and social networks by asking them directly about the impact of these variables on their perceptions of mental and physical health.

## Significance to Nursing

This study is significant to the nursing profession in several ways. First and foremost, the body of nursing knowledge regarding one of the fastest growing subgroups of the population will be expanded. The numbers of middle-aged women continue to increase, while knowledge of their health needs and concerns is still lacking due to insufficient research using midlife women as subjects. Furthermore, women are twice as likely as men to utilize health care services (Clancy and Massion, 1992; Connors, 1985; Duffy, 1988; Kasper and Soldinger, 1983; Lempert, 1986; Thomas, 1990; Wood, 1994), and are considered to be the 'gatekeepers' of family health. Women are, however, more likely to experience greater barriers to care and gender discrimination. How can health care professionals provide adequate services to a subgroup of the population for whom little is known, but who access services the most?

Secondly, the phenomenologic method utilized in this study supports the holistic framework that is the hallmark of the nursing profession. The philosophy of 'wholeness' or 'holism' sets nursing apart from the traditional methods of scientific inquiry that are inclined to embrace a reductionist approach to research (Chinn and Kramer, 1995). Investigation of the lived experiences of participants from their perspective provides a closer conceptual fit with nursing, and is similar to the philosophies expressed by all major nursing theorists (Beck, 1994; Cohen, 1987). Tilden and Tilden (1985) provide support for the qualitative method by claiming that:

> for the science of nursing to be relevant to the practice of nursing, nurse researchers cannot rely solely on scientific rigor to seek knowledge. Personal knowledge that

> accrues from personal engagement in nursing practice must guide the thrust of scientific inquiry to produce knowledge of nursing in human terms (p. 88).

The phenomenologic method allows for personal engagement to occur while respecting women as the only accurate sources of information regarding their health. A thorough knowledge of the health needs and concerns of midlife women must start with personal dialogue. Failure to begin by listening to the voices of women will lead to the provision of health care services that have little meaning or value for this subgroup of the population.

Lastly, nurses constitute the overwhelming majority of health care professionals. Many providers are middle-aged women with numerous life roles and various social network affiliations. Nurses may gain personal insight of the effects of multiple roles and social networks on their own health, thus reaping benefits as both providers and consumers of health care.

This study will increase the knowledge base of middle-aged women, and may provide insights into the social and role-related systems that perpetuate gender imbalances with regard to access, delivery, and research in women's health. Information based on the lived experiences of women is essential to nurses in providing health care services important to midlife women, and in taking politically responsible action that supports equality in health care access and research.

# CHAPTER TWO

## Stress-Anger Recipe

**1 cup crushed ego**

**1 teaspoon job discrimination**

**1/4 teaspoon chauvinism**

**1 well-beaten path to the**

**washing machine**

**1/2 teaspoon grated nerves**

**1 pinch from a man on the street**

**1 dash from the dentist and home in heavy traffic to**

**release the babysitter**

**Mix all ingredients together and stir violently. Cook until you get a slow burn and then add one last straw. Serves 53% of the population**

(Author unknown. Appeared in a column by Ina Hughs
in the Knoxsville News-Sentinel, April 30, 1992.
As cited in Thomas and Donnellan, 1993, p. 112)

# Chapter Two

## Review of Related Literature

This chapter presents a review of the literature relevant to the research question and states assumptions regarding the variables of interest. The philosophical underpinnings of the study are conceptualized within a framework grounded in feminist poststructuralsit theory that links the research question and literature review to the chosen methodology.

The literature review begins with an analysis of studies of the primary roles women currently occupy in contemporary western society including paid worker, spouse/partner, parent, homemaker, caregiver, and friend. Research regarding women's social networks will follow. The focus will be on studies of middle-aged women as is feasible, given the paucity of available research on women in this age group. The review will conclude with a summary of the literature on multiple roles and the potential health implications for midlife women.

## Paid Worker Role

When women began rapidly entering the workforce following the women's liberation movement three decades ago, concern was expressed as to whether this "additional" role was beneficial or detrimental to a woman's health (Baruch and Barnett, 1986; Froberg et al., 1986; Waldron and Jacobs, 1989). This concern reflected a societal uncertainty of the ways in which employment would impact traditional homemaker and motherhood roles. A 1963 advertisement for Travelers Insurance portrays the culturally excepted sphere for women in relation to paid work outside the home:

keeping house and caring for the kids fills a woman's day – and more. But what if

she had to earn a living too? Your wife will never have to face this double duty if you protect yourself (Wallis, 1989, p. 80).

Due to societal views of women's accepted functions, research has historically focused on the impact of the paid worker role in relation to family and social tasks, and has failed to address the health effects of this variable in isolation on women's health (Hartman, Kuriansky, and Owens, 1996; McKinlay et al., 1990; Woods et al., 1993). This is perhaps due to a culturally grounded inability to view women apart from reproductive, maternal, and other social roles, while supporting men's long accepted place in the working world. Studies of the health impact of employment for midlife women are notably sparse.

One of the primary concerns related to women entering the paid work force centered on the influence of this role on pregnancy and motherhood. The 1970's and 80's saw not only an increase in the shear numbers of working women, but a new phenomenon – women choosing to work throughout pregnancy. Women were also choosing to return to work early in the postpartum period. This change was precipitated by the adoption of the 1972 discrimination statutes extending the 1964 Civil Rights Act. These statutes mandated protection of a woman's right to work during pregnancy (Brown, 1987).

This legal triumph required health insurance benefits to be extended to female employees "disabled" by pregnancy, miscarriage, abortion, or childbirth, or "recovering" from these conditions (Brown, 1987). The days when women stopped working after they 'began to show' soon became an antiquated practice. Although most early research focused on neonatal outcomes of pregnant, employed women, several studies have

focused on the health effects of work force participation on the health of the pregnant woman herself.

Brown (1987) conducted a quantitative study of 313 partnered pregnant women to assess the health status and level of social support perceived by pregnant women working outside the home and homemakers. Subjects ranged in age from 16-42 years of age and represented various educational and socioeconomic backgrounds. The majority (87%) were Caucasian, and 97% were married. Study subjects were equally divided between paid workers and domestic workers. All participants were in their second trimester of an uncomplicated pregnancy. Participants completed the Support Behaviors Inventory (SBI), the Health Responses Scale (HRS), and an employment inventory created by the researcher.

Point biserial correlations indicated a statistically significant relationship between employment outside the home, reported health status, and satisfaction with social support. While employed women experienced greater incidences of fatigue, leg cramps, and daily stress, they reported a higher level of overall health and feeling of control over the pregnancy than did the homemakers. Furthermore, homemakers placed more value on social support, yet reported significantly less satisfaction with their support networks than did employed women.

Caution should be taken in interpreting the results for several reasons. First, the researcher fails to address reliability and validity of the employment inventory tool. Secondly, it is difficult to determine whether healthy women are more likely to be employed outside the home regardless of pregnancy status. Pregnant women with

increased adverse symptomatology may leave the work force during pregnancy, leaving women without complications in the work force. Results cannot be generalized to non-Caucasian or lesbian women.

Rankin (1993) conducted telephone interviews with 118 working mothers with a mean age of 32.75 years who had preschool children attending daycare to determine the stresses and rewards of being an employed parent. The majority of subjects were Caucasian, middle-income, married women with an average of 13.3 years of education. Participants responded to the Working Mothers Questionnaire designed by the researcher for the study.

Although participants experienced stresses related to time constraints, child-related problems, and maternal guilt feelings of having to leave their child in the care of others, several benefits to working outside the home were identified. These included personal rewards, ability to make a financial contribution to the family, improved quality of family life, and making a societal contribution. The interpersonal rewards of employment alleviated the experience of role conflict for these women. Reliability and validity of the research tool need to be tested with further studies, and results are significant only to women fitting the sample characteristics.

In a longitudinal study of 93, 576 married women aged 15-59 at the time of the 1971 census, and followed through 1986, Weatherall, Joshi, and Marcan (1994) studied the effects of the combination of parenthood and employment on women's health. Utilizing a data set that matched census characteristics to mortality data, the investigators identified working female parents and homemakers with children and correlated mortality data over

a fifteen-year period. The researchers concluded that combining parenting and work force participation exert a neutral effect on women's health. Both variables failed to show a beneficial or detrimental effect on mortality either independently or as combined variables.

Due to the fact that mortality data were used as predictors of health, few conclusions can be drawn from this study. Many other confounding factors exist that may have influenced mortality, independent of parental or work status, such as age, genetic predisposition, and accidental death.

In an effort to determine the potential benefits of the work experience for women, Aston and Lavery (1993) studied 120 women in various occupations with clerical, managerial, and professional backgrounds. Participants responded to the Rosenberg Self-esteem Scale, The Depressed Mood Scale (CES-D), and Andrew's Quality of Life Scale. Physical well-being was measured using an eleven-item self-reported symptomatology inventory adapted from the Health Opinion Survey (1957) while quality of the paid worker role was assessed by a 22-item scale developed by Baruch and Barnett (1986). Subjects also completed the Sarason's Social Support Questionnaire Scale (1983).

Using corelational and hierarchical multiple regression analysis, findings suggest that the paid worker role for women is a rewarding and health-enhancing experience. Although negative aspects of employment were expressed such as having too much to do, juggling conflicting tasks, and lack of recognition, the rewards of paid employment outweighed the negative characteristics of work for these women. Rewards included a sense of accomplishment, opportunities for learning, performing challenging and stimulating work, appreciation and recognition, and the opportunity for advancement.

Bromberger and Matthews (1994) recruited 541 menopausal women between the ages of 42-50 who participated in a prospective study involving an initial interview in 1983, and a follow-up session in 1985. Participants were categorized at each of the two interview encounters as either employed, unemployed, newly employed, or newly unemployed, then were given the Beck Depression Inventory (BDI). One-way analysis of covariance (ANCOVA) revealed that at study entry, non-employed women had a significantly higher mean BDI score than did employed women. At follow-up, newly unemployed women showed a statistically significant increase in symptoms of depression from baseline, while newly employed women showed a decrease in depression symptomatology. Participants who were continually employed for the three-year period had relatively little change in BDI scores, suggesting that women who work outside the home are psychologically healthier than those who do not. Results should be utilized carefully due to the fact that the sample population was not well defined, and it is unknown whether subjects had any pre-existing psychiatric illnesses prior to, or during, the course of the study.

Using a grounded theory approach, Keddy, Cable, Quinn, and Melanson (1993) analyzed the stories of seven older Caucasian women who had worked outside of the home during the 1920's and 30's, and who had experienced interrupted work histories due to marriage and raising families. Women shared stories of their work life from their first job through the retirement process. Many factors contributing to the fragmentation of their paid work life were described including becoming a homemaker, performing unpaid family work, caring for ill children, or leaving the labor force as a condition of marriage.

Subjects also portrayed the general disapproval of women in paid employment in a patriarchal society. One woman described her experience of being "forced" to resign her position as a school teacher when she decided to marry stating "you weren't allowed to teach once you were married...not even substitute" (p. 444). These women attributed broken job histories to feelings of lower self-esteem, anger, and lack of accomplishment. When asked what she would do differently if she had the opportunity to live her life over, another participant replied:

> I would become somebody, make big money, that's what I'd do. I would be remembered for more than my fish batter (p. 444).

Analysis of shared stories further revealed themes of low social status, lack of power, and a tendency for self-blame for not getting more education and remaining in the work force. Additional qualitative studies are warranted with women of various cultural and socioeconomic backgrounds as a means of understanding the meaning of work for women, and the potential link between interrupted work histories and health outcomes.

Aber (1991) conducted a study of 157 widows aged 55-75 to assess the effect of employment on health during the bereavement period after the loss of a spouse. Participants completed the Widowhood Questionnaire, a tool developed specifically for the study. Cronbach's alpha test for reliability of the instrument was .80 for work attitude and .82 for work history. Over the period of their married lives, 76% of subjects reported working outside the home in some capacity, while 24% were never employed in paid work. Step-wise regression was used to determine which of eight independent variables had the greatest power in predicting health during bereavement. A work history and a

positive attitude toward working outside of the home were the two most significant predictors of well being during the bereavement period regardless of whether or not participants were currently employed. Findings suggest that the paid worker role offers a measure of health protection during stressful periods by adding meaning and purpose to life, increasing self-confidence, and as a source of social support. The sample is not sufficiently described with regard to socioeconomic or cultural characteristics, and repeated studies are needed to further determine the reliability and validity of the research tool.

In summary, the paid worker role has been shown to exert a beneficial effect on the physical and psychological health of women regardless of the number of other life roles women engage in (Aston and Lavery, 1993; Baruch and Barnett, 1986; Hartman, Kuriansky, and Owens, 1996; Nathanson, 1980; Verbrugge, 1985, Waldron, 1980). Employed women are also more likely to have health insurance which increases access to care. In addition, workers tend to have more resources and support within the work place for participating in positive health practices such as smoking and substance abuse cessation.

The fact that this role is often viewed as an 'addition' to the numerous other roles women occupy in our fast-paced western society perpetuates unequal division of labor between the sexes and may be a major causative factor in women's negative appraisals of employment including role conflict, juggling tasks and time, and "having too much to do" (Aston and Lavery, 1993, p. 21). The potential stress of the paid worker role combined with other roles may negatively impact more women in the future, given that women's

work force participation is increasing while male employment activity is expected to decline (Wynne, 1994).

In addition, women still have to work harder and longer to earn wages that continue to fall below their male counterparts for comparable work, and often suffer personally and financially from interrupted work histories (Velsor and O'Rand, 1984). Wynne, (1994) reports that the pay differential between the sexes,

> is now even a wider differential in the non-manual sector for both hourly and weekly wages than at any time since the Equal Pay Act came fully into force in 1975. (p. 2).

Unfortunately, the societal view of the paid worker role for women continues to lag far behind social reality (Baruch and Barnett, 1987), and as Oakley (1986) determined – women still work outside the home when it suits the nation.

## Spouse/Partner Role

Historically, heterosexual coupling and marriage were accepted as the cultural, moral, and religious norm – the goal of every young female. If a woman had not been chosen as a mate before middle age she was often branded as an 'old maid' with the assumption that something was wrong with her that rendered her unacceptable as mate material. In today's society, other forms of partnerships are recognized and accepted as alternative choices to marriage, including heterosexual cohabitation and lesbian relationships.

Many studies exist that evaluate various aspects of heterosexual marriage for women, primarily in the context of other life roles. Research is lacking in all aspects of alternative partnerships, including multiple roles and social networks for these individuals. Literature reviewed for the purpose of this study includes selected aspects of the primary partnership

roles middle-aged women are most likely to be engaged in, in contemporary western society: heterosexual spouse, heterosexual cohabitant, and lesbian partner.

Kurdek (1994) studied 75 gay, 51 lesbian, and 108 heterosexual couples who were childless. The goal of the study was to compare areas of conflict reported in their relationships, and to relate the frequency of conflict to both current relationship satisfaction, and change in satisfaction over a one-year period. Subjects were primarily white, middle-class, educated professionals in their late 30's and early 40's. Each individual within the sample completed identical questionnaires concerning marital satisfaction and conflict at the beginning of the study, and one year later. Utilizing one-way multiple analysis of variance (MANOVA) to control for age, education, income, and duration of relationship, the three types of couples were found to experience the same kinds of relationship conflict. Multiple regression analysis confirmed these findings.

Areas that created conflict in all three types of relationships (in rank order) included: intimacy, power, personal flaws, social issues, and distrust. Furthermore, the relation between frequency of conflict and relationship satisfaction was identical for all couples. The study represents one of the first attempts to describe and compare the nature of conflict and satisfaction for gay, lesbian, and heterosexual couples. The findings however, can only be generalized to well-educated, Caucasian couples without children.

Prior to becoming a socially approved partnership choice, heterosexual cohabitation was sanctioned as "a part of the courtship process and not an alternative to marriage" (Macklin, 1987, p. 320). Utilizing data from the 1987-1988 National Survey of Families and Households (NSFH), Schoen and Weinick (1993) reviewed characteristics of 349

married and 157 cohabiting couples aged 19-29. Subjects were of various ethnic backgrounds. The goal of the study was to determine the patterns of partner choice. Couples who were married or cohabiting on the survey date, and who began their relationship within the 24 months preceding the study were included. Characteristics examined were age, education, religion, and race.

Using cross-tabulations, or arrays, the overall propensity to marry was found to be greater than the inclination to cohabit. Significant differences emerged in characteristics of mates sought for each relationship. Cohabiting women were more likely to choose partners with the same educational level, whereas married women tended to favor someone of the same age, religion, and race. Results support the theory that cohabitors are not necessarily seeking mates as a precursor to marriage but that these couplings are an alternative to marriage for many people. Studies of patterns of partner choice provide insight into how these relationships differ, and point to the need for additional research on the types and characteristics of relationships desired by middle-aged women.

Loomis (1994) concluded from her study of 4,483 black and white women who responded to the NSFH survey that race and socio-cultural differences exist between married and cohabiting relationships regarding childbearing practices. Black women and economically disadvantaged Caucasian women had increased birth rates for both types of relationships with the vast majority of couples in this subgroup conceiving within the first year of a new relationship. Caucasian women with higher socioeconomic status involved in cohabiting relationships had significantly lower childbirth rates than their married counterparts regardless of age. As profound changes in coupling and childbearing

patterns continue in the United States, additional research is needed that increases knowledge of the reasons women choose certain coupling patterns, and the costs and benefits of these relationships for women.

The current ideal in our western culture continues to be the heterosexual marriage union. In her meta-analysis of the literature on feminism and family research, Thompson (1993) proposes a "gender perspective" as a means of expanding current thinking and theory development of the impact of gender on marriage. She concludes that gender inequities continue to be prevalent in heterosexual marriage in the following spheres: division of household labor, political and economic power, and position in the social hierarchy. Thompson suggests that the gender perspective be utilized in research to move beyond blaming society, men, or women for perpetuating role inequality in marriage to identifying conditions necessary for a shift in thinking to occur. This analysis highlights some of the characteristics that may make marriage unhealthy and unattractive as a coupling choice for many women, while identifying the culturally based underpinnings that influence women to continue to desire marriage.

Langhinrichsen-Rohling, Smutzler, and Vivian (1994) compared 81 couples seeking therapy for marital conflict with 51 married community controls who scored at least 200 on the Dyadic Adjustment Scale, and had a negative history of spousal aggression. Participants were middle-income couples in their late 30's and early 40's who had been married between 12-14 years. Pertinent characteristics of the couples such as race and parental status were not described. Using MANOVA to compare perceived relationship

positivity, controls were found to have significantly higher ratings of frequency and quality of communication, caring gestures, and reports of happy memories with their spouse.

Of the couples seeking therapy, a husband's aggressive behavior was the major factor in marital discord. Interestingly, the most aggressive husbands in this study rated themselves as performing more caring activities in the relationship, while receiving less care from their spouse. Within coupling types, much variation exists as to what constitutes a health-enhancing relationship for women. Due to the fact that abuse and inequalities are prevalent relationship problems in our society – regardless of the relationship type, additional research is warranted that examines how various coupling patterns effect women's health.

Studies were unavailable in the literature on the characteristics of partner roles of lesbian women, which is a large gap in need of attention by nurse researchers. In regards to partnership issues impacting health, lesbian women report concerns over rights to health benefits and control of a partner's wishes in the event of a serious illness or disability (Haas, 1994). Little is known about the meaning of multiple roles and social networks for this subgroup of the population, therefore determinations of the health impact of this role cannot be made in the context of partner choice.

Although many studies exist on various aspects of heterosexual marriage and cohabitation, few specifically address issues of midlife women, and even less is known about the meaning of multiple roles for lesbian women. While similarities exist in gay, lesbian, and heterosexual relationships regarding conflict and satisfaction issues, much individual variability exists in all partnerships. Research has illuminated several differences

between cohabiting and married couples regarding partner characteristics and childbearing practices. More research is needed that investigates how western culture has evolved to being more socially accepting of alternative partner choices, what forces attract women to particular coupling relationships, and the characteristics of healthy relationships for women.

## Parent Role

The literature abounds with research on women and the parent role due to the intimate link between a woman and her reproductive functions. In an effort to narrow the literature review on the parent role, studies relevant to middle-aged women with multiple roles were chosen. As a basis of comparison of childrearing issues of mothers versus fathers, two studies were chosen for review.

The current trend for professional women is postponement of childbearing until the third, and even fourth decade of life (Quimby, 1994). Meisenhelder and Meservey (1987) used a descriptive, correlational method to gain knowledge of women's postponement of conception and satisfaction with the maternal role. Participants were 68 Caucasian, middle-income, married women between the ages of 29-38 who were employed professionals. The primary reasons women identified for delaying childbirth (in rank order) were:

1. Needed time to develop the marriage
2. Needed time to develop a career
3. Needed time to establish financial base, home, or husband's career
4. Infertility

5. Recently married

Adjusting for age, socioeconomic status, and infertility history, the frequency scores for maternal satisfaction were significant. The mean score on the Maternal Attitude Questionnaire (MAQ) was high, as was the standard deviation for the sample, suggesting disparity amongst the subjects. Participants' averaged a lower response to the positive aspects of parenting, but showed much higher tolerance of the negative aspects of parenting. A factor in the outcome may be that 62% also reported being the primary child-care provider in the relationship. The two variables with the most significant impact on maternal satisfaction were age and positive history of infertility. Results cannot be generalized due to the relatively small homogenous sample.

Klein (1987) studied the childbearing choice of professional women to examine the relationship between career commitment and childbearing values, intentions, and behaviors. One hundred-fifteen women aged 23-40 who were either professionally employed or completing an advanced degree, responded to mailed questionnaires. Findings indicate that professional women perceive career goals as a deterrent to childbearing. Women least committed to career goals expressed plans to conceive in the near future while those with the highest commitment to their profession were the most ambivalent about starting a family. Sixty-three percent of respondents intended to have a child "someday", while 18% indicated "not ever wanting to have a child" (p. 25). This trend has tremendous implications for midlife women's health, and for the future of the American family. Two handicaps of the study exist: the homogenous nature of the sample, and the lack of psychometric testing of the research tool.

Divorce has also become commonplace in western society, prompting several studies of the effects of marriage dissolution on the family. Fishel and Samsa (1993) examined gender role perceptions of middle-aged parents during the transition from marriage to divorce for a sample of 101 women and 87 men. Structured, qualitative interviews revealed gender differences in perceptions of the co-parent relationship. Fathers perceived more financial responsibility for children while women focused on parenting issues. Fathers also reported feeling supported by their ex-wife in their new role, while women felt less supported and stated that parenting issues frequently led to arguments.

A significant finding of the study was the stated reasons each spouse gave for divorce. Women felt that changing their roles was a major factor leading to marital discord. Ex-husbands reported feeling unable to meet their former wives' needs, while viewing them as "having become less domestic and more independent" (p. 94). Results cannot be generalized to individuals not meeting the homogenous sample characteristics.

To assess differences in parental roles regarding participation in childcare, Heermann (1992), and Tiedge and Darling-Fisher (1993) conducted quantitative studies to address similar research questions. Heermann (1992) studied 351 families with healthy infants from uncomplicated pregnancies to explore the relationship of maternal employment and infant characteristics to division of infant caregiving. Mothers provided the vast majority of infant caregiving with little variation based on employment status. Controlling for demographics, infant characteristics were weak predictors of maternal caregiving and predicted only a small amount of variance in paternal caregiving.

Tiedje and Darling-Fisher (1993) used the Social Address Model (SAM) to examine demographic factors that influence a father's participation in childcare. Trends were examined in two heterogeneous data sets of 353 couples using the following variables: physical care, playing interactively, and getting up at night with the child. Congruent with past research, fathers and mothers reported similar amounts of time spent in childcare, but differed significantly on the type of care given. Fathers played more with their children, but were much less involved in direct physical care activities including getting up during the night. Using multiple regression analysis, fathers' education and work hours were the only variables consistently related (inversely) to participation in childcare. Characteristics of the sample population are not well defined making generalizability difficult.

In her qualitative study titled *"Day Care for Ill Children: An Employed Mother's Dilemma"*, Thompson (1993) described the process employed mothers use to make child care decisions for their children who become sick during working hours. Twenty married, full-time working mothers of preschool children responded to open-ended interview questions created by the researcher for the study. Participants were either Caucasian or Asian American, middle income women, between the ages of 21 and 50 (75% fell between the ages of 31 and 40). The major themes of anxiety and decisional conflict between work and motherhood responsibilities, and limited care options were identified.

Factors influencing decisions regarding sick children and work included: severity of

illness, available options, job flexibility, and availability of paid leave. Although fathers were identified as "caregiver options" (p. 82), the majority of the responsibility for juggling work and child responsibilities fell squarely on the working wife – hence the title *"A Working Mother's Dilemma"*.

As early as 1986, 54% (31.8 million) of American children had mothers who were employed outside the home in some capacity (Rodgers, Morgan, and Fredricks, 1986). As a result, the parental role for women has become intimately associated with her role as paid worker – and nowhere is this more evident than in the population of middle-aged women. This trend will only continue as women wait longer to have children while simultaneously increasing workforce participation. The cultural reality is that women, regardless of marital status, continue to assume the lion's share of domestic and caregiving roles while contributing financially to the family. The potential health impact of the combination of multiple role responsibilities has yet to be fully understood for the midlife woman.

## Homemaker Role

Traditionally, the homemaker role has encompassed tasks and responsibilities associated with home maintenance (shopping, cooking, cleaning, laundry, etc...) and the role of parent. The following review focuses primarily on the maintenance aspects of the role. Childrearing is discussed in more detail in the previous section titled *Parent Role*. Also, while many theories have been developed to account for gender differences in the division of household work (Primeau, 1992), such an analysis is beyond the scope and purpose of this review.

Feminist scholars were among the first social scientists to expose inequities in women's unpaid work in the home and to give a formerly "invisible" role attention as both economically relevant and socially discriminating (Primeau, 1992, p. 981). Although recent studies indicate that change is occurring in the distribution of household labor (Feree, 1991), the division of work inside the family has been extremely resistant to change, despite major social changes for women outside the home (Coltrane, 1996; Hochschild, 1987; Gunter and Gunter, 1991; Primeau, 1992; Rexroat and Shehan, 1987; Ward, 1990). Overwhelming evidence exists of the considerable time and energy women expend compared to men in the homemaker role regardless of their status as labor force participants or time spent in other life roles (Coltrane, 1996; Gunter and Gunter, 1991; Hartman, 1987; Hoschschild, 1987; Primeau, 1992, Ward, 1990).

In *The Second Shift*, sociologist Arlie Hoschschild (1987) presented data from personal interviews with fifty couples attempting to balance family and employment responsibilities. She concluded that the women in these relationships spent fifteen hours more per week than their spouses on all types of work - paid and unpaid - equaling a full extra month of 24-hour workdays per year. From his meta-analysis of the literature and personal interviews with Hispanic couples, Coltrane (1996) reports that women perform over 2/3 of the total household work regardless of employment status. He further states that for women, the addition of the roles of spouse and mother "have traditionally increased wives' domestic labor while men's' domestic labor typically remains unchanged" (p. 47). Results of his study can only be generalized to Hispanic married couples.

Thompson and Walker (1989) state that although men report performing more housework than ever before, the actual increase is approximately 10% (from 20%-30%), but that gender-specific tasks have not changed over time. Women continue to perform the repetitive, unrelenting, and routine tasks of shopping, cooking, laundry, and house cleaning, while their male partners perform more of the infrequent, irregular jobs such as taking out the trash, lawn mowing, and household repairs. Furthermore, women report performing an average of three household tasks at one time which may partially explain why they find housework more stressful than men (Shaw, 1988).

Maret and Finlay (1984) studied the distribution of household labor among women in dual-earner families. A subsample of 622 women aged 30-44 years was obtained from the National Longitudinal Survey of Work Experience. Respondents completed a six-item questionnaire on level of involvement in the following tasks: grocery shopping, childcare, cooking, washing dishes, cleaning house, and washing clothes. Controlling for race, education, employment status, income, and attitude toward housework, 40-60% of respondents reported having sole responsibility for all six tasks.

The wife's income was the most significant predictor of the degree of task sharing between spouses. As the wife's wages increased, time spent doing housework decreased, supporting the notion that "it is the wife's relative economic contribution in the household that determines her power and domestic responsibilities" ( Maret and Finlay, 1984, p. 362). Findings should be utilized with caution for several reasons. Male spouses did not participate in the study, which may have biased results. The researchers also focused on

tasks traditionally performed by women making it difficult to ascertain the proportion of all types of domestic work performed by wives compared to their spouses.

As a means of determining spouses overall time performing housework across the family life cycle, Rexroat and Shehan (1987) extrapolated data from 1,618 Caucasian couples in intact marriages who enrolled in the Panel Study of Income Dynamics from 1976–1986. Spouses estimated the number of hours spent each week in all housework functions by self-report during six stages of the family life cycle from newly married without children to having grown children living outside of the home. Relative measures of spouses' time devoted to housework were obtained by dividing the total number of hours reported by both spouses by the individual hours of each partner.

While time spent in homemaking tasks varies slightly throughout the life cycle for men and women, multiple regression analysis indicates that women spent an average of 28.2 hours per week in the homemaker role compared to 5.2 hours for their spouses. Employed women with pre-adolescent children spent the greatest amount of time in the homemaker role. During this stage, women reported an average of 77.8 hours of combined work both inside and outside of the home while their spouses reported an average work week of 63.8 hours. While this study represents a large sample with data collected over time, self-report data has inherent problems of bias and recall. Results cannot be inferred to non-Caucasian, non-heterosexual couples.

Gunter and Gunter (1991) investigated the relationship of gender, education, years of marriage, parenthood, sex-role orientation, and need for cleanliness, on the division of household labor of working couples. Subjects were 139 married couples in their 20's to

late 50's who worked forty or more hours per week outside the home. Couples responded to a questionnaire designed specifically for the study. Utilizing five-way analysis of variance (ANOVA), the significant predictors of division of housework were found to be gender, sex-role orientation, and the presence of children in the home. Women performed almost all domestic tasks, especially working mothers. Androgynous and feminine oriented individuals performed more housework than those indicating a more masculine orientation. Reliability and validity issues of the questionnaire were not addressed and results cannot be assumed to be similar for non-Caucasian or homosexual couples.

Research on the homemaker role emphasizes the time commitments of this role for women but fails to address the potential health affects of inequities in the division of household labor that continue to exist. Women still perform the majority of housework compared to men, regardless of the amount of time devoted to other life roles, yet no study has been undertaken that specifically addresses health issues related to this phenomenon. More importantly, methodology has not been utilized that asks women directly for their views of the positive and negative impacts of unequal division of labor within the home. A logical assumption can be made that a role that increases a woman's already busy life, decreases leisure activity, and reinforces gender-based imbalances in the allocation of domestic work has tremendous potential for perpetuating stress-related illness - especially in light of women's time commitments to other life roles. More research is needed in this area as well as studies on lesbian families and women as single heads of household.

## Caregiver Role

Women have traditionally been, and continue to be, the primary caregivers to all family members, including aging parents (Brackley, 1994; Green, 1991; Guberman, Maheu and Maillle, 1992; King, 1993; Langner, 1995; Ward and Carney, 1994). Stone, Cafferata, and Sangl (1987) report that 63% of adult caregivers are daughters between the ages of 45-64 years of age. Green (1991) states:

> Although midlife sons are involved with their parents, their involvement is marginal when compared to the hours and nature of work performed by midlife daughters (p.7).

Guberman et al. (1992) reviewed seven studies on the caregiver role to ascertain the characteristics that determine who undertakes this role in western society. Female gender was the single most constant indicator of caregiver involvement in all of the studies. While many studies support the negative impact of this role on women's mental, physical, and financial well-being, women will be called upon to take on even greater responsibility as caregivers in the future, despite simultaneously increasing involvement in other life roles (Brackley, 1994; King, 1993; Langner, 1995; Obendorf, 1990; Russo, 1990; Quimby, 1990; Ward and Carney, 1994).

King (1993) used a grounded theory approach to analyze interviews of seven midlife daughters who were caregivers to their aging mothers. These women ranged in age from 42-69 years, were married, had children living at home, and also worked outside of the house. Themes that emerged centered on the conflict that arose for the caregiver between meeting her mother's needs, and the needs of herself and family. While daughters

experienced rewards associated with the caregiver role, they also identified a variety of stressful emotions including anger, shame, concern, embarrassment, exasperation, and resentfulness that ranged in intensity and duration along a continuum. While highlighting the emotional stress of the caregiver role for midlife women, the results cannot be generalized due to a lack of knowledge of participant characteristics such as socioeconomic status and culture.

Several phenomenologic studies have looked at various aspects of the caregiver role. Brackley (1994) and Langner (1995) both conducted in-depth interviews using the phenomenologic method focusing on the meaning of the caregiving experience for the caregiver. Brackley interviewed ten women aged 30-68 who spent an average of 3.4 hours per day in this role. Over half of the subjects (60%) reported having significant mental and/or physical illnesses themselves and 50% also cared for other dependents. Langner used a similar interview approach with 23 participants, 78% of whom were women. Both researchers concluded that although feelings of reward, fulfillment, and personal growth are experienced by many caregivers, the role is fraught with emotional stress that has tremendous implications for caregiver health.

Ward and Carney (1994) concluded from their phenomenologic study of 10 low-income women that, over time, the burden of continual caregiving is greater than the perceived rewards, especially when economic resources are extremely limited. Repeated studies are needed to ascertain whether the same themes will emerge both with similar cohorts and with caregivers of varying cultural, socioeconomic, and lifestyle characteristics.

Gaynor (1990) utilized a case control design to examine differences in health status between caregivers and non-caregivers. Participants (n = 155) were wives of male patients aged 55 and older who were classified as either long-term caregivers (average of 7.5 years) or short-term caregivers (average of 3.0 years). A third group comprised the control group of non-caregivers. Subjects responded to three questionnaires: the Zarit Burden of Care Scale, the Linn and Linn Self-evaluation of Life Function Scale, and Liang's Model of Self-reported Physical Health. Using one-way ANOVA, long-term caregivers were found to experience significantly increased feelings of burden and personal illness ($p < .01$) than either the short-term or non-caregivers, while the non-caregiver group reported the least physical illness of all three groups. It cannot be concluded from this study whether the caregiver role alone accounted for this difference or whether other factors were involved.

In a study of depression among wife caregivers to husbands with irreversible memory impairment, Robinson (1989) studied 78 women ranging in age from 47-85 years of age. Participants completed the Louisville Health Scale (LHS), the Marital Adjustment Test (MAT), the Inventory of Socially Supportive Behavior Questionnaire (ISSBQ), and the Center for Epidemiological Studies Depression Scale (CES-D). Depression scores were higher in this group than the cut-off considered indicative of a need for professional intervention, and a full standard deviation higher than studies of non-caregiving women of similar age. It is not reported whether participants had a history of depression prior to taking on the caregiving role, or whether the spouse's particular illness was a factor.

Repeated studies are needed, as results cannot be generalized to non-Caucasian women not fitting the sample characteristics.

The care provided to aging family members is most often studied in behavioral and attitudinal dimensions. The literature reveals that researchers have focused almost exclusively on the emotional and psychological consequences of caregiving (Horowitz, 1985). Ward (1990) applied a completely different approach to the study of the caregiver role. She analyzed caregiving from the perspective of time and income - "widely comprehensible measures by which work is analyzed and illuminated" (Ward, 1990, p. 223). Data was used from a previous study by Ward (1987) of 1,924 caregivers who completed the Informal Caregiver Survey (ICS). Respondents (72% female) spent a mean of four hours per day, seven days per week, in the caregiver role. Based on this data, and using an estimated $6.50 per hour average wage for purchasing home health aide services, Ward calculated that the tremendous service female family caregivers provide is worth $18 billion dollars per year.

In conclusion, caregiving has become a "normative but stressful experience" (Brody, 1985, p. 19) that affects women's physical, psychologic, and financial well being. Nursing's concern for the health effects of this role on caregivers has resulted in the acceptance of a new diagnosis - *Caregiver Role Strain* - by the North American Nursing Diagnosis Association (NANDA) in 1992 (Burns, Archbold, Stewart, and Shelton, 1993). Merely assisting women caregivers to "adjust" to the role, however, only serves to support a cultural view that exploits women (Brackley, 1994) and fails to consider altering family structures to be more egalitarian with respect to caregiver responsibilities. The

American health care system counts on women to assume heavy demands of giving extended care to all family members that the system could otherwise not afford, yet does little to prevent these women from becoming the "hidden patients" - prime candidates of stress-related illnesses that will cause them, in return, to need a caregiver (Gaynor, 1990; Green, 1991, p. 7).

## Friend Role

Friendship is a very meaningful and highly significant role in western society. As support persons, friends play an important role in enhancing the emotional and physical health of others (Caroline, 1993; Hays, 1989; Lea, 1989; Palasi and Ransford, 1987). Women place tremendous importance on friendships, both in having friends, and providing friendship to other people. The concept of friendship, however, has not been well defined in the literature, and few studies exist that assess the role of friendship in regards to health enhancement for women. As with social networks, friendship is very individualized and changes over time. Furthermore, several types of friendships are described in everyday speech by modifiers including "close", "true", "work", "best", and "casual", creating difficulties for researchers (Caroline, 1993, p. 264). The following review includes available studies undertaken within the past decade on the friendship role.

In one of the earliest and largest studies on friendship, Palisi and Ransford (1987) used secondary analysis of pooled data from the General Social Surveys from the years 1974, 1975, 1977, 1978, 1982, and 1983 – the years in which the National Opinion Research Center collected data on friendship involvement. The pooled data included 9,424 interviews. Using multiple regression analysis, researchers concluded that friendship was a

highly voluntary activity most likely engaged in by urban, unmarried, childless individuals of higher socioeconomic status. Married couples with children, older individuals, rural residents, and lower socioeconomic status groups were less likely to engage in friendships, especially if it required traveling from their community of origin.

This study has many methodological flaws. First, characteristics of the sample such as age, sex, and race were not described. Secondly, the term 'friendship' is not conceptualized making it difficult to conclude whether the mere act of socializing was synonymous with friendship in this study. Lastly, the study focused on number of friendships, not on the value, quality, or meaning of these relationships.

Hays (1989) studied 65 single undergraduate students (28 females, 37 males) to assess the characteristics and day-to-day functioning of close versus casual friendships. Participants selected two same-sex friends – one casual and one close friend. The subjects kept daily written accounts of their interactions with the chosen acquaintances for a period of one week. Repeated measures-multivariate analysis of variance (MANOVA) was used to compare the interaction patterns of close versus casual friends, and to examine potential gender differences. Participants of both sexes interacted more often with close friends over more days during the week than with casual friends. Interactions with close friends tended to be deliberately initiated, while casual friends often met by chance.

Both males and females indicated receiving overall equivalent benefits from close friendship, however, females reported receiving more emotional support. Women also offered more benefits to both close and casual friends than did men, and reported more

satisfaction from same-sex friendships than their male counterparts. The participants did not define the concepts of close and casual friendships, so gender differences in meaning cannot be determined. Additional research is needed with larger sample sizes of muli-cultural populations.

Lea (1989) administered the Acquaintance Description Form (ADF) and the Maintenance Difficulty Scale (MDS) to 105 single subjects aged 18-32 to determine the positive and negative characteristics of friendships and to lend support to Wright's Friendship Model. Wright proposes that friendship is valued to the extent that it fulfills or facilitates the expression of self-referent rewards. Product-moment correlations were calculated from the data that clearly disputed the idea that individuals enter friendship relationships primarily for the reward value. Although rewards are gained from friendships, the very essence of friends that make them unique from other acquaintances is their reciprocal nature. The author concluded that Wright's model be regarded with speculation. The study itself should be viewed with speculation for the following reasons: reliability and validity issues related to the instruments are not addressed, lack of information of participant characteristics, and failure to adequately define 'friendship' or describe Wright's Model in detail.

Due to the fact that a theoretical understanding of the friendship role fails to exist due to inconsistent definitions and lack of quality studies, Caroline (1993) used concept analysis to identify and describe qualities in adult, non-kin, dyadic friendships. The purpose of her research was to propose a definition of the term 'close' or 'best' friend.

Through analysis of nursing and other scholarly literature as well as case examples, the following definition of friendship was proposed:

> a meaningful and highly significant human activity defined as voluntary, primary, and enduring, without clear legal or social norms, that can be engaged in throughout most of the life span (p. 241).

Caroline's definition is vague which may be problematic in the research arena. . While many people can easily define casual or work-related friends, problems arise in attempting to define a 'best' friend due to the subjective, personal, and highly individual nature of the term. This study, however, provided a beginning base for theory development for understanding friendship and the important role it plays in the health and well-being of all humans, and highlights the difficulty in defining such an abstract concept.

Friendships are very important and highly valued relationships in our society, yet problems in conceptualizing the variable due to the personal nature of the term create difficulties in producing high quality studies that can be utilized with confidence. Additional research is needed to better understand the meaning of friendship and the impact friendship has on health status. Studies of the friendship role for midlife women are virtually non-existent – a gap in need of quality studies by nurse researchers.

## Social Networks

The concept of social support has been long established in the nursing literature to be significantly related to health outcomes (Steward and Tilden, 1995). Historically, the positive dimensions of social interactions have been emphasized, however, several

researchers acknowledge that social ties may not be positive, beneficial, or enhance health in a favorable way (Broadhead et al., 1983; Rook, 1984; Tilden and Galyen, 1987; Wellman, 1981). Social relationships are potential sources of stress as well as support (Broadhead et al, 1983), and as Tilden (1987, p. 10) states: "a significant share of stresses people experience in their daily lives emanate from interpersonal relationships". Wellman (1981) has suggested the use of the term *social networks* as a means of avoiding bias implied by the word *support* and will be used for it's neutral quality in this study. The overwhelming majority of researchers, however, continue to utilize the term *social support.*

Conflicts in research findings on the effects of social networks stems from several conceptual and methodological problems. Bloom (1982) and Thoits (1987) state that the definition of the concept is hindered by inconsistencies in conceptualization and operationalization of the term. Tilden (1987) reports that instruments designed to measure the effects of social interactions have perpetuated bias by focusing on positive subdimensions. Furthermore, although gender has been indicated as a significant variable in social networks, research studies are lacking that address gender as an isolated variable (Broadhead et al., 1983). This review focuses on available literature on social networks as they pertain to women's issues and health.

Bloom (1982) and Waxler-Morrison, Hislop, Mears, and Kan (1991) undertook prospective studies to assess the impact of social support on adjustment and survival of women with breast cancer. Bloom's (1982) study involved 133 women with a mean age of 51 years who had mastectomy following a diagnosis of non-metastatic breast cancer to

evaluate the role of social networks on post-operative adjustment following surgery. Participants were interviewed between one week and again at 2 ½ years post-surgery. Four independent measures of support were used to determine the levels of adjustment to the diagnosis and to mastectomy. Adjustment levels were based on self-concept, sense of power, and level of psychological distress.

Regression and path analyses revealed that social support networks were the single strongest predictor of positive coping responses to breast cancer, and also exerted indirect effects on all three measures of adjustment. Racial/cultural characteristics of the sample are not specified, nor does the researcher identify which individuals or groups comprised the social network structures that provided the greatest sources of support.

Waxler-Morrison et al. (1991) used a similar cohort of 133 women to assess the relationship between social support and breast cancer survival four years post-diagnosis of primary ductal carcinoma utilizing data obtained through questionnaires. Using the Cox proportional hazards method, and adjusting for age and clinical stage of the disease, six of eleven measures of social relationships were found to be significantly associated with survival rates: being married, contact with friends, total support (friends, relatives, and neighbors), employment contacts, and a positive overall evaluation of social networks. The dependent variable, four-year mortality rate, is influenced by many factors other than social network status, so caution should be taken in interpreting study results. Additional research in this area is warranted to determine the precise ways in which support networks enhance recovery from illness.

Friedman (1993) tested Cantor's (1979) Model of Hierarchical Compensation on a sample of 80 women with heart disease. The model postulates that older adults compensate for the loss or absence of social support networks in an ordered fashion with family members selected before non-members. Subjects were 55-92 years of age who had been hospitalized for congestive heart failure at least once within the 12 months preceding the study. Eighty percent were Caucasian, 51% were widowed, 29% were married, 14% were divorced or separated, and 48% lived alone. Participants completed a modified version of the Inventory of Socially Supportive Behavior, the Positive and Negative Affect Scale (PANAS), and the Satisfaction with Life Scale (SWLS).

Regression analysis and one-way ANOVA revealed that although Cantor's model only partially explained the order in which women sought out social support, it shed light on the types of support older women rely on in our society. Consistent with the model, married women sited their spouse as their primary support person. Women without spouses who had children depended on their offspring, making children the most frequent source of extended support and caregiving for older women. Participants with neither a spouse nor children named friends and neighbors as their main support network. Further studies are warranted to determine the support patterns of women from various races and socioeconomic backgrounds, and those of lesbian women.

Utilizing a qualitative, prospective format of guided, interactive interviews, Harrison, Neufeld, and Kushner (1995) studied 17 women aged 24-65 who were experiencing one of three life transitions, (having a first child, returning to work, or retiring), to determine

the access and barrier issues to social networks women experience during normative life changes.

Instead of describing individuals whom the participants felt provided positive support, participants described what they sought in a supportive experience. Support was defined as having someone who listened during problem solving - not someone who provided opinions, but who assisted in helping the woman gain insight into her own experience of transition. Women preferred support that "came from individuals in their inner circle who they viewed as sharing commitment, history, and close emotional ties" (p. 860).

Barriers to seeking support from others included the perception of being a burden to others, reluctance to ask for support, fearing an inability to reciprocate, and receiving non-supportive messages in the context of supportive actions from others. A number of participants cited delaying asking for support until they experienced a crisis which resulted in increased demands that jeopardized health. More qualitative research is needed to fully understand what women mean by "support" and to explore the origins of perceived barriers for women.

Social networks are effected by a myriad of variables, including marital status and parenthood. In a study of dual-earner couples with children, Leslie (1989) examined the effect of support in husbands' and wives' adjustment to work and family stress. Sixty, primarily Caucasian, couples with a mean age of 33 years who had at least one child at home completed a series of questionnaires. The goal of the study was to determine the level of support received, and the effect on perceived stress. Both men and women who

reported greater amounts of stress in general experienced decreased wellbeing, with women experiencing more stress than men, particularly family stress.

For men, neither support received nor support given was associated with stress, however, a significant increase in stress related to social networks was experienced by men who characterized themselves as feeling too "attached" and "embedded" in supportive relationships (p. 455). For women, only the amount of overall support received was associated with increased wellbeing, regardless of reported stress level. Reasons for these gender differences regarding stress and support cannot be determined from the cross-sectional nature of the study due to an inability to determine a direction to relationships. Additional research in this area may serve to identify gender differences in social support that will enhance the health of both men and women with multiple roles.

Support networks are especially vulnerable for women during major life events such as childbirth, when life roles are in transition and expectations are tested. Levitt, Coffman, and Loveless (1993) interviewed 43 mothers at one month and at thirteen months after delivery. Consistent with previous studies, a small but significant decline was found in relationship satisfaction with support persons. Unmet expectations for support were the primary determinant of dissatisfaction with level of support received. Increased stress levels were directly related to decreased amount of support suggesting that lack of support increases stress and therefore negatively affects support relationships. The study failed to identify individuals comprising the participant's support network.

Duffy (1993) conducted a study of 148 divorced women with children to determine how their social networks had changed and to identify unmet needs. Utilizing telephone

interviews and questionnaires, participants were assessed shortly after divorce and two years later. A significant decrease in the total size of support networks was identified due to loss of certain former friendships at the time of divorce. The primary unmet needs at this time were emotional support, financial assistance, an intimate relationship, time for self, and childcare. Over the two-year period, the support network of friends and family increased with the addition of new networks. At follow-up, women identified only one or two unmet needs. Results suggest that supportive social networks enhance emotional and physical wellbeing of divorced women. Furthermore, it is suggested that non-supportive individuals are substituted with supportive persons over time following periods of relationship upheaval. Results cannot be applied to women not fitting the Caucasian, educated, middle-class characteristics of participants.

In summary, social support as a research variable has been criticized as "lacking in theoretical density" (Tilden and Stewart, 1985, p. 381). Problems arise in defining the concept and in instrument development due to a tendency to focus on positive attributes. Perhaps part of the controversy stems from the fact that support networks, like friendships, are very individualized, change over time, and may be effected by gender and cultural differences. Although social support has long been established as a factor in women's physical and emotional health, recovery from illnesses, and during major life transitions, more research is needed that focuses on what a woman means by "social networks", and what types of support are needed for women with multiple role demands. In addition, women who perceive themselves as a burden to others when seeking support

may benefit from research that identifies the origins of this misconception and assists women to access support networks when they would be most beneficial.

## Summary

Controversy continues to exist relating to two hypotheses used to explain the effects of multiple roles on women's health. The "Expansion Hypothesis" expounds the benefits of multiple roles while the "Scarcity Hypothesis" emphasizes the negative aspects such as 'role stress' and 'role overload' (Baruch and Barnett, 1986; Froberg, Gjerdingen and Preston, 1986; Waldron and Jacobs, 1989; Hibbard and Pope, 1993a). Research supporting both hypotheses exist in the literature, prompting studies of the effects of women's multiple roles to shift from examination of the effects of the number of roles on health outcomes to a focus on the health effects of specific role combinations, patterns, and characteristics (Frober, 1986).

As roles and responsibilities for midlife women continue to increase along with the escalating pace of life, it is perhaps time to broaden the view from one of 'quality versus quantity' of multiple roles to an examination of the effects of multiple roles and social networks in the broader realm of the lived experiences of women. Only then can we develop an appreciation for the meaning of life roles within social and cultural contexts, and understand the gender-based influences impacting the lives of middle-aged women.

Until nurse professionals understand fully the costs and benefits to health for this subgroup of the population from their perspective, and gain knowledge based on what women themselves perceive they need, interventions aimed at reducing adverse health

outcomes from role overload, stress, and lack of appropriate support will be palliative at best. To the researcher's knowledge, a phenomenologic study of midlife women's multiple roles and social networks has yet to be undertaken as a means of understanding the physical and psychologic impact of multiple roles and social networks on midlife women's health.

## Philosophical Underpinnings

The underlying matrix of this study is based on the perspective of poststructural feminism which arises from the convergence of two separate ideologies: feminism and poststructuralism. Doering (1992) states that the two philosophies are particularly relevant to women, and to the female-dominated profession of nursing because "they incorporate the concepts of the female experience and of power" (p. 25). In this nursing study of midlife women, a poststructural feminist underpinning serves to acknowledge the existence of oppressive political and social systems sustained by unequal power relationships between men and women, and "reveals avenues for resisting that which sustains the status quo" (Chinn, 1990, p. 270).

Feminism has been defined as a world view that values women as equals to their male counterparts, and that confronts systematic social and political injustices based on gender (Doering, 1992). Feminists acknowledge women's experiences as the legitimate sources of knowing because women are the only true experts about their lives (Li, Carlson, Snyder, and Holm, 1995). Feminist nursing literature draws from several perspectives including Liberal, Social, Cultural, and Radical thought. The feminist ideology embraced

in this study is Cultural feminism which views women's values, and ways of thinking and knowing as inherently different from men. These differences are recognized as worthy of validation, respect, and research inquiry.

Rose (1990) writes that "the voice and experiences of women have been excluded from much of the knowledge about women" (p. 59). Not until the feminist movement began in the 1960's did women begin insisting on theory development that viewed and supported the female as unique and worthy of study. Until that time the male dominant social structure placed little value on research focused on women. Long-standing assumptions about women's health have been based on patriarchal standards that historically viewed male physiology and behavior as normative and therefore deserving of the lion's share of research dollars (Doering, 1992, Duffy, 1985, McBride and McBride, 1981, 1984; Ward, 1995). Although knowledge of women and women's health is increasing, nursing must be flexible in utilizing theoretical frameworks and methodologies that validate the unique experiences, ideas, needs, and perspectives of women. Nursing must also be critical of empirical paradigms aimed to predict and control nature from a patriarchal vantage point that may distort knowledge unique to women.

Poststucturalism is the antithesis of the logical positivist philosophy which has historically dominated quantitative medical research aimed to predict, explain, and control nature, thus preventing individualization of human experience. ( Li et al., 1995; Dickson, 1990). Poststructuralsits believe that no single approach to knowledge development can adequately address all research questions; structure itself is seen as a "necessary but limiting boundary of thought" (Doering, 1992, p. 25). The three principles of

poststructuralist thought are power, knowledge, and subjectivity. These principles have tremendous implications for women and for nursing. Doering (1992) defines the concepts as follows:

* Power: A strategic situation in any given society where the specific purpose is to maintain a specific social hierarchy through the day-to-day activities of it's members. Power limits what is acceptable to be known, and is always exercised in relation to resistance; power is knowledge and vice-versa.
* Language: The common element in the analysis of social organization, social meanings, power, and individual consciousness. Language gives meaning to the world around us and is imbued with social power.
* Subjectivity: The concept that individual actions are shaped by and reflect social power relations; individuals internalize social power relations into a sense of self and understanding of the world (p. 25).

Contemporary western society, and the current health care system that operates within it, are based on a patriarchal power structure (Watson, 1990) imbued with its' own power base and language that subjugates those without power - women.

Gender discrimination within the health care system occurs for women as both consumers of health care and as health care professionals. American women use twice as many health services as any other segment of the population (Clancy and Massion, 1992); Connors, 1995, 1985; Duffy, 1988; Kasper and Soldinger, 1993; Lempert, 1986; Thomas, 1990; Wood, 1994) yet encounter more barriers to care than men. This occurs via

financial obstacles, access problems, lack of knowledge about women's health, and the provision of fragmented services. Women are twice as likely to be underinsured, to have limited coverage with higher cost sharing, and to be dependent on their spouse for coverage (Clancy and Massion, 1992; Massion et al., 1995).

Moreover, middle-aged women pay higher insurance premiums than middle-aged men, are less likely to obtain insurance from employers, and are twice as likely to have no insurance at all (Clancy and Massion, 1992; Massion et al., 1995). Lastly, analysis of Medicare benefits reveals that acute illnesses more common in men receive greater coverage than chronic illnesses more prevalent in middle-aged and elderly women because they generate lower overall costs to insurers (Clancy and Massion, 1992; Kasper and Soldinger, 1983; Massion, et al., 1995).

It has been suggested that women have been subjected to other "abuses" within health care including exploitations via surgical and chemical manipulation. Hysterectomy is the most common surgical procedure in the United States; approximately 50% of women will have this surgery prior to the age of 65 (Dyehouse, 1992; Morgan, 1984; Opie, 1986). Greenspan (1981) reports that data from the Centers for Disease Control estimated that 500,000 of the 3.5 million hysterectomies performed on women of reproductive age from 1970-1978 were for questionable reasons.

Inequities exist between men and women with regard to the prescription of tranquilizers and sedative agents, and in the "indiscriminate prescribing of insufficiently tested drugs and hormones" (Dyehouse, 1992, p. 231). Women are two to three times as

likely as men to receive a prescription for tranquilizers and/or sedatives (Fidell, 1984), however, 33% are written in the absence of documented mental or emotional dysfunction (Anderson and Holder, 1989, as cited in Dyehouse, 1992). These "abuses" may result, in part, from lack of knowledge of women's unique health needs and the resultant inability to adequately educate women to be informed consumers of health care.

In a system fraught with gender discrimination, women make up the vast majority of health care workers and professionals in both western and folk traditions, yet most decisions regarding the delivery of health care are made by men (Duffy, 1985, Watson, 1990). Leuning (1994, p. 6) points out that "nursing came of age in a society that did not value women or women's experience". Feminist research has further illuminated nursing phenomenon uncovering "layers of patriarchal prejudice that has repressed women and the profession for years" (Leuning, 1994, p. 6). Doering (1992, p. 27) states that the principle of 'language' in poststructural thought has historically epitomized the power relation between the genders in nursing with the notion that physicians are "educated" whereas nurses are "trained", and in society in general by statements such as "a woman's work is never done". The development and maintenance of power imbalances between the primarily female profession of nursing and the primarily male discipline of medicine can be linked to the control of scientific knowledge relevant to both disciplines (Doering, 1992).

Nurses today continue to take on additional complex roles as health care professionals while still embracing the nurturing and caring qualities that are the essence of nursing. Watson (1990, p. 63) states that "caring is either women's work and therefore invisible, or it is something to fear because it reminds us that we are all equally human". The holistic

and nurturing framework that is the foundation of the profession continues to be devalued in the delivery of health care services.

Today, medical care management and cost-containment programs are targeting nursing by increasing workloads, decreasing time allotted to care, and minimizing the significance of nurturing and caring to healing. In this way, the nursing profession mimics what has historically happened to women in our western society. It is obvious that the same patriarchal prejudice that has repressed women, devalued their roles, and made redistribution of social role responsibilities so difficult, has similarly plagued the profession of nursing.

Feminist poststructuralism and the phenomenologic method chosen for this study are both philosophies as well as approaches to research questions. Feminist theory evolved from the premise that women must be studied in the context of their lived experiences as a means of gaining accurate accounts of the health issues, needs, and concerns of women (Bruenjes, 1994; McBride and McBride, 1981, 1994; Worell and Etaugh, 1994) which supports the phenomenologic approach. According to Dyehouse (1992, p. 221), women's health at the very core means "taking women's lived experiences as the starting point of *all* health efforts". Worell and Etaugh (1994) reviewed sources of feminist thought and identified key issues essential to conceptualizing women's lived experiences. The following themes from their report are supported by the purpose, research question, and methodology of this study:

* Valuing women as legitimate targets of study,
* Studying women apart from the standard of male as norm,

* Encouraging questions that are grounded in personal experiences of women researchers,
* Exploring research questions that are relevant to women's lives...,
* Constructing methods of research that target issues of importance to women's lives...such as gender role beliefs..., and,
* Studying women in the context of their lives and natural milieu... (p. 447).

In conclusion, feminist theory has been used successfully in several studies of women's health issues (Bruenjes, 1994; Chinn, 1990, Rose, 1990; Stevens, 1993), several of which have utilized the phenomenologic process. Feminist poststructuralism has been advocated as an approach to understanding women and nursing in the context of historical, social, and political power (Andersen, 1991; Doering, 1992) and has been successfully utilized by Dickson (1990) to analyze midlife women's perceptions of menopause.

## Researcher Assumptions of the Phenomenon of Interest

Given that the goal of phenomenologic research is to understand human experience from the individual's perspective, study participants themselves will - in their own words - give meaning to the concepts of "multiple roles", "social networks", "physical health", and "psychologic health". This approach preserves the basic assumption of the "primacy of the life-world"; the experience of humans within their world as they live it, prior to any theoretical interpretation or explanation (Knaack, 1984, p. 109).

The researcher has made several assumptions as a means of guiding the reader in understanding the purpose and intent of this study:

1. Multiple roles: The researcher assumes that many midlife women in our

contemporary western society assume more than one life role. Examples of these may include paid worker, homemaker, partner/spouse, parent, friend and caregiver.

2. Social networks: The researcher assumes that women enact their various life roles within one of a variety of social network patterns common to our society. Examples of social networks may include friends, partners, children, extended family, or other social affiliations such as church.

3. Physical and psychologic health: The researcher assumes that middle-aged women experience both physical and mental health (or lack thereof) to varying degrees, which may be impacted by a number of factors at any given point in time including multiple life roles and social networks.

In the phenomenological process, the researcher was also open to the possibility that the aforementioned assumptions would not be true for the participants in this study, and was cautious not to introduce bias based on predetermined beliefs and ideas. The process required of the researcher to minimize bias in phenomenologic inquiry and to fully participate in the research experience, is described in the Methods section in chapter three titled *Roles of Researcher and Participant.*

# CHAPTER THREE

**What do we want from each other**

**after we have told our stories…**

**do we want to be healed…**

**do we want mossy quiet stealing over our scars…**

**do we want the all-powerful unfrightening sister**

**who will make the pain go away…**

**the past be not so?**

(Audre Lorde, 1986, as cited in Rich, 1986, p.x)

# Chapter Three

## Methods and Analysis

This chapter describes the methods utilized in this study to explore and analyze women's experiences of the multiple roles they enact within various social network structures, and to determine the impact of these variables on health status. This chapter addresses the following elements in detail: the research design, roles of researcher and participant, sampling procedure, sample characteristics, protection of human subjects, setting, measures, procedures, data collection and management, and method of analysis.

## Methods

### Design

An interpretive phenomenological approach was used to capture the lived experiences of middle-aged women regarding the meaning of multiple roles, as well as the issues and concerns evolving from engagement in various life roles. Phenomenology is a philosophically derived method of inquiry that allows for the exploration of phenomenon as it is actually experienced by the participants (Benner, 1994; Cohen, 1987; Jasper, 1994; Knaack, 1984; Oiler, 1982; Van Manen, 1990). The phenomenologist's approach emphasizes the inherent complexity of all humans, the belief that humans create and define their own reality, and the understanding that the truth is a composite of these realities (Polit and Hungler, 1995).

A phenomenologic design was chosen in favor of more common empirical and structured qualitative methods of research because of the unique potential of extracting

actual meanings of life events through shared stories. The free flowing, non-structured format allows the process of natural inquiry to unfold with a minimum of imposed structure. Empirical approaches, as well as many studies utilizing structured questionnaires often reduce data to the point of deprecating the holistic perspective essential to nursing inquiry by measuring only a portion of reality.

Phenomena is fully understood only in the context of their dynamic interplay with other human factors. The phenomenological method allows information obtained to be directed by the participants with minimal involvement of the researcher, thus reflecting more closely the actual lived experiences of mid-life women. Phenomenology is based on accurately capturing the reality of these experiences from the perspective of the participants, which can only be verified by those telling the story. Van Manen (1990) describes phenomenological human science research efforts as: "explorations into the structure of the human lifeworld, the lived world as experienced in everyday situations and relations" (p. 101).

This method was chosen as a means of accurately capturing the participant's true experiences of multiple roles and social networks as they define them. This qualitative process has been used successfully by several researchers in the field of women's' health (Anderson, 1991; Appleton, 1994; Beck, 1992; Bansen, 1992; Brackley, 1994; Brown, 1994; Bruenjes, 1994; Coward, 1990; Dalton, 1992; Darbyshire, 1994; DiPalma, 1994; Dobbie, 1990; Hall, 1990; Jarrett and Lethbridge, 1994; King, 1993; Langner, 1995; Lethbridge, 1991; Munhall, 1993; Parratt, 1994; Rose, 1990; Scannell-Desch, 1996; Schaefer, 1995; Seals et al., 1995; Steen, 1995; Ward and Carney, 1994, Zalon, 1997).

In addition, use of the phenomenologic approach upholds the philosophical underpinnings of this study by supporting the three feminist principles of research (Acker, Barry, and Esseveld, 1991):

1. Research should contribute to women's liberation through producing knowledge that can be used by women themselves,
2. Should use methods of gaining knowledge that are not oppressive, and,
3. Should continually develop a feminist critical perspective that questions intellectual traditions and can reflect on it's own development (p. 133).

## Roles of Researcher and Participant

In phenomenological research, inquiry not only involves gathering data from participants, but also encompasses the researcher's effort to experience the phenomenon in the same way as the participants experience it (Polit and Hungler, 1995). Researcher involvement in phenomenology differs markedly from other research methods in which the researcher plays the role of objective observer, creating a distance from the subjects studied (Jasper, 1994). Participation is required on the part of the researcher by adhering to the four components necessary for full involvement in the phenomenologic process: bracketing, intuiting, analyzing, and describing (Munhall, 1994; Oiler, 1982; Polit and Hungler, 1995). Following is a description of each step utilized by the researcher, and a description of the purpose of each component in phenomenologic research (Polit and Hungler, 1995, p. 198):

1. Bracketing: The researcher identified preconceived beliefs, feelings, and opinions in order to prevent bias regarding the phenomenon of interest. The researcher

"bracketed out" any preconceptions in order to understand the data in it's pure form through use of a journal to record personal thoughts for reflection. The researcher also actively refrained from using identifying or suggestive terms relating to personal beliefs or ideas about the research question that stemmed from either personal experience, or from information gathered in the literature review.

2. Intuiting: The researcher was aware of the importance of being open-minded and only interpreting the phenomenon as experienced by the participants. A nurse expert in the field of phenomenology assisted in controlling for this potential bias.
3. Analyzing: Extrapolating meanings and categorizing themes was an ongoing process throughout the data gathering process, transcription, and analysis phases. A nurse expert in the phenomenologic method assisted with data analysis.
4. Describing: The researcher understood and defined the phenomenon. Results were validated by study participants via follow-up contacts, and through collaboration with a nurse expert in the field of phenomenology.

The role of the research subject is one of collaboration with the researcher in a mutual agreement based on equality of all parties involved in the research process. This differs from the power relationship implicated in many quantitative studies. This relationship is possible only if the researcher communicates interest in understanding the participant's experience, and suspension of moral judgment (Keen, 1975 as reported by Knaack, 1984, p.110). The researcher communicated interest by actively listening, refraining from interrupting, and through careful attention to verbal and non-verbal language.

The creation of an atmosphere of equality and trust in the research process supports the assumption of phenomenological inquiry that both the participants and the investigator are simultaneously changed through this existential method (Von Eckartsberg, 1971 as cited in Knaack, 1984). The process of preparation for the phenomenologic interview undertaken by the researcher also adhered to the feminist ideals of social science inquiry. Harding (1987) states that "the best feminist analysis...insists that the inquirer her/himself be placed in the same critical place as the subject matter, thereby recovering the entire research process for scrutiny in the results of research (p. 9).

## Sampling Procedure

Midlife women between the ages of 35-65 years of age were recruited to participate in this study. Little consensus exists in the literature as to the parameters defining "middle-age" (Thomas, 1990), and controversy is likely to persist as humans continue to live longer. This age group was chosen to encompass a range found in the research literature on women in midlife. A homogeneous sample of Caucasian, middle to upper-middle socioeconomic status women who currently hold at least two life roles were enlisted to participate. Homogeneity was desired within the scope of this project to enhance the potential for extracting similar themes that are often common among cohorts of a similar population and culture. The homogeneous group was also favored as a means of extracting comparable themes due to the "cuing phenomenon" – a natural occurrence that results when people with similar life experiences share their stories with others (Morgan, 1993). In addition, English-speaking subjects were recruited that were able to articulate well, and who did not have a disability preventing them from being audiotaped.

Faculty members and other colleagues in the School of Nursing at Oregon Health Sciences University assisted in obtaining a snowball sample from personal and professional resources from the greater Portland metropolitan area. Three women were initially identified from these resources who verbally agreed to participate. These participants were then asked to identify other potential subjects through their personal and professional contacts. Seven additional women were suggested as potential study participants through this method. Phone calls were then placed to all seven women with a follow-up call in one week if no contact was made. This process continued over a five-week period until three more women consented to participate in the study. A potential study subject was classified as not interested in participating in the study if the individual verbally declined, or if no response was heard after two messages were left within a two-week period at the telephone numbers provided by initial subjects. The entire recruitment process extended over a three-month period from October through December, 1996.

## Participant Characteristics

The 6 participants were Caucasian, heterosexual women between the ages of 39-52 years (M = 45.8). Three participants were currently married and three were divorced. All six women were parents with between 1-6 children (M = 2). This statistic is somewhat misleading since four subjects had only one child. Children's ages ranged from 3 years to18 years (M = 10.7). At least one child was living in the household during the study, with the range being between 1-3 children currently at home.

Participants reported at least some college education. Educational level was between 12-16 or more years (X = 15.5). Four participants held an undergraduate degree, and two

were pursuing graduate education. A variety of occupations were represented including homemaker, staff nurse, mediator/administrator, stockbroker, and nurse manager, and art broker. Women worked outside of the home an average of 22 hours per week. The range was zero hours for the homemaker to over 40 hours per week. Annual household income was $12,000 - $100,000 (M = 61,200). Characteristics of participants are summarized in Table 1. The women held between 5-7 life roles each (Table 2) and reported from 3-6 social network affiliations (tables 3 and 4).

## Protection of Human Subjects

This study was undertaken with permission of the Institutional Review Board on Human Research (IRB) at Oregon Health Sciences University (OHSU) and in keeping with protocols to protect human subjects. Each participant was given a full description of the study and signed a consent form (Appendix E) to participate. The researcher kept confidential all information obtained during the data collection process. Names of participants were not divulged in any context of the study. During data collection and analysis, audiotapes and field notes were stored in a locked file (location known only by the researcher), and used only by the researcher and research committee members. Demographics and Health History forms were coded as were all transcribed audiotapes. . The list of participants and their corresponding code numbers were kept in a second locked file separate from audiotapes, manuscripts, and data forms. No identifying information was transcribed or shared, and names were changed in the presentation of data to protect the anonymity of participants and their families. Audiotapes were destroyed after data analysis was complete.

Table 1

Participant Characteristics

| Characteristic | Value or Frequency |
|---|---|
| Age (years) | |
| Actual ages: | 39, 43, 43, 48, 50, 52 |
| Range: | 39-52 |
| Mean (M) | 45.8 |
| Education (years) | |
| Number of Years: | 14, 15, 16, 16, 16, 16 |
| Mean (M): | 15.5 |
| Income: | |
| Annual income: | $12,000, $32,000, $55,000, $68,000, $100,000, $100,000 |
| Mean (M): | $61,200 |
| Marital Status: | |
| Married: | 3 |
| Divorced: | 3 |
| Number of Children | |
| Actual number: | 1,1,1,1,2,6 |
| Mean (M): | 2 |
| Number living at home: | 1,1,1,1,1,3 |
| Mean (M): | 1.3 |

Table 2

Number and Types of Life Roles Held by Sample

| Participant Number: | 01 | 02 | 03 | 04 | 05 | 06 |
|---|---|---|---|---|---|---|
| Role: | | | | | | |
| 1. Paid worker | -- | X | X | X | X | X |
| 2. Spouse/Partner | X | X | X | -- | -- | -- |
| 3. Parent | X | X | X | X | X | X |
| 4. Homemaker* | X | X | X | X | X | X |
| 5. Family Caregiver (to immediate family) | X | X | X | X | X | X |
| 6. Extended Caregiver (to extended family) | X | -- | -- | -- | -- | X |
| 7. Friend | X | X | X | X | X | X |
| 8. Student | X | X | -- | -- | -- | -- |
| Total: | 7 | 7 | 6 | 5 | 5 | 6 |

* Independent of time spent in the paid worker role, or marital status, all subjects regarded the homemaker role as a significant life role.

Table 3

Social Network Affiliations of Married Women in Sample in Rank Order of Importance

| Participant Number | Support Networks |
|---|---|
| 01 | 1. Spouse |
| | 2. Friends |
| | 3. Children |
| 02 | 1. Spouse |
| | 2. Children |
| | 3. Extended Family |
| | 4. Friends |
| | 5. Work Colleagues |
| | 6. School Colleagues |
| 03 | 1. Spouse |
| | 2. Sister |
| | 3. Extended Family |
| | 4. Friends |

Table 4

Social Network affiliations of Divorced Women in Sample in Rank Order of Importance

| Participant Number | Social Networks |
|---|---|
| 04 | 1. Daughter<br>2. Friends<br>3. Ex-husband |
| 05 | 1. Child<br>2. Friends<br>3. Work Colleagues |
| 06 | 1. Children<br>2. Friends<br>3. Brother<br>4. Ex-husband |

## Setting

The setting for the initial group interviews was a spacious, comfortable conference room in the School of Nursing at Oregon Health Sciences University, Portland, Oregon. This space was large enough to accommodate participants seated in a circle to promote maximum communication and a sense of equality. A kitchen area was located near the conference room as were restroom facilities. The setting provided a safe and secure atmosphere conducive to the sharing of personal experiences. Initial interviews took place in the evening when the School of Nursing was less occupied as a means of optimizing privacy and minimizing distractions.

Individual follow-up interviews were held at a site convenient to the women. Four interviews were held at separate times in an unoccupied classroom at the School of Nursing at OHSU. This room was spacious, private, and comfortable, with access to restrooms and refreshments. Two of the participants had scheduling conflicts with their work or family responsibilities, so follow-up interviews were held at their place of employment either during a lunch hour, or in the late afternoon. Private conference room or office space was available to protect confidentiality.

## Measures

An informal interview guide (Appendix A) was jointly created by the researcher in collaboration with Diane M. Dietterle, RN, BSN, a fellow colleague currently conducting phenomenologic research on rural midlife women. The guide is composed of open-ended, unstructured questions. The guide served only as a means of keeping conversation focused on the research purpose, keeping in mind that one of the hallmarks of

phenomenologic research is the free-flowing nature of inquiry. For example, the concept of "multiple roles" was understood by asking the following question: "Describe what a typical day is like for you in detail from the time you get up in the morning to the time you go to bed at night". Ideas for sample probes were also jointly developed (Appendix B) as a way of extracting meaningful information specific to the variables of interest. The sample interview question provided as an example is based loosely on an actual conversation with a woman fitting the sample characteristics who consented to the use of the information for proposal development.

All interview statements were reviewed by nurse experts in the fields of women's' health and/or phenomenologic research for validity and appropriateness in addressing the research question. In addition, the interview guide was field-tested by the researcher on a group of 3 middle-aged women who fit the sample characteristics. This pilot session allowed the researcher to elicit feedback, evaluate the effectiveness of the interview guide, enhance interviewing skills, and become more comfortable with the phenomenologic process of data gathering.

Participants did not know the questions prior to the group meeting. A flip chart was used with the pilot group to display each question, but was cumbersome and made for less of a spontaneous atmosphere. Based on feedback from the pilot group, the flip chart was abandoned for the subsequent group interview.

The researcher served as moderator while taking careful field notes. All participants were given the opportunity to fully communicate their experiences related to each

question in an atmosphere that supported sharing of personal stories. Minimal structure was imposed based on the understanding that rich information is obtained when participants are given the opportunity to articulate their experiences in their own personal way.

Participants also complete a confidential Demographics Form (Appendix C) and a Health History Form (Appendix D) prior to the beginning of the session. These tools in their original form were also jointly developed with Diane M. Dietterle, RN, BSN and were altered for the purpose of this study. Forms were mailed to the women upon obtaining their verbal consent to participate, along with the Consent Form (Appendix E) and information about the study. Data forms were sealed in an envelope and were not viewed by the researcher until data analysis of transcripts was complete as a means of reducing potential bias.

Based on preliminary analysis of data, a follow-up interview guide (Appendix F) was created by the researcher to elicit more in-depth information regarding the themes and core meanings that emerged from women's lived experiences of multiple roles and social networks. The follow-up guide served the same purpose as the initial interview guide.

## Procedures

Two small group interviews consisting of 3 participants each was conducted during the months of January through March, 1997. Each group session lasted between 2 – 2 1/2 hours. Tanner, Benner, Chesla, and Gordon (1993) state that group rather than individual interviews create a natural conversational setting for story telling, and were utilized for this purpose. The researcher used the Interview Guide discussed in the Measures section

as an informal tool. Probes were used as needed to extract more detailed information regarding areas of significance expressed by the participants and to extract accurate meanings of dialogue. The phenomenologic interview served the research purpose cited by Van Manen (1990):

> It may be used as a means of exploring and gathering experiential narrative material that can serve as a resource for developing a richer and deeper understanding of human phenomenon, and as a vehicle to develop a conversational relationship with participants about the meaning of experiences. (p. 66)

Individual follow-up interviews took place during the months of February through April, 1997, after preliminary data analysis was complete. Follow-up interviews lasted an average of 1 ½ hours each, and served the purpose of sharing and validating research findings with participants, and in further exploring themes that emerged from the data. As Oiler (1982) states, the absolute test of validity directly relates to whether the results are recognized as true by those having the experience.

## Data Collection and Management

Prior to the beginning of each session, the researcher prepared for the interview by adhering to the components necessary for involvement in the research process that are outlined in the Methods section under *Roles of Researcher and Participant*. Bracketing and intuiting were accomplished through journaling about personal experiences regarding multiple roles and social networks.

The group and individual sessions were audiotaped in their entirety and transcribed verbatim by the researcher. The researcher chose not to videotape the sessions.

According to Morgan (1993) video cameras do not add to the quality of the group, may distract from it, and may also be perceived as threatening. The researcher compensated for the loss of important non-verbal communication by taking careful field notes.

Data was analyzed throughout the interview process, transcription, and follow-up phases of the study. Christine Tanner, RN, PhD, FAAN, co-analyzed the data from the first group and individual follow-up interviews to enhance the validity and reliability of the study, and to guide the researcher in phenomenologic interpretation of results.

## Analysis

In phenomenologic research, "a genuine attempt is made to ensure that conclusions reached arise from the data, and not from interpretation imposed by the researcher" (Jasper, 1994, p. 311). Data analysis occurred through collaboration between the participants and the researcher, and by the researcher in collaboration with a nurse expert in the field of phenomenology.

All transcribed tapes, field notes, and any information obtained from follow-up contacts with participants were analyzed by the researcher for essential meanings. Data from each interview was reviewed several times in isolation, then in comparison to other participant's stories. Recurring themes were identified, and 'tagged' using color-coded markers, and grouped together for analysis across interviews. From coded data, themes were described and relationships between themes identified.

Exemplars were used as actual illustrations of dialogue to convey meanings of the themes that emerged from the data and were grouped together for the purpose of describing the lived experiences of women regarding each theme. Prototypical paradigm

cases were then selected and examined for the extent to which they typify many of the life stories shared by participants relating to multiple roles, social networks, and health. Refer to chapter four, *Results and Discussion*, for an in-depth description of the findings.

Finally, initial interpretations of the data were presented to the participants via follow-up interviews to validate the findings, and to further explore the meaning of the phenomenon for these women. This step was critical to the understanding of the essence of the lived experiences of multiple roles and social networks, and to acknowledge and respect the participants as the expert sources of this knowledge.

The criteria of credibility of fittingness (Sandelowski, 1986) utilized by King (1993) in her phenomeonologic study of midlife daughters who are caregivers to their mothers, was used in this study to address the issues of internal and external validity. Internal validity is established by validating the findings with participants to ensure that interpretation of data truly reflected lived experiences. External validity was accomplished by having a nurse expert in phenomenological research read and co-analyze portions of the transcribed data to ensure that findings were grounded in the women's experiences and reflected their meanings of the phenomenon of interest.

# CHAPTER FOUR

**"You know, this old world**

**just keeps on spinning around, and around,**

**and around.**

**And sometimes it just spins too fast**

**and you, you not only lose your balance**

**but you lose your rhythm, and**

**it's at times like these that you just need to**

**STOP**

**and not only find your way again**

**but find your rhythm,**

**because life has a rhythm,**

**and mother nature has a rhythm..."**

(Anita Baker, "Rhythm of Love"

Electra Entertainment, 1994)

# Chapter Four

## Results and Discussion

This study was undertaken to identify and examine the perceptions midlife women have of both the physical and psychologic health effects of two variables: multiple roles and social networks. The focus is on the meaning of concepts as they are understood by the participants. Themes that emerged from the data are discussed, and core experiences presented. Lastly, multiple roles and social networks are related to women's lived experiences of health. Excerpts from interviews are presented to both illustrate and provide evidence for the interpretation of themes, core experiences, and meanings of phenomenon. Names of participants and family members have been changed in the presentation of results to protect anonymity.

## The Meaning of Multiple Roles

### Multiple Roles as Cultural Identity:

### *"What Should I be When I Grow up?"*

The essence of multiple roles was understood through participant's descriptions of what a typical day is like for them. Each woman described a day that reflected the many tasks and responsibilities of her multiple roles. The following example provides a prototypical day for the women:

> "...a typical day for me, um, starts at about 5:15, and...my role is to get up in the morning...I get dressed...my eight year old daughter is still sleeping, so I...prepare her lunch, feed the dog and the cat...walk the dog, come back in, get my daughter out of bed, get her getting dressed, make the bed, get her to daycare by about 7:00, um, I

have a very compacted day…my mission is to pick up my daughter at 3:20 from school so I work straight through. I eat lunch at my desk, I don't get up and go anywhere, I just work very intensely so that I can leave by…3:00 to pick her up… I pick her up from school, we get home, um, we immediately start in on homework and I sort of monitor that. I walk the dog, I feed the dog and the cat…I start fixing dinner, continuously urging my child to concentrate on her homework…we eat dinner…sometimes like on a Monday or a Wednesday we might be heading out at 6:30 to go to basketball practice for her, so we have an hour of basketball practice, uh, we come racing home, I physically pick her up and throw her in the shower, and we work to try to get her settled in and I will read her a story, and by nine o'clock we are both in bed asleep".

A typical day for all six women began between 5:00 and 6:00 am and ended between 9:00 and 11:30 pm. The time spent performing tasks of daily living lasted between 16 and 18 ½ hours per day. One woman who worked an eight-hour night shift three days per week (while raising a child), reported getting an average of two hours of sleep on those nights. Her awake-time performing multiple roles on those days averaged 22 hours.

Five of the six women stated that this pace was continued seven days per week due to child rearing responsibilities and the need to "make up for lost time on the weekends" with tasks left over from the work week. One participant worked all weekend in order to attend school during the week. She was also raising a child and working outside the home. She summed up her experience of a typical day by saying "you know, a typical day is one thing – a typical week for me is a little different in the fact that I really don't have a

day off'. Another woman lends support to the long workdays by reflecting on the events of the past several days in a typical week:

> "yesterday I got up and I was going to work and I was saying to myself, I feel kind-of tired, and then when I thought back, Sunday was a ten-hour day away from my family doing things and getting caught up with school. Monday was, um, an eleven-hour day from the time I got up, dropped my son off at school...you know, ten and eleven hours away from the house...Tuesday was a twelve-hour day, Wednesday was a twelve-hour day, I mean it's no wonder I'm tired!"

All women shared stories of how their multiple roles "consumed their lives". One woman described her multiple roles as "swallowing her up" and several others stated, "I don't have one spare moment for myself". While positive consequences of engaging in many life roles were expressed, negative effects were also cited. Table 5 lists both positive and negative consequences of multiple roles as they were reported on the Demographics Form (Appendix C), and taken verbatim from transcribed stories.

One participant is unique due to the fact that she made significant lifestyle and role changes five months prior to participating in the study. Her stories of both past and present life experiences are compared and contrasted to other participants in several sections as a means of understanding the phenomenon of multiple roles in different contexts. She is labeled "change case" for the purpose of discussion.

After understanding the essence of a typical day, the meaning of multiple roles was understood through asking women the following three questions:

1. What are your current life roles?

Table 5

Positive and Negative Consequences of Multiple Roles

| Participant Number | Positive Consequences | Negative Consequences |
|---|---|---|
| 01 | Excitement | Exhaustion |
| | Energized | Chronic Stress |
| | Accomplishment | Lack of Exercise |
| | Positive work experiences | Mentally/Emotionally drained |
| | Satisfaction | Guilt |
| | | Anger |
| | | Gastrointestinal illness |
| 02 | Energized | Exhaustion |
| | Challenged | Chronic Stress |
| | Thrive on Activity | Lack of Exercise |
| | Independence | Too Many responsibilities |
| | Accomplishment | Anger |
| | | Asthma related to stress |
| | | Lack of Social Networks |
| 03 | Able to stay at home with child | Exhaustion |
| | Balance between work and child rearing | Chronic Stress |
| | | Lack of personal time |
| | | Anger |
| | | Tension |
| | | Depression |
| | | Professional goals on hold for family |
| | | Lack of Social Networks |

| Participant Number | Positive Consequences | Negative Consequences |
|---|---|---|
| 04 | Accomplishment<br>Gratification from work<br>Independence<br>Positive feelings from helping others | Exhaustion<br>Chronic Stress<br>Lack of Exercise<br>Anger<br>Tension |
| 05 | Challenge<br>Accomplishment<br>Independence | Exhaustion<br>Stress<br>Frustration<br>Anger<br>Lack of time for self |
| 06 (Before lifestyle change) | Financial Independence<br>Maintenance of standard of living | Exhaustion<br>Chronic Stress<br>Lack of Exercise<br>Anger<br>Mentally/Emotionally drained |
| 06 (After lifestyle change) | Happy<br>Healthy<br>In Control<br>Thankful<br>Balanced | Lower Income<br>Loss of certain friendships |

2. How did you get to where you are now with taking on all that you do in your life, and
3. What keeps you doing it?

Responses led to an understanding of the phenomenon of multiple roles both as "cultural identity" and as "trade-offs".

The meaning of multiple roles as cultural identity emerged from the way in which women described their roles. Women did not speak of roles in terms of "this is what I do" but as "this is who I am". When asked to list their life roles, all women began with words describing identities, not functions:

Tonya: "I'm 'mommy' first..."

Kimberly: "I'm a student first...I'm a mother and a wife secondly...I'm an employee...and, um, I am a friend of sorts"

Sarah: "Prioritizing I would say I'm a parent first, then an employee..."

Rebecca: "The first is I'm a parent – and everything that goes with it...the second role is being a good friend, the third is being an employee..."

Julie: "I still feel that being a mother is the major role...."

When multiple roles are understood as comprising a woman's identity, the cultural influences impacting midlife women can be appreciated. Participants spoke of cultural expectations as a factor, not only in the types of roles they enacted, but in the way in which society defines each role. The following are typical stories that depict the cultural impact on multiple roles for these women:

Pamela: "...I always planned to have a family, which in my day women did as a part

of their life. It was an expectation…and when I went to college I really wanted to be a doctor, but I wasn't encouraged to do that, so of course, I became a nurse"

Kimberly: "I always envisioned myself as being a mom…"

Julie: "When I was little, all the girls - well most of them, played with dolls and boys played sports …come to think of it, they were usually outside and we played a lot in the, in the house – funny, this didn't change when I had kids of my own"

Rachel: "…speaking of taking care of your aunt, I remember actually hearing once when I was little – it was at one of those family gatherings or something, anyway, I heard a woman say that she was glad she finally had a daughter so she would have someone to take care of her in her old age!"

The differences between how midlife women experience multiple roles in the context of culture result in large part to the relationship with their primary role model – their mother. The roles and lifestyles of the participant's mothers had a tremendous impact on this cohort during early identity formation. One participant states feelings common to the group:

"We had role models of mothers, not all, but a lot of them stayed home and maintained the home and raised the children, and now there's some pressure from society to be out there working in the work-field and that somehow you're supposed to be able to do this and do all the other things…"

Middle-aged women also came of age in a time when role identities for women were in a great stage of change. From the 1960's and beyond, women have achieved greater equality in the workplace and in the home – the result of many decades of struggle. These cultural shifts, combined with exposure to traditional roles has created a dichotomy for midlife women. Societal pressures combined with personal life goals have resulted in women assuming numerous roles in an effort to "do it all". The consequences of this struggle to be "everything to everyone" has caused midlife women to experience multiple roles as a series of "trade-offs".

## Multiple Roles as Trade-offs:

### *"Stop the World, I Need to do the Laundry"*

In an effort to balance the many roles they perform in our society, women are experiencing stress related to lack of time to adequately attend to the tasks and responsibilities expected of them. This is evident in comments such as these:

Sarah: "It doesn't feel good when you aren't doing anything in your life at one-hundred percent, you know, performing everything seventy-five percent – sometimes only twenty-five percent doesn't make you feel good, but we just don't have the time"

Tonya: "…I feel like I should be accomplishing more in my life, um, and I often feel that I'm not, in my various roles, not performing any of them as well as I would like to"

It is evident from the literature that women still perform the bulk of household and child rearing tasks, as well as caregiving responsibilities, regardless of status as paid workers.

This phenomenon holds true for the women in this study and has caused them to experience multiple roles as a series of trade-offs. All women spoke of "having to set priorities" to get things done and reported putting their own needs "on hold" in an effort to accomplish what they perceive as necessary tasks in their daily lives. A major factor in the experience of multiple roles as trade-offs is the unequal division of household and childcare responsibilities. All women felt they were responsible for the bulk of the tasks associated with both roles, regardless of marital status. Differences existed; however, in the experience of housework between the married and divorced groups, and in the importance given to this role.

Women shared stories of the tremendous rewards reaped from the parenting role despite the time commitment to it. A divorced woman summed up the feelings of the single parents in the group:

> "I don't have anyone to fall back on. I have sole responsibility for my daughter who I love dearly, yet being the single parent does take it's toll. Her father participates in her life on some weekends, but I take care of all the day-to day stuff. If there is a problem or she gets sick, I handle it"

The married group also shared experiences of performing the majority of child care tasks. One married woman summed up her feelings of having primary responsibility for child care and housework this way "I get mad because it seems that that is truly my role, and no matter how much I nag, it still pretty much remains my role".

The Participant termed "change case" is an example of a single parent who raised her two children alone for 22 years. Seven months prior to the beginning of the study, her

oldest child left for college and she subsequently sold her large home in favor of a small loft apartment. The change in her life resulting from not having the day-to-day caregiving responsibilities for children is apparent in the ways she describes her multiple roles (Table 6). The change in her parenting role alone had a tremendous positive impact on her experience of multiple roles, lending evidence to the time and energy commitment of this role for women. She expresses the meaning of this change in her story:

"I have been through all of this for 22 years – raising children and working…but the last five years have been a real struggle for me getting my kids through school. They're both in college now…and I kind-of feel like it, it's MY turn, um, I worked SO hard for the last five years that I think sometimes I was physically sick because of it… and now this little apartment is a new experience for me…but I feel that I almost HAD to do it to save my life".

The time commitment to the household role is also significant, and many trade-offs are apparent in the shared experiences of women. The divorced women were able to give the homemaker role lower priority than the married women, yet it still remained a major role. One single woman shared thoughts about housework that were typical of the divorced cohort:

"…what I've done is I've let the house go. I don't care what it looks like anymore – well maybe I care, but I don't do anything about it anymore in terms of keeping it up".

The married women felt that maintaining the house was a high-priority role, one which they considered unequally allotted to them. All married participants shared stories of their experiences of lack of reciprocity in this role:

Tonya: "I think we probably all have our stories about who does what around the house and it's pretty much I do it all, and you know, there are times when it builds to the point where you're angry and you kind-of explode at, at your spouse or what-have-you, and, uh, his solution is, he's very computer oriented…so he'll make out a schedule and he'll put it on the refrigerator, and do you think it ever gets done?"

Pamela: "…when you consistently tell them, 'could you pick up your socks?' or 'could you at least take the newspapers off the kitchen table and put 'em in in a pile so that I can set the table?'…I don't think it's too much to ask…you know, he will say 'yeah, oh I'll do that tomorrow, just write me a list or something, but he never really does it…and so I feel, you know, just OFFENDED".

Kimberly: "You know last week when we were preparing for… people to come over and [my husband] is wrestling on the floor with [our son]…I'm THROWING a load of clothes in and I'm VACCUUMING, and doing all of this kind-of multiple stuff, and it's like , I don't want to do this!…and God damn it, why am I always doing this!"

The issue of making trade-offs occurs as women attempt to accomplish daily role-related work with limited resources of time and energy. The result of constantly having to set priorities has led many women to be critical of what they are able to accomplish. This theme is discussed in more detail in the section titled *Self-Blame*. Middle-aged women were raised in a time in our culture when females were primarily homemakers, mothers,

and caregivers. Women's entry into the workforce has not altered the cultural expectation that women continue to fulfill traditional roles, while engaging in "additional" roles. It is difficult to redistribute role responsibilities due to a socially reinforced belief that a woman's identity and value is reflected in the types of roles she has. The addition of new roles has forced women to prioritize tasks and resort to making trade-offs in order to meet the demands of their busy lives. The following is a prototypical response that captures the meaning of multiple roles as trade-offs:

> "You know, we have all these guilts about 'I'm not going to be the good spouse', or 'I'm not going to be the good mother…I think it is an inborn sense in a woman – she does truly want to take care of her home, and she wants to raise her family in a certain way and instill her value system into them, and not somebody else at the daycare doing it. And we really don't know what the long-term effects of [multiple roles] are going to be anyhow…I think it's going to be a long time before we really know…"

## The Meaning of Social Networks

### Social Networks as Primary Relationships:

### *"I get by with a little help from whoever is around"*

All six women shared experiences of having stable social network systems that they described in the aggregate as "generally very supportive"; however, all participants illuminated both positive and negative attributes to the support networks they described. Differences existed between the married and divorced women as to how they rank-ordered their support persons (Tables 3 and 4), but not in the ways in which they experienced support. The meaning of support networks was understood through analysis of responses

to the question, "In what ways and by whom, do you feel supported or not supported in the activities of your typical day?" Shared experiences led to an understanding of social networks as comprised of the individuals in the participant's immediate family with whom the women lived with – their primary daily relationships. Women also experienced social networks in much the same way as multiple roles as a series of trade-offs.

Women reported that the support networks they relied on most were the people they had primary relationships with in their daily lives (Tables 3 and 4). The three married women cited their spouse as their number one support person, followed by either a family member or a friend. The divorced group felt that their children were their number one support system, regardless of age, followed by friends. One married women described her primary relationship as her most important support person by stating,

> "I mean my husband, overall is my greatest support person...I guess he's my greatest supporter for one thing because I see him every day...so I mean from that standpoint, I think he is probably my greatest support".

This statement is typical of all women in the study, regardless of marital status, in the fact that participants cited the people they shared their lives with and saw every day as their primary support networks. This is true despite the fact that the people comprising their most significant social networks may not perform the most supportive actions, and in many instances, may not be viewed as reciprocal supporters.

This was evident during both initial and follow-up sessions with the married group. Women stated that their husbands were the number one supporter in their lives; however,

problems within the spousal relationship regarding support were shared. The discord centered on the lack of reciprocity in the tasks of housekeeping and childcare:

Pamela: "I think it [referring to her social support network] is both positive and negative. I would say it's almost 50/50 maybe, or maybe the negative part is a little more…I also get angry with my husband because the negative part of it is that he says OK, look, I'm giving you the financial support, and I'm proud of what you're doing, but that's it, I don't do windows, I don't do floors…"

Tonya: "…a lot of times I sit alone with my stuff…um, [my husband ], I guess would be my number one support person, but I hesitate to unload on him because he's carrying a lot and so sometimes I will try to just work it out in my head and, um, resolve my problems on my own.

Kimberly: "Oh…um, I mean, my husband, overall, is my greatest support person… I guess he's my number one supporter because I see him every day… so I mean from that standpoint he is probably my greatest support".

During the individual follow-up interviews, women were again asked to reflect on their social support networks. All women continued to cite the people within their immediate household as their primary supporters, although the married women continue to be more verbal regarding lack of reciprocity issues. One woman who spoke of her primary supporter in this way typified this feeling:

"…what is our major support system?, that should be the person we count on the most, and so we say 'this is the person – our husband', and yet, really, they're

not really much of a support system, so this is ALL we have, which isn't much, and we end up giving this person even more, so, than we should, so what kind of support system is that? But it's ALL we have, and I think this is what tends to happen".

While women spoke of an immediate family member as part of their primary support system, it was friends with whom all the women shared the greatest reciprocal and nurturing support. The following are comments shared of relationships with friends:

Pamela: "...I don't know how I'd live without my friends. I've always had friends, and, female friends, and male friends too – but mostly female, and I mean they are great 'cuz who else can you talk to? I can tell them things I would NEVER, ever tell my husband in a million years, you know, and he wouldn't understand anyhow...I think my friends, at this point in my life, are more important to me than my own relationship with my husband".

Rachel: "...when I went through my divorce...I realized how important friends are. Before that, the sole source of support was my husband, um, and when I realized how un-supportive he was, and I was just flailing, I discovered that I had a lot of good friends who were VERY supportive and I've taken that Lesson to heart".

Tonya: "...I feel I have several friends that I trust and I can talk about my intimate feelings and details and problems, and...they are really good about listening, and you know, just saying 'It's alright'".

The phenomenon of social networks for women is understood in the context of their socialization. Women rely on those immediately around them for support due to many reasons (covered in detail in the section on *Health as Social Experience*), but ask for it only when it is absolutely necessary to do so. Because women have so long been considered the primary support networks of others, it is difficult for them to articulate what they need in a supportive relationship. This is articulated by one woman who stated:

> "We have different roles that we've never confronted before and it's going to be a while before this all evolves, you know, and we find out just what we do truly need for support systems".

This may explain why women cite the family members they reside with as their number one supporters even when they simultaneously report a lack of support by these very individuals, while describing their friends as providing significant and meaningful support.

## Social Networks as Trade-offs:

### *"Lets do Lunch – Next Year"*

The experience of social support was similar to the experience of multiple roles because the act of providing social support is an integral part of many life roles for women. As a result, women find themselves having to set the same priorities and make trade-offs to incorporate time for social networks in their lives. Midlife women have been socially groomed to provide nurturing support to others, and are reluctant to seek out support for themselves until the need is great. This phenomenon of "waiting until the need is great" before seeking out support is analyzed in the section on *Health as Social*

*Experience*. It is mentioned here because this tendency to prolong seeking support plays a role in the experience social networks as trade-offs. The reasons women gave for not seeking support included the inability to reciprocate, not wanting to "burden others" and fears of rejection and failure. This supports data obtained from Harrison, Neufeld, and Kushner (1995) in their study of women's access and barriers to social support. When the need for support becomes great enough , it overrides the reasons women give for not seeking it out. Women then experience the negative feelings associated with asking for help, which reinforces the decision to not seek it out in the future (Harrison, Neufeld and Kushner, 1995). This phenomenon may partially explain why women consider their immediate family members as their main support, even when they are not always experienced as supportive. They may not have the time to seek out other (perhaps more supportive) relationships due to the time constraints of their busy lives or may actively refrain from seeking support when it is readily available to them for the reasons cited above.

## Major Themes Related to Multiple Roles and Social Networks

Four major themes emerged from the analysis of shared stories of midlife women: the fast pace of life, feelings of isolation, the need for escape, and self-blame. Although discussed separately, each theme is intimately interrelated with the others and should be considered as interwoven experiences within the broader context of women's lives.

## Fast Pace of Life

### *"The Everydayathon"*

The primary theme emanating from the lived experiences of participants was the rapidly increasing pace of life. All six women related stories about how their lives have been altered, and continue to change, due to the escalating tempo of everyday life and the rapid infusion of technology. One woman shared that she was constantly "on the go" – having to communicate with people "either by phone, fax, computer, or pager" in an effort to meet the demands of her busy schedule. Not only are the number of roles held by midlife women increasing, as well as role demands, but the pace at which tasks and responsibilities are performed is faster than ever before. Women also shared feelings about the day "never seeming to end". All women reported that it was not necessarily the events of one typical day that caused stress, but the experience of the "typical day, day after day, after day, with no end in site" that was problematic for these women.

The fast pace of life was understood through women's accounts of a typical day, and from stories of reminiscing about a simpler time in their younger lives. One woman spoke of a time in her childhood that typified other midlife women's memories:

> "In the age of technology, this world is moving faster and faster. You know what? I was just talking the other day about simple things, like a Christmas day when I was growing up and everything was closed. You couldn't go to the grocery store for milk. I mean, you, you couldn't buy gas. You know, everything stopped for a minute. And nothing stops now. I mean, you could go somewhere 24 hours a day and I think that this is just a real different time in our lives, and, uh, I think the anxiety

level is higher, I think much more so for women because they have the struggle of balancing things".

The following excerpts from dialogue about the effects of the fast pace of life for these women helped the researcher to understand the meaning of this phenomenon in their lives:

Sarah: "There simply is not an extra minute ANYWHERE, and I find myself thinking about how to sandwich in...how to sandwich in time to do things".

Tonya: "...there's this whole roaring, you know, roaring pace that goes on if you let it, and perhaps different personality types thrive on that...but for myself, it's too much..."

Rachel: "I feel like I have at least three things I'm thinking about at the same time... how am I going to get out of the office on time, what am I cooking for supper, did I leave the coffee pot on, you know, I can't stop long enough to concentrate on one damn thing at a time!"

Pamela: "I don't have quite enough time to follow through with the things in my life that are really good..."

The meaning of the rapid pace for women is reflected in the expression of increased pressure to enact many multiple roles in an insufficient amount of time. The pace of life increases stress, anxiety, and fatigue for these women. Health concerns become "the little nagging things that I don't have time to take care of". In addition, participants articulated that having to constantly prioritize tasks left little time for personal enhancement of health, including exercising and obtaining routine preventative care. Feelings of the effects of the

fast pace of life is reflected in answers to the question "What do you feel the fast pace of life does to your health?":

Kimberly: "I know it's affecting our health! Well actually we KNOW it's affecting our health, you know, I mean heart disease is the number one killer of women, and that wasn't the case 50 years ago, so I think all of this is catching up with our society..."

Sarah: "I have this ongoing medical, kind-of 'take care of yourself' contest going on with my woman friend and we are constantly badgering each other...did you get your pap smear?...did you get your mammogram?, and so far she's winning now, and I'm WAY behind doing this stuff...I just don't have the time".

Women experienced the fast pace of life as yet another trade-off with the positive aspects of living in our contemporary society. Women expressed a desire to slow down, yet want to maintain the fulfilling elements of their lives. Several participants spoke of the gratifying aspects of the rapid tempo of life:

Kimberly: "I can be real energized by things and that tends to make my day go better..."

Pamela: "I enjoy the challenge, I really do...I have a lot of energies so I probably would never be content to sit home anyway"

Tonja: "I don't think I would be very comfortable slowing down...but I don't like going at a pace that I'm just exhausted all the time"

Sarah: "There are pieces of my busy day that are so incredibly gratifying..."

This phenomenon is directly related to how women envision health as a "balance" between the positive and negative aspects of multiple roles which is discussed further in the section titled *Health as Balance*.

Along with feeling the pressure of having to keep up with the demands of a fast- paced society, women expressed fear, both for themselves and for their children, of the long-term impact of the speed of life on health. Women are concerned that their offspring are growing up in a world that doesn't know how to slow down. They state that young people don't have any basis of comparison to a slower pace of life when you "didn't microwave a meal, talk on the telephone in the car, or leave a voice-mail for you grade-school child's teacher". Another woman said about her six-year-old son, "There's a big push to be able to do it all and I certainly hope that children growing up nowadays don't hear that". A third woman shared that she felt her three-year-old daughter was being pressured to learn computer skills in her preschool class. She sums her feelings up this way:

> "I, I feel split...I feel like, yes, in order to succeed you have to kind-of play along with it, and go at the pace that everybody else goes at, but at the same time, uh, I don't think that it's healthy to go at that pace".

Fear related to the rapid tempo of life was also expressed in personal terms of the consequences of not being able to "keep up the pace" as women reached their middle and older years. One woman expressed this concern common to the group:

> "We just keep going and going, and ignore the signs that tell us we better slow down. And society doesn't support that anyway – we live in a time where you better keep up

the pace, and if you can't you better take a pill of some kind so that you don't miss a beat. People are afraid to slow down the pace for one minute, because if they do, someone will come along and do it better, faster".

According to Walljasper (1997), it was predicted in the 1960's that one of the biggest challenges facing the future was what humans were going to do with all the free time created by advances in technology and labor-saving devises. Now he states, "More and more it feels like our lives have turned into a grueling race toward the finish line" that he termed "the everydayathon" (p. 41-42). Much of the current lay literature claims that we create the pace of our lives and therefore have the power to slow down whenever we choose to (Baldwin, 1994; Walljasper, 1997), Kelly (1994) contradicts this view in her essay on the rapid pace of life by saying, "our faith in our ability to control the future might be touching if it weren't so absurd" (p. 63).

## Isolation:

### *"Is Anybody out There?"*

A second common theme centered on feelings of isolation. The fast pace of life combined with many role responsibilities is leaving precious little time to cultivate friendships and spend with loved ones. Isolation was also understood as intimately linked to the cultural beliefs of midlife women. The meaning of isolation was revealed via women's experiences with social networks and through the experiences of their life roles. One woman revealed feelings of isolation common to other participants:

"I think what happens there is that we are so busy most of the time accomplishing that we don't take the time to spend with people, um, and establish long-term

relationships and make some memories..."

While the women in the study reported having an adequate support system, they also had a tendency not to utilize it except in cases of extreme need. In addition, the married cohort shared their reluctance to have friends and family over very often because they felt their homes "weren't clean enough". All three married women expressed this reluctance which was articulated by these experiences:

Kimberly: "I tend not to have people over just because, I mean, it would be a major Workout for me to clean the house, but also I would be too embarrassed, you know, if people walked into my house and saw it like that".

Tonya: "...even though I spend all this time with the house I think my house isn't clean enough to have people over 'cuz these are the women that I go over to their house and it's always immaculate and I wonder, how do they do it?"

The experience of isolation as a consequence of "not having a clean enough house" reflects the extent to which multiple roles are imbued with cultural messages for midlife women. The divorced women all shared that they had operated under the same belief system during their married years of being valued by others partially for the extent to which they kept up the household. When they became single heads of households; however, they verbalized allowing housework to "fall on the list of priorities" as they juggled other multiple roles and their sense of self-worth evolved. The woman termed "change case" was the only participant who currently did not feel isolated, but reminisced about feeling extremely isolated and lonely for many years prior to her lifestyle change.

As with other emerging themes, the women were not able to link specific health consequences to isolation, but had a sense that being isolated from others was potentially unhealthy. Participant's understanding of the meaning of isolation in their lives is captured in these remarks:

Tonya: "I know isolation is not healthy...and any time that you feel bad or isolated isn't a conducive way to feel, and I'm not further than coming to grips with that".

Kimberly: "I'm feeling some isolation, and you know, the people that are very close to me like [my husband and my son], as much as they try to express themselves , um, I know sometimes they really don't understand the pressure in my life right now..."

Sarah: "I feel very isolated, and I am the perfect example of someone who never asks for help until it is evident that I can't function or get something done without it".

The concept of isolation for midlife women has yet to be explored; however it is well established that women are diagnosed twice as often as men with psychiatric illnesses (Conner, 1985; Cowan, 1996, Woods, 1996). Perhaps instead of labeling a woman as psychologically impaired and giving a prescription drug to fix the problem, the larger cultural issues of social support and isolation should be assessed as a means of providing effective interventions.

## Need for Escape Time:

### *"You can run, but you can't Hide"*

A third theme that emerged from women's shared stories was a need for personal time. Participants referred to this phenomenon as "my time" – time that they plan regularly, sporadically seek out, or fantasize about having. The term "escape" describes this life experience because women reveal using the time to "get away" from the demands of their active lives, if only for a brief respite. They also talked about having to "actively seek it out"; the time did not offer itself within their busy schedules. Various methods were used to experience escape time:

Rachel: "I will sit and do nothing sometimes on the weekends I don't have my daughter…I will not schedule ANYTHING and just sit there and stare off into space. I mean it literally. And I think it's very healthy".

Pamela: "Well, reading to me is therapeutic…I get in bed in my nightgown, you know, and I just turn on my nightstand light, and that's MY time – nobody bothers me other than my cat and dog. That's it with me, but that's IT, and they know that".

Tonya: "…if it's a preschool day, I go off to the health club, and that's MY time…I feel stressed a lot of the time, and…the only thing that seems to ease that is going down to the gym and working my butt off…"

The participant classified as the "change case" was referred to by other women in the group session as having made "the ultimate escape" when she sold her large house and moved into a small loft apartment. She accomplished on a larger scale what the other

women were attempting to do on a limited and sporadic basis. The feelings of the group regarding her lived experiences were summed up in this comment:

> "I mean, it's like I listen to you talking about doing things for yourself right now and what a GLORIOUS, absolutely GLORIOUS thing that is, and it's like a gift I don't even give myself".

Women who felt their life roles did not allow for personal escape time fantasized about it. When asked what she would do to enhance her life if she won the lottery, one woman described what her escape time would be like:

> "I would have my own little room where nobody could mess it up 'cuz sometimes when I get very angry about the dirty socks , and you know, the total mess, I'll say OK, I'm going to get my own apartment and I'm taking the furniture! I mean it would be MY space that nobody else could invade".

Escape time was defined by the women as a health-enhancing experience that was necessary as a means of attempting to create balance in their hectic lives. Typical responses to the question "How does taking personal time effect your health" are presented:

Tonya: "I could use a little more of that because usually it's just brief, brief moments, but yeah, it's great to feel some freedom for a little bit".

Sarah: "It's not enough...it's just not enough".

Pamela: "I have to have it. I, I shudder to think what I'd be like without it...I wouldn't be good for anyone. It's the only thing I do for myself".

Although women experienced personal time as a health-promoting activity, they felt they

did not have adequate time to engage in it on a routine basis. Lack of personal time to rejuvenate both physically and mentally may have tremendous negative health impacts on midlife women and contribute to the onset of chronic, debilitating illnesses.

### Self Blame:

### *"It's all my Fault"*

Women had a tendency to blame themselves for their involvement in multiple roles, and for the negative health consequences resulting from the pace of their daily lives. Along with self-blame were critical appraisals of how women felt they were performing in the tasks and responsibilities of their life roles. Participants verbalized lacking a sense of control over many of their life circumstances, yet placed personal blame for creating many of the factors causing dissatisfaction. This phenomenon was understood as women reflected on their feelings of engaging in multiple roles:

Pamela: "I just feel angry, and I think, well this is ridiculous! I shouldn't feel angry because I'm creating these circumstances...just looking at the overall picture, I think we kind-of make our, a lot of our situations, and we have these multiple roles because we want them, really".

Sarah: "I also look at...the tension of not having the time to do anything in a quality way. I feel I'm not as good a parent as I could be. I'm much shorter-tempered, I get angry very quickly, and, um, I feel I can't do any tasks very efficiently, because there simply isn't enough time to do ANYTHING efficiently".

Tonya: "I chose this, you know. I want to be the homemaker and the mom and

take care of my family...but I always feel that I'm not doing enough, I'm not doing it well enough, um, and so I beat myself up a lot...the ongoing stress, you know, I'm the one who creates it".

Taking responsibility for our lives and our health is a concept that has been spoon-fed to the public in the popular lay literature. We have been conditioned to believe that we have ultimate control over the choices we make in all aspects of our lives, including health (Acres, 1994; Goodwin, 1995; Maas, 1996). At a time when midlife women are engaging in many roles with tremendous responsibilities, an appraisal of what women truly have control over, and power to change in their lives, is a necessary first step in providing interventions based on realistic goals. The cost to women of making change must also be evaluated. The effects of self-blame on the long-term health of midlife women have not been studied; however, it can be safely hypothesized that the act of blaming oneself for making certain life choices is not a health-enhancing activity that promotes well being. One woman speaks to the irony of self-blame by saying,

"It's our own choice see, so this is the problem...I mean how important is it going to be? I don't think we are going to know until we are very old, and then it will be to late to change it".

## Core Experiences

Two core experiences were identified from the lived experiences of multiple roles and social networks for midlife women. These experiences are conceptually different from the themes identified because they are at the very foundation of the lived experience for all

women in the study. A sense of disillusionment with life and lack of control over life choices were threads that linked other experiences together. Core experiences represent the essence of the meaning of multiple roles and social networks.

Disillusionment:

*"It wasn't supposed to be like this Cinderella!"*

The experience of disillusionment became evident as women described how they came to the point in their lives that they are now by engaging in multiple roles. Women reminisced about their childhood visions of becoming adult women, and of the plans they made early in life to fulfill certain life roles. The reality of their lives at middle age has turned out to be somewhat different than they had envisioned. This is true for both the married and divorced groups. The feeling of disillusionment is expressed by one women whose story is representative of the other participants:

> "I was so stretched and worn out and pulled in so many directions that I thought – middle life! All these things that I'm having to do, taking care of the kids by myself, and on top of that an elder person to look after…a house that's practically falling down around your shoulders, and having to do all of the maintenance, and you can't afford to hire people to come and take care of everything, and thinking MY GOD, what is the reward in this? Being a midlife person is WAY harder than I ever could imagine".

Women talked of the plans they made in childhood and young adulthood to "become" many things including a wife and a mother, and to fulfill a role in the workforce. The following stories were shared about the thoughts women had about what their life would entail, and capture cultural undertones impacting choices:

Tonja: "I kind-of made decisions back when I was 17-18 years old that I wanted to do schooling and that kind of stuff, and travel, and kind-of get some of the fun stuff out of the way before I got bogged down with too many roles... getting married and having a family...and it kind-of roles along according to plans that started way back there..."

Pamela: "My mother was a career woman, she was a career woman all her life, and so I think I followed in her footsteps...I couldn't just see staying at home all the time, although I did want to have children – that was part cultural I guess coming from an Italian family..."

Rachel: "My mother stayed at home and took care of EVERYTHING – the house, my dad, us kids. I wanted to have a family when I grew up and a career, but I didn't want to be as devoted to the house as she was. It was all she did".

These stories depict the importance of role models in the lives of these women – primarily their mothers, whose lives they used as a springboard for making decisions about who they wanted to be. Part of the disillusionment sprang from the intention to "do things differently" than their mothers in order to avoid some of the negative aspects of their mother's lives while incorporating the positive dimensions they witnessed.

Disappointment resulted when "doing it differently" didn't equate with gaining more satisfaction with multiple roles. One woman verbalized eloquently the feelings of disillusionment expressed by all women in the study when she said of her life:

"...no one forced me to make the choices I've made in my life. I mean, I wanted to have a career and get married, and have a family. I guess I didn't imagine it being this

way, but I chose it, and all that goes with it. I think we all had an idea or an image of what we wanted to be when we grew up, and for me and most of my friends way back then, we were going to do it all…and do it well. After all, our mothers did. Only we were going to do it differently because we were going to be career women as well as moms and wives. Yeah, we were going to do it all…and the thing is, we are".

Disappointment also resulted from filling the role of traditional homemaker and mother - from not doing it differently than their mothers. The lone homemaker in the group expressed her feelings of disillusionment from this role:

"being the homemaker is not the glorified position in life, and it doesn't increase your worth in the outside world. I mean it's not skills that are highly sought after, um, as being highly compensated…it's not something you get a lot of pats on the back or recognition about 'WOW, you're a great housekeeper – you should be proud of yourself!".

From the women's stories, the essence of wanting to fulfill many roles meant adding on additional roles to the ones they planned to have as children – the culturally accepted roles for women of their generation. This phenomenon has resulted in women "doing it all" in an effort to balance what they feel they should be doing with what they want to do. Dr. White, a therapist who specializes in stress disorders believes that women today "still have an inferiority complex" and the way they compensate for that is to "try to prove they're adequate by taking on too many responsibilities" (as cited in Maas, 1994, p. 168).

What this view fails to address is the part our culture plays in encouraging and rewarding women to 'do it all" while placing little value on the roles of homemaker and

caregiver. This message has survived the women's movement and still persists in today's society. At the heart of disillusionment is the feeling that midlife women aren't experiencing either fulfillment in the lives they thought they would have, or the ones they actually do have. One woman's comment sums up the unique position of midlife women and the hope for the next generation:

> "I hope it is different for the generation that is growing up is that you don't have to do it all. I think that was a real disservice to women to make them think that they could, and I think that what my generation of women are struggling with is that we had role models of mothers, and not all, but a lot of them stayed home and maintained, you know, the home and raised children, and now there's some pressure from society to be out there working in the work-field, and that somehow you're supposed to be able to do this and all of the other things, so I think from a cultural standpoint, for at least my generation, there's a big push to do it all, and I certainly hope that children growing up nowadays don't hear that".

## Lack of Control:

### *"I chose this life – at Least I Thought I did"*

The core experience of lack of control was understood from women's accounts of the typical days in their current lives and from extracting meaning from shared stories of how they arrived at the current place in their lives fulfilling multiple roles. Women described feeling in control of their lives via descriptions of "choosing" roles and having control over life choices, including those related to health behaviors. The lived experiences of these women; however, reveal a lack of control over many aspects of life circumstances. This is

evident for both the married and divorced participants. The following stories represent situations of lack of control that has impacted their current lives:

Pamela: "I didn't choose to have my first husband cheat on me and leave me with five children to raise where I HAD to work! So some things I planned and some things I haven't, and that's just part of life".

Julie: "I certainly didn't plan to be in the position of having to care for my Aunt after she had her stroke, and it couldn't have happened at a worse time in my life…I was so stressed! Of course there never is a 'good' time for these things to happen, but it was so unexpected, and there was this unspoken decision in the family that I was the one who was going to take care of her".

Sarah: "I grew up in a dysfunctional family – the child of alcoholics, and it's not like you CHOOSE this, but it has had a tremendous impact on me, and I know it has affected the relationships I've chosen in my life".

While women spoke of circumstances in their lives for which they had little or no control over, they also spoke of choosing their life circumstances. This lack of congruency is expressed in the following comments and also in experiences detailed in the section titled *Self Blame*:

Sarah: "I chose to live my life the way I do so I can spend as much time with my daughter as possible. I control the events of my day as much as possible to make that happen"

Pamela: "I chose to be a student…"

Rachel: "I choose to prioritize my life the way I do because it works for me. I don't worry too much any more what other people think I should be doing – I used to, but I don't anymore"

At the same time, women experienced periods of lack of control. These times coincided with feeling out of balance. One woman described this feeling which typified other women's experiences:

"there are occasional times when it feels like it gets out of control, and I think that that's partly hormonal. I mean the PMS time, and I frequently feel things get out of balance then, and um, I realize that...this too shall pass, and just get through it the best way that you can".

When the lack of control and balance reached the point where it was interfering with women's daily lives, women would take 'escape time' in an effort to restore balance. All participants had a tendency to wait until they absolutely had to take personal time for themselves before doing so. Likewise, their life circumstances had to be out of control before women accessed their support networks.

The woman termed "change case" who made major life style changes after her children left for college was the only participant who felt currently in control of her life. She shared experiences of being extremely out of control for the 22 years preceding her move, stating that "I was on a downward spiral – totally out of control". She shared the feeling of having to make choices to regain control over her life in this way:

"I gave so much of myself away to others that there wasn't anything left over. I was totally 'out of it' – completely drained. I came to the point where I had to take a long

look at what I was doing, and make some drastic changes soon. Now I feel in control again, and at peace with my life for the first time in a long time..."

These women feel empowered to make certain life choices, yet sense a lack of control over many aspects of their lives, including participation in activities that enhance health. All women shared feelings of having "created" or "chosen" their life circumstances; however, their lived experiences reveal many instances of not being able to control many of the events of their lives. Examples of this phenomenon are given in the sections on *Self-Blame* and *Disillusionment*. As women increase participation in life roles in a fast-paced world, feeling in control of meeting their personal needs will become even more critical. Although in the natural course of life many things happen for which we have little or no control, women must be empowered to assert themselves to get their personal and health needs met on a regular – not sporadic basis.

## Effects of Multiple Roles and Social Networks on Health

Participants described in detail how their multiple roles and social networks impacted their physical and psychologic health. Women were asked to describe how these variables affected each of the two aspects of health as separate entities; however, the meaning of health emerged as a melding of both. One woman summed up the feelings typical of all participants when she said, "I think it's really hard to distinguish whether the physical stuff impacts the mental stuff, or vice-versa".

All six women rated both their mental and physical health as either "excellent" or "good" on the Health History Form (Appendix C). Three women reported having one of

the following chronic health problems: asthma, gastrointestinal problems or hypertension. One woman indicated two health concerns – musculoskeletal and gastrointestinal illnesses. Two women cited situational anxiety and depression as mental health problems and two women stated they had no physical or psychologic health concerns.

Only two participants directly related their physical health problems to the experience of life stress. Both women were nurses, which may account for this phenomenon. Nurses may have an increased understanding of the potential health impact of stress related to life roles, both from increased knowledge, and through direct observation of patients. This is important, since nurses are in a unique position to assist their clients in identifying factors affecting health and providing health education.

The women reporting situational mental health problems related their problems to issues of divorce. This was experienced as situational depression and/or anxiety directly related to the end of a significant relationship for which counseling was actively sought. Although most of the participants reported the presence of either ongoing or sporadic health problems, the experience of health for all women was not associated with either the presence or absence of disease during the sharing of lived experiences of health. From analysis of shared stories of multiple roles and social networks, three meanings of health emerged: health as balance, health as self-responsibility, and health as a social experience.

## Health as Balance:

### *"Just add it to the List"*

All women experienced health as a striving for balance in their lives. The measure of health status was the extent to which participants were accomplishing a sense of balance

or felt an imbalance between the stresses of everyday life and the ability to take time for self-care. The experience of health as balance is directly tied to the core experience of lack of control and to the rapid pace of life. When women felt in control of life situations they experienced balance; lack of control resulted in an imbalance that participants associated with stress and fatigue. One woman describes the "balancing act" as an analogy to spinning plates up in the air on sticks "like in the circus":

> "...you're just standing there juggling and, you know, I've got child care over here, and I've got school over there, and I've got this little job, and, oh yeah, and I've got to be a wife, so I keep that plate kind of thing going...and [I] keep all of these plates spinning...we are ALWAYS going to be juggling those plates! I wonder where you set down those little sticks you balance them on when you need to rest – probably when you're dead..."

This poetic example is typical of the feelings all women had regarding having to balance multiple responsibilities on an ongoing basis.

Participants reported attempting to achieve a sense of balance by eating properly and trying to get enough rest. This was expressed by one woman:

> "I have always been conscious about trying to achieve some balance where even though I can be very busy working...that you also take time to take care of your physical body, and I try to provide healthy foods and take care and get my sleep... so I feel good that I am achieving some kind of balance".

Two women felt they obtained adequate exercise, while four women reported lack of exercise as the primary activity missing from their lives that contributed to less than

optimal health. Women also attempted to restore balance by taking personal time for themselves (discussed in section on *Need for Escape Time*). Efforts to restore or maintain balance by doing certain health-enhancing behaviors; however, did not result in creating balance for these women. The phenomenon of waiting until their lives were "totally out of balance" before attending to their needs was the primary reason as experienced by these women:

Tonya: "I guess that my life has been going at such a fast pace that I am almost getting used to being in a state of unbalance...and since I sometimes feel like a single parent, I count on myself to get things done, so I guess I do wait until the scales are really tipped out of control before I put it straight again"

Pamela: "I just keep going until I absolutely am worn out, and you know, I have done it for so long that I don't even pay attention to it until it grounds me, you know. I know a lot of women like that...if we don't do it, it doesn't get done"

The 'lack of attention' described in the above story is a phenomenon experienced by all but one woman in the study. Participants ignore signs indicating a need to restore balance prior to it reaching a critical peak or wait until a problem arises that forces them to take respite time to regain balance. Ignoring health needs and waiting until stress and fatigue levels are high has caused women to fall out of touch with what they are feeling. One woman spoke of the confusion she felt:

"you know, when you get really, really tired sometimes, it's hard to sort out all the other things that you feel, and I think if you have enough stress in your life and it keeps

going, that after awhile you kind-of don't know how you feel, and I mean there are some days that I think 'am I really depressed?'…then I think 'no', I think I'm just tired…"

When women feel totally out of balance, they may not know what is at the root cause of their health symptoms. It is essential for health care providers not to be too hasty to label a women with an illness or condition prior to gaining a thorough understanding of her life circumstances. Also, recommending interventions such as taking the time to exercise must be suggested in the context of women's lives or it will just become one more thing to become stressed about – one more thing to "add to the list".

## Health as Self-Responsibility:

## *"All I Have to do is Choose it!"*

The meaning of health as a personal responsibility was understood through expressions of self-blame for not doing everything the popular literature and media claims we must do in order to maintain adequate health. One woman summed up the feelings of all participants this way;

"guilt is much higher because the media keeps telling you how you need to do all these things with your kids, or you need to be doing all these things for your health, and the world is going faster and faster, and your typical day isn't allowing for ANY of that stuff!"

The media, along with the health care profession has advocated personal responsibility for choices related to health practices. These messages have become ingrained in our society

and in the minds of the women in the study. The following are examples of their views of health as self-responsibility:

Kimberly: "The pace of the world is affecting our health, and again, I think it's that people have to take responsibility – one for both relaxing, and two for exercising. I mean…that part hasn't changed since the beginning of time…"

Sarah: "Every time I turn around I'm reading about one more thing I should be doing to be healthier. Just this morning I read in the newspaper about natural therapies – how about taking a nap, now there's a natural therapy! I know I'm supposed to do more for my health, but I simply don't have the time"

Rachel: "If I spent as much time actually doing all this stuff they tell you is good for you instead of reading about it everywhere I look, I'd probably be in a lot better shape. I do what I can, but it's obviously not enough"

Women recognize the need to take responsibility for their own health and make efforts to perform activities such as exercising and eating well to promote well-being Unfortunately, for women with multiple role responsibilities, lack of time for personal health is minimal, causing guilt and anxiety. Our culture advocates health, but does very little to incorporate time for health practices within a woman's hectic life. For example, very few job sites have gym facilities, and few gym facilities have day care available. Health is a personal responsibility as well as a social responsibility. Midlife women are more likely than men to suffer from chronic and disabling illnesses, many of which begin to

manifest themselves during middle age (Massion, et al., 1995). Health care practices must be realistically incorporated into women's schedules or the result will be increased stress and guilt resulting from "one more thing to do". This feeling is captured by one woman's story:

> "I got a membership to a health club, but I don't go. It was one of those New Years resolutions – I was going to finally do it. But, you know, the reality of it is that I don't go because my schedule doesn't allow it, and when it does, I'm just too tired to go. I feel rotten for spending the money and guilty every time I see the gym bag sitting in the closet".

## Health as Social Experience:

## *"I'd rather die than ask for Help"*

Regardless of marital status, all women felt that their overall social networks were adequate, albeit that some networks were more supportive than others. A significant phenomenon emerged from shared stories; however, revealing the conditions under which women access support networks. All six women stated that they had a tendency to wait until they absolutely needed support before seeking it out, even when it was readily available to them. Every woman shared stories of how she would attempt to handle situations on her own, and only ask for help when she absolutely had to - when things "got really out of hand". Not one woman considered asking for support on a regular basis before the need for help was great, but felt good when she could provide support for others.

Women shared several reasons for not seeking support. Reasons given included not wanting to burden others, feeling like a failure, fear of rejection, and fear of not being able to reciprocate. The following are examples from stories reflecting this phenomenon:

Tonya: "I could ask for help before I let it get so bad, and I don't because I just don't want to burden people…I usually let it get to the point where I'm feeling really down and depressed before I will go out and seek some support…and I don't do that until I'm feeling suicidal or something, you know, really depressed".

Rachel: "I'm not used to or comfortable with anyone taking care of me, of being the one in the sick role who needs to be cared for…that's extremely uncomfortable. I didn't even think the whole time I was sick – it didn't even occur to me that it would have been handy to have someone around".

Sarah: "I have to be strong and I have to be tough, because truthfully there's no one to fall back on. And, um, I think I have so genuinely conditioned myself into believing that, that I don't trust that there are people there for me…well they are, except that I don't let them be".

Pamela: "I just NEVER tend to ask anybody for help unless I absolutely need it , and even then sometimes it can be painful…I don't think any of us do too well with rejection…or maybe it's just that it makes you feel like a failure because you think you shouldn't ask for any help".

Kimberly: "I don't do a lot of, um, calling my girlfriends just to chat…mostly because I just don't have the time. I'm afraid they're going to need something, you

know, and it's a terrible thing to say...but I just can't reciprocate right now"

All six women indicated that this tendency to prolong seeking support was potentially detrimental to both physical and mental health, yet participants did not indicate feeling empowered to change this practice. Women are socially educated be the caregivers to others, not the ones in need of care (Harrison, Neufeld and Kushner, 1995). This theme is evident in women's stories of reluctance to seek out social networks before a significant problem arises, and in the discomfort experienced from being in the sick role. The social experience of health for women as needing to feel desperate before seeking support reinforces the culturally laden notion that women are valued only to the extent to which they fulfill socially accepted functions of providing care and support, in addition to all other role responsibilities (Oakley, 1993, Watson, 1990).

It may be that it is not the type and amount of support available to midlife women that has the greatest potential for negative health consequences, but what our society has taught women to believe regarding their cultural identity as caregivers. Midlife women must be validated as persons worthy of nurturing and support, and encouraged to seek support before the need for it reaches a crisis level.

## Summary

Through the dialogue of lived experiences of participants, an understanding of multiple roles, social networks, and health for this group of midlife women was revealed. Multiple roles were experienced as a cultural phenomenon intimately associated with participant's identities. Both the roles women chose to enact, and the tasks undertaken within each role were affected by women's beliefs learned in childhood. Women shared that their mothers

were significant role models who had an impact on the roles they planned to experience when they became adults. The women's movement also played a role in the participant's lives by encouraging them to "do it all". Thus, multiple roles were experienced as comprising a woman's identity – they are the means by which women understand who they are, not what they do.

Multiple roles were also experienced as a series of trade-offs. As women attempt to "do it all", the reality of engaging in multiple roles with limited resources of time and energy result in women having to prioritize the tasks and responsibilities of their daily lives. This leaves little personal time for health enhancement. Participants reported having primary responsibility for both household and child rearing, regardless of marital status, or number of other life roles. This phenomenon is supported in the literature, and may be a major reason women struggle to prioritize and balance their multiple roles.

Women cited their immediate family members who they resided with as their primary support networks, although these relationships were not always supportive or reciprocal. They also reported friendships as playing an important role in their support systems, but sought them out less often. Reasons for not accessing support included not wanting to be a burden, fear of rejection, and feelings of not being able to adequately reciprocate. Women had a tendency to wait until the need was great before seeking out support, when a "crisis level" was reached. This may partially explain why they tend to utilize the individuals most readily available – their family members, when in need of support.

Because multiple roles and social networks are intimately linked – and in some cases indistinguishable as is the case with the parent role, social networks were also experienced

as a series of trade-offs. Women felt more comfortable giving support to others than in receiving support which may impact their ability to balance role-related tasks and responsibilities.

Several themes emerged from shared stories that affect how women experience multiple roles and social networks. Themes included the fast pace of life, a sense of isolation, the need for escape time, and a tendency toward self-blame. The increasing pace of life is effecting women's ability to keep up with multiple role demands. As a result, participants reported either taking 'escape time' or fantasizing about it when the rapid pace of their lives resulted in increased stress. This was one way in which the women sought to achieve some form of balance between meeting the needs of others versus self.

Isolation was linked to women's experience of social support (not accessing support when it is most needed) and from lack of time to seek out social encounters due to the fast pace of their lives and multiple role demands. The married cohort reported not engaging in social activities in their home when they felt their houses were not clean enough for others to see. In this way, the role of homemaker is linked to feelings of isolation, and perpetuates a culturally imbued notion that a woman's identity and worth stem from her role as homemaker.

Women blamed themselves for "choosing" the roles and social network affiliations in their lives while simultaneously sharing experiences of lack of power over many of the circumstances of their lives. This theme is revealed in the two core experiences of midlife women – disillusionment and lack of control. Disillusionment was experienced as women compared their current lives to the lives they planned to have as children, and to the lives

of their mothers. The idea of taking on multiple roles has proven to be somewhat different than the reality of taking on multiple roles. Several participants expressed anger that they were taught to "have it all" – work, home, and family, which has come to mean "doing it all". The reality of assuming multiple roles, and for taking primary responsibility for the tasks associated with them has caused women to feel constantly engaged in fulfilling role-related responsibilities with no respite time.

Lack of control was experienced as both powerlessness over certain life events, such as a divorce or an elderly family member in need of care, and in the feelings of lacking control over day-to-day activities of life. Priority setting was utilized as an attempt to gain some control; however, women shared that they prioritized the needs of others before self, including health care needs.

Understanding the meaning of multiple roles and social networks for midlife women provided a basis for gaining knowledge of the meaning of health for participants. Health was experienced as a striving for balance, as self-responsibility, and as a social experience. Health was not defined as the presence or absence of illness – a concept from which the western medical model is based. Instead, women shared experiencing good health when they felt in control of their lives and had a sense of balance between the demands of multiple roles and respite time. Unfortunately, feelings of being in balance were experienced only sporadically. Stress, fatigue, and potentially negative health consequences resulted from an inability to sustain balance over long periods of time.

Women felt responsible for creating the situations that caused their lives to be out of balance (self-blame), and also felt responsible for not attending to their personal health

needs. The idea of personal responsibility for health is encouraged by the media and by the health care system. "Self-help" is a market strategy used to hook consumers on the latest health-enhancing strategies that count on individuals to feel personally responsible for creating optimal health. The health care and insurance industries are based on the belief that individuals must take responsibility for personal lifestyle choices in order to change health-damaging behaviors. Self-responsibility for health for the women in this study caused guilt, frustration, and stress, due to a lack of realistic means to achieve health within the context of daily lives.

Health was also experienced within the context of women's social networks. First, women are the nurturing caregivers to others within their social structures, and have a tendency to put themselves last on the list in terms of seeking support, including support to enhance health. Secondly, the women all reported waiting until the need was great before accessing support, and shared experiences of unease when being the one in the sick role. Participants also felt more isolated from others due in part to multiple role demands. These social experiences have tremendous potential consequences for women's health as they wait longer to seek help, put themselves last on the priority list, and are isolated from support networks.

Historically, health care for women has focused on reproductive issues and menopause – "conditions" requiring medical interventions. The long-standing medical model has defined health for both genders as the presence or absence of diseases or conditions for which treatment is metered out to fix the problem. For the women in this study, health was not defined in these terms. The concept of health was experienced in relation to the

stresses and rewards of daily life within the context of social networks. Unless the meaning of health is understood from women's unique perspectives, health care services aimed at meeting women's needs will fail to provide the types of services important to women in achieving and maintaining health.

Additional studies on the meaning of health are needed for all ages, races, and socioeconomic status women. Until the concept of health for women is understood and validated in terms that have meaning for women, care will continue to be based on assumptions of predetermined health needs. Health care, then, will be palliative at best because the underlying issues will not be addressed. At a time when cost containment is becoming a reality in the provision of health services, quality, low-cost, effective care for women can only be achieved if it is based on services that target women's needs as defined by women.

## CHAPTER FIVE

*"Written on the breeze"*

*Looking back on a woman's life*
*born into another time*
*half a lifetime ago*
*creating a self –*
*the fullness of potential.*

*And knowing now*
*a woman born to be all that she can be*
*in the land of freedom where*
*all men are created equal,*
*generally speaking, of course,*
*and all doors to the future are open,*
*more or less.*

*Small girl creating a future*
*With arms spread wide…*
*HERE I AM!*
*I want to fly!*
*and be a mommy.*
*I want to soar in a space ship!*
*and take care of the children, the sick.*
*I want to be president of this country!*
*and help other people.*
*HERE I AM WORLD! I can be anything I want to be,*
*and you need me…*
*and messages are carried on the gentle breezes*
*Less than less than less than*

*School girl learning all she must know*
*to fly*
*to soar*
*to become!*
*HERE I AM WORLD! I can be anything I want to be,*
*and you need me…*
*And messages come through the floorboards, the air,*
*the crackle of new textbook pages*
*Less than Less than Less than*

*Young woman popping with life born and to be born*
*caring for…*
*HERE I AM WORLD! I can be anything I want to be*
*(when today's work is done)*
*and you need me…*
*And messages course through her veins*
*Less than less than less than*

*Woman in the middle of her years*
*wondering how she has come to this place in her life…*
*HERE I AM WORLD! I can be anything I want to be*
*(in the time I have left)*
*and you need me…*
*And messages come from the places in her life,*
*creeping into her center*
*less than less than less than*

*Because you squash the life force,*
*sap the energy you need,*
*because you are afraid*
*of the powerful energy*
*that comes from woman*
*giving.*

*And she moves into the second half of her life*
*with joy and anger*
*with tears and laughter*
*with pain and exuberance*
*with the possible yet to unfold…*
*And wonders*

***How will it?***

(Brown, 1994, pp. 84-86)

# Chapter Five

## Implications for Theory, Research, and Practice

This chapter includes a discussion of the research participant's experience, limitations of the study, and suggestions for further research. Implications for nursing practice are described for the nurse as clinician, researcher, and consumer of health care services.

## The Research Subject Experience

Following each group interview, all participants were asked to reflect on their experience of participating in the study. All six women described one or more of the following feelings prior to the group interview: fear, ambivalence, excitement, and frustration. The women who experienced some degree of frustration related these feelings to having committed to participate in the study, and then not feeling they had adequate time in her schedules to participate.

One woman expressed fear about not having enough to share about her life. Another woman became tearful during the sharing of personal experiences, and several participants demonstrated nervousness or fatigue during the end of the group interviews via non-verbal body language. Despite the feelings described above, all women expressed thanks at the end of the study for being asked to participate. Four women verbalized gaining personal insight of the potential impact of multiple roles and the pace of life on health status, and two women stated they felt motivated to make some positive changes in their lives by allowing themselves more personal time. One woman described her experience in the following statement:

"I've enjoyed talking with you, and I think it has helped me a lot having these

questions verbalized to me and to give them some thought".

Another woman summed up her feelings this way: "This is a great thing you're doing –it's about time".

## Limitations of the Study

There are several limitations of this study that warrant discussion. First, the small number of women who were interviewed for the study prohibits a full understanding of the phenomenon of interest. The sample size is appropriate for a master's research project; however, further studies with larger numbers are necessary to comprehend the lived experiences of multiple roles and social networks for middle-aged women. Although generalizability is not a goal of phenomenologic studies, validity is an important issue in all qualitative research methodologies where small sample sizes are utilized to describe phenomenon (Jasper, 1994).

A second limitation involved the homogenous characteristics of the sample. While homogeneity was desired within the scope of this project to enhance the potential for extracting similar themes, the lived experiences of the women in this study cannot be assumed to mimic those of women not fitting the sample characteristics. Validity in phenomenological research is "grounded in the uniqueness of each lived experience of the phenomenon, while permitting an understanding of the meaning of the phenomenon itself" (Banonis, 1989, p. 38). To fully understand the broader meaning of the health impact of multiple roles and social networks on midlife women's health, studies of women from various cultural and socioeconomic backgrounds are needed with adequate sample sizes. Lesbian women must also be included as study subjects. A meta-analysis of additional

studies in this area would allow a greater depth and breadth of understanding of the phenomenon.

The sampling procedure may also have introduced bias into the study. The snowball method (described in the Methods Section under *Sampling Procedure*) is a type of convenience sampling that "is expedient, but runs the risk of sampling bias" (Polit and Hungler, 1995, p. 233). The risk, however, may be negligible when the phenomenon under investigation are fairly homogenous, as was the case in this project. Although convenience sampling is the most commonly used method in nursing research, it is also the weakest form in terms of introducing potential bias (Polit and Hungler, 1995).

Another important limitation relates to the time constraints of the study. The lack of time and resources available to fully devote to analysis of findings may have effected the way in which the phenomenon was understood by the researcher. In phenomenology, much time is needed for immersion into the data to understand completely the lived experiences of participants. This problem was somewhat compensated for by having the first set of group and individual follow-up interviews co-analyzed with a nurse expert in phenomenology.

Lastly, the principle researcher who conducted the interviews is a Caucasian, middle-aged woman with many life roles – characteristics fitting those of the study subjects. A determined effort was made to adhere strictly to the components required for full, unbiased involvement in the phenomenologic process, (refer to Methods Section under *Roles of Researcher and Participant*) This was accomplished by journaling of personal experiences prior to the interviews and through careful interpretation of the data based on

the women's stories. Although the researcher took precautions not to introduce bias from either personal experiences or via knowledge obtained from the literature review, the possibility exists that verbal and/or non-verbal feelings or opinions were communicated to participants which may have effected their responses to questions. According to Jasper (1994, p. 311) a genuine attempt must be made to "ensure that conclusions reached arise from the data and not from the interpretation imposed by the researcher".

A knowledge of the limitations of this study is important for consumers of research for several reasons. First, the reader is guided to critically appraise the study for its' strengths and weaknesses. Secondly the reader is able to utilize findings wisely and to avoid inferring results to inappropriate populations. Lastly, it guides future research methodology in this area.

## Suggestions for Further Research

To the researcher's knowledge, published studies on the lived experiences of the health impact of multiple roles and social networks for middle-aged women are not yet available. A tremendous gap in the literature exists as to how a woman's life and social structures impact her health, as well as that of her family. This gap requires the attention of nurse researchers at a time when this subgroup of the population is growing, while simultaneously increasing participation in many life roles. The paucity of research in the area of lesbian health issues related to the two variables studied is even greater. Research in this area would increase knowledge of this subgroup of the population for whom little is currently known.

Repeated studies utilizing larger numbers of midlife women, as well as women of various ethnic and socio-cultural backgrounds would broaden the understanding of the meaning of health for midlife women, and the health impact of multiple roles and social networks. Further studies in this area would also be beneficial in determining the consistency of results (Lincoln and Guba, 1985), in theory development, and in testing theoretical relationships.

A quantitative study derived from women's experiences of multiple roles and social networks may increase knowledge of the extent to which themes and core experiences identified in this study occur for large populations of midlife women. Research of this nature would also be beneficial for further theory development.

Research utilizing older children and young adults of both genders would add greatly to an understanding of the cultural impact on choices related to life roles and social affiliations, and may assist nurses to empower young women to make educated lifestyle and role-related decisions that enhance their health. Studies on midlife men of various backgrounds would increase knowledge of how this subgroup of the population defines health as a basis of comparison to how the concept is known by women. Research on men's perceptions of multiple roles and social networks would increase an understanding of these variables on their lives, and may help future generations of men and women to solve inequities related to child care and homemaking roles.

Additional research is needed in the area of women as extended caregivers since their participation in this role is expected to increase. Likewise, studies of the effects of

foregoing childbearing until later in life are needed to better understand the impact of this relatively new phenomenon on a broad range of health issues for women and their families.

Research utilizing women as subjects is increasing, and has added greatly to the knowledge base of this subgroup of the population. More research is needed, however, to better understand issues regarding women's health and women's lives. Until we fully understand the meaning of health from women's perspectives, research efforts will be fruitless in generating recommendations for health promotion and enhancement.

## Implications for Nursing Practice

Women utilize health care services more often than men and are considered the gatekeepers to family health, yet little is known of the health needs and concerns of this subgroup of the population due the lack of research devoted to women's health. Even less is known about the health needs and concerns of midlife women – one of the fastest growing subgroups of the population. Prior to determining what women want and need in terms of health care services, education, and support, the meaning of health for women must be understood. This understanding must stem from women's actual experiences in order to be valid. Definitions of health for women not derived from their lived realities is speculative at best.

The meaning of health for women emerged from lived experiences of multiple roles in the context of social support networks. The sense of health as balance has tremendous implications for nurses. Women must be encouraged to participate in health-enhancing behaviors, but must be educated to do so in a way that fits in with the reality of their lives. Health care providers must be aware of the tremendous time commitment women have to

life roles and the potential impact on health in terms of stress, fatigue, and other potential health problems, and assist women to garner social support networks when they can be most useful – not when it's too late.

Perhaps most important, nurse professionals are in an excellent position to help women identify the root causes of ill health by assisting them to identify primary life stresses stemming from engagement in many life roles. Health care providers should take great caution in diagnosing illnesses, especially mental health problems, prior to gaining a thorough understanding of the elements comprising women's hectic lives. It may be that some women would benefit more from taking a nap than they would from the Prozac prescription – one more thing to put on the list.

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## Appendix A

### Interview Guide

1. Think back to a typical day in the past week. Describe what this typical day is like for you in detail from the time you woke up in the morning until you went to bed at night.
2. How did this typical day make you feel?
3. How do you feel the events in your typical day:
   a. Contribute to your sense of health? (mental and physical)
   b. Detract from your perception of health? (mental and physical)
4. In what ways, and by whom, do you feel supported in the activities of your typical day? Unsupported?
5. In what ways do you feel that the level of support you receive in your typical day:
   a. Adds to your sense of health? (mental and physical)
   b. Detracts from your sense of health? (mental and physical)

## Appendix B

### Interview Guide: Sample Answer and Probe Questions

Question 1: Think back to a typical day in the past week. Describe what this typical day is like for you in detail from the time you woke up in the morning until you went to bed at night.

"A typical day for me starts at five in the morning and ends at about midnight. I get up, fix a cup of coffee and just sit there for fifteen minutes to get myself in gear for the day. My coffee time in the morning is sacred to me. It's the only part of the day that is mine. Then I take a shower, figure out what I am going to wear to work, and get myself ready. If I don't do this first, I end up late for work because there is usually a last minute crisis getting everyone out of the house by 8:30. I usually have a load of laundry going, have breakfast ready for the girls and John, and lunches made. Susan reminds me that I have to go with her to back-to-school night, and I remember I have to take the cat to the vet at 5:00 p.m. - which means that I will have to leave work early. Then I think about what I am going to fix for dinner because John has a city council meeting and won't be home until 10:00. By the time I get on the road, which is supposed to be 8:30 like the rest of the family, it is usually 8:40 am., and I usually roll into work about 9:15. My boss lets me come in late if I take time off my lunch break. I feel like I've already had a full day..."

Example Probe Questions:

* After describing what you have done so far, could you elaborate on your alone time and the importance it has for you?

* Based on your description of the morning up until your arrival at work and felling like you already had a "full day", can you identify factors that caused you to feel this way?

## Appendix C

## Demographics Form

**Code #_____**

1. Age:_____

2. Highest level of education completed: (circle)

   1 2 3 4 5 6 7 8

   11 12 13 14 15 16 more than 16

3. Employment Status:

   Working Full-time_____ Hours per week_____

   Working Part-time_____ Hours per week_____

   Homemaker_____

   Other_____

4. Occupation(s):_____

5. A. Annual Family Income:_____

   B. Amount or percentage of your

   contribution to annual family income: _____

6. Marital Status:

   Single:_____ Married:_____ Partnered:_____

   Separated:_____ Divorced:_____ Widowed:_____

7. Who lives at home with you now? (Check all that apply):

   A. Live alone_____

   B. Spouse/Partner_____ Is partner: Male_____ Female_____

   C. Children_____ Total number at home_____

      age_____ sex_____ age_____ sex_____

      age_____ sex_____ age_____ sex_____

      age_____ sex_____ age_____ sex_____

   D. Parent(s)_____ age_____ sex_____ age_____ sex_____

   E. In-law(s)_____ age_____ sex_____ age_____ sex_____

   F. Other family members (list)_____

      _____

   G. Roommates_____

   H. Other (specify)_____

   I. Total number of people living with you _____

8. Do you assist in providing care for anyone, either in your home or outside of your home (other than employment related)?

   Yes_____ No_____

   If "yes", please describe:_____

   _____

   _____

9. List (**in order of importance**) the primary support networks in your life. Include only those that apply (i.e. spouse, partner, child/children, friend(s), church, other organizations etc...):

   A. Does not apply, I have no support network(s):_____

   B. Most important:_____

   C. Second most important:_____

   D. Third most important:_____

   E. Fourth most important:_____

   F. Fifth most important:_____

## Appendix D

## Health History Form

**Code #_____**

1. A. How would you rate your current physical health status?

   Excellent_____ Good_____ Fair_____ Poor_____

   B. If you answered "fair" or "poor", please explain why:_____

   _____

2. A. How would you rate your current mental health status?

   Excellent_____ Good_____ Fair_____ Poor_____

   B. If you answered "fair" or "poor", please explain why:_____

   _____

3. Please list any acute mental and/or physical health problems you have experienced in the last 12 months for which you sought professional treatment. Check here if none_____.

   Date Health Problem

   _____

   _____

   _____

   _____

   _____

4. Please list any chronic mental and/or physical health conditions you have experienced

that have lasted longer than one year for which you have sought, or are currently seeking professional treatment. Check here if none_____.

| Date | Health Problem |
|---|---|
| | |
| | |
| | |
| | |
| | |

5. Please list any medications (prescription, over-the counter, herbals, vitamins, etc..) you are currently on. Check here if none_____.

| Medication | Amount | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

6. Have you ever been hospitalized? Yes_____ No_____

If "yes", please explain:

| Date | Reason | Length of Stay |
|---|---|---|
| | | |
| | | |

IRB # 4181

Approved: September 20, 1996

**Appendix E**

**Consent Form**

THE OREGON HEALTH SCIENCES UNIVERSITY

**TITLE.** The Affects of Multiple Roles and Social Networks on the Physical and Psychological Health of Middle-aged Women

**PRINCIPAL INVESTIGATOR(S).**

Judith A. E. Chandler, RN, BSN, graduate nursing student, OHSU (360) 254-9396

Mary Ann Curry, RN, DNSc, WHCNP, FAAN, Research Committee Advisor, OHSU (503) 494-3847

**PURPOSE.**

You have been invited to participate in this research study because you are a Caucasian woman between 35 and 65 years of age. The purpose of this study is to identify and examine the multiple roles middle-aged women occupy in our contemporary Western society within their social network structures, and the impact on physical and psychologic health. You will participate in one small group interview session lasting approximately 2 1/2- 3 hours. You will also be contacted by the researchers after data analysis is complete. Follow-up contact will be via telephone, personal contact, or small group session depending on participant's availability and time constraints of the study.

**PROCEDURES.**

If you agree to participate in this study you will be asked to fill out a confidential health history form and demographics form. These forms will be mailed to you with a self-addressed return envelope approximately two weeks prior to the beginning of the study. You will be requested to complete the forms and return them in the envelope provided within 2 business days of the scheduled session.

You will also be asked to share your life experiences regarding the roles in your life such as paid worker, partner, spouse, mother, etc... in a small group interview of 2-3 other participants. In addition, you will be asked to share information about the social network structures in your life. An informal interview guide will be used to elicit information regarding the multiple roles and social networks in your life. For example, you will be asked to describe what a typical day is like for you and what this typical day makes you feel like. The group session will be audiotaped and the researcher may take written notes during the session.

After data analysis is complete, you will be asked to be available for follow-up contact, either by telephone, in-person contact by the researcher, or via a second group meeting with the same participants. Method of follow-up will depend on participant availability and time constraints of the study. Follow-up contact will last no longer than one hour and will also be audiotaped.

**RISKS AND DISCOMFORTS.**

Participation in this study will require a contribution of your time . Some participants

may find the sharing of personal experiences difficult, uncomfortable, or emotionally upsetting. There may be other unanticipated risks from participation in this study.

**BENEFITS.**

You may or may not personally benefit from participating in this study. However, by serving as a subject you may contribute to new information, which may benefit patients in the future.

**ALTERNATIVES.**

The alternative to participation in this study is to choose not to participate.

**CONFIDENTIALITY.**

Neither your name nor your identity will be used for publication or publicity purposes. Audiotapes will be transcribed with all personal identifying information deleted and no identifying information will be linked to your responses from demographic or health history forms. Audiotapes and field notes will be kept in a locked file and reviewed only by the nurse investigator. Following completion of data analysis, all audiotapes will be erased. It is expected that you will respect the confidentiality of other participants and not share any information outside of the group session. According to Oregon law, suspected child or elder abuse must be reported to the appropriate authorities.

**COSTS.**

There is no charge for participating in this study. No reimbursement or compensation will be given to you as a result of your involvement in this study.

**LIABILITY.**

The Oregon Health Sciences University, as a public institution, is subject to the Oregon Tort Claims Act, and is self-insured for liability claims. If you suffer injury from this research project, compensation would be available to you only if you establish that the injury occurred through the fault of the University, its officers, or employees. If you have further questions, please call the Medical Services Director at (503) 494-8014.

**PARTICIPATION.**

Participation in this study is voluntary. You may refuse to participate, or you may withdraw from this study at any time without affecting your relationship with or treatment at the Oregon Health Sciences University. If you decide to stop participating, the information you have already given will be destroyed. You will be informed of any new information throughout the study that may affect you regarding your participation. Mary Ann Curry, RN, DNSc, WHCNP, FAAN, has offered to answer any other questions you have about this study (503) 494-3847.

If you have any questions about your rights as a research subject, please contact the Oregon Health Sciences University Institutional Review Board at (503) 494-7887. Your signature below indicates that you have read the foregoing and agree to participate

Signature of Participant:_____ Date:_____

Signature of Witness:_____ Date:_____

Signature of Investigators:

_____ Date:_____

_____ Date:_____

## Appendix F

### Follow-up Interview Guide

1. How did you get to where you are now with taking on all that you do in your life?
2. What do you perceive that the current pace of your life does to your body?
3. What do you perceive that the current pace of your life does to your psyche?
4. Where do you see yourself health-wise with continuation of the current pace and the multiple roles in your life?
5. Does your social network structure play a part in either contributing to, or detracting from, your sense of health, or both?
6. What keeps you doing it?